proponents or opponents of something that they called CAM. They simply did what they did every day, and in our day and age, we have I think, unfortunately, confused the concept of religion and spirituality, and the claims that are made by many within complementary and alternative medicine is that it is somehow better because it is spiritual.

It trivializes -- trivializes the thousands of years of traditions by saying that this is only a property of those who use or deploy complementary and alternative medicine.

In that way, that is how I have looked. That is something I call CAM rhetoric.

DR. GORDON: Thank you, Linnea.

Ming, and then Tierona.

DR. TIAN: A question for the Table I. First of all, I understand that, first, the category is a system, medicine system. Regarding traditional Chinese or Oriental medicine system, does that include the acupuncture, Chinese herbal medicine, because the definition here is Chinese and Oriental?

I am a little confused what we are talking

about here.

DR. GORDON: In this instance, I would just like to ask you, how would you say it was best worded?

DR. TIAN: It should be traditional Chinese medicine. If you mention another, for instance, Ayurveda medicine, that is from India.

DR. GORDON: One thing that I think, that is an important point, one thing is these lists are not exhaustive, so it's fine to have traditional Chinese medicine if that is clearer, I believe, and there many, many. There are a zillion other systems besides the ones that we are listing.

DR. TIAN: Thank you. The second one, when we talk about second categories, I think we need to reorganize that, because you put that herbal therapies with mind and body methods, that is not accurate.

DR. GORDON: No, it is not accurate, and we just covered that when David raised that point earlier.

DR. TIAN: By the way, biological therapies is pretty confusing to me. What does that mean?

DR. GORDON: I'm sorry, which?

DR. TIAN: The first one, enzyme is very

confusing. This sounds like conventional medicine, enzyme, does that belong to dietary supplement or not?

DR. GORDON: Jim, do you want to address how you established these categories?

MR. SWYERS: I am going to punt this one to Wayne, because this is adapted from the table he gave me, so I will let him answer this one.

DR. JONES: Actually, this comes out of the five categories that NCCAM has in which there is biological and pharmacological therapies, and which they have a whole list, and if you want to list a bunch of them in parentheses to help clarify it, that could be done also.

DR. LOW DOG: Could you add pharmacologic there, though? It might make more sense.

DR. JONAS: I think it might be better to use the actual categories that are out of NCCAM, I mean the terminologies out of NCCAM. These are abbreviated in order to put them easily into a table form, but maybe you could sacrifice that and list the entire thing, which I can help you do if you want.

DR. GORDON: Wayne, what about just listing the

categories as opposed to all the examples that NCCAM has?

DR. JONAS: I think that would be fine. The examples, you don't have to list all the examples, but I think some of the example are helpful to clarify exactly what he said, what are biological therapies.

MR. SWYERS: Jim, the other way we could deal with it is if we don't want a list in the table, we could put it in the glossary and say here is what these things are.

DR. GORDON: I'm sorry. Let's come back to this issue again, because I want to move through all of them and I want to make sure we settle all of them in order.

Tierona.

DR. LOW DOG: I think that Linnea's comments about spirituality are very important to address because they are woven through much of this document, and I do think it is kind of a coaptation. The rhetoric is throughout the report, and I think we do have to be thoughtful. We may have read this so many times that we just don't even catch it ourselves, but even like on page 12, under Safety Issues, "Despite evidence that CAM

systems, approaches, and products are effective in managing and treating a variety" -- you have made a big statement there. Actually, there is not that much evidence for a whole lot of them.

It needs to say something like, "Despite evidence that some CAM systems," so I think we just have to be more thoughtful when we go back through the document, as a general comment in the text, to look for areas where we may have overstated or exaggerated.

DR. GORDON: Great. Thank you. Let's put that as a separate category to be discussed, that kind of rhetoric, and we can make some comments here, and then we may want to make some as we go along, as well.

Joe.

DR. FINS: I am just going to echo some of these things. This point on page 7, line 7, partly because conventional medicine has been slow in developing adequate treatment, it is like, yeah, well, we were really asleep at the switch here and we really didn't care about chronic conditions, it is accusatory like we didn't care.

I would just point out that there are lots of

new drugs for diabetes, which is a chronic condition, that spare people from insulin; a psychiatric illness, which is a chronic condition, we have had a renaissance in the treatment of psychiatric illness in the last 10 years, Cox-2 inhibitors for arthritis. There is this editorial tone here which is really unacceptable.

DR. GORDON: Okay. We have got that.

DR. FINS: Good. I want to just give you examples.

Then, we go into the notion here that CAM has been helpful for people with chronic conditions. I would add here protease inhibitors is a treatment for a chronic condition and we have one example here, about back pain, and that simply talks about people's preferences for the choice of practitioner is now a proxy somehow for efficacy.

The fact that people desired or chose or wanted to go to these people doesn't mean that it was safe and effective. Again, I think the disingenuous use of the data, about 83 percent of people using CAM for cancer ignores the vast majority who seek conventional treatment, and the scope of the intervention.

If you went to church and you prayed, you got listed as using CAM, and it is problematic.

Also, on page 10, there is a lot here, like on line 16. It doesn't makes safety and efficacy. People turned to CAM because they perceived their conventional drugs as ineffective. Perception is not necessarily evidence. It borders on anecdote.

We see that again on page 11, line 7, where physicians believe in the efficacy of these treatments, and then I think the bullet points on page 12 are very vague, that heart disease, well, what is the first article there? Benefits of CAM for heart disease.

Again, I think the point that Linnea and Tierona were making before is that it overstates the efficacy of these interventions to be proven, it understates the available treatments, and the final point, on page 14, line 29, is this line here that we want to have models where people are walking together, side by side, as equals.

Now, each of us as human beings are equal, and we all have intrinsic worth, but the interventions are different. I do not want to equate what we all do as

having parity. We make contributions in different ways.

I think that if we get over that desire to say that CAM is as effective, and you are trying to use these numbers to sort of say, well, look at the prevalence of the use, as a proxy for efficacy and for parity, is problematic.

DR. GORDON: Thank you, Joe. We are going to discuss each of these -- and I think the points are very well made -- we are going to discuss each of them in turn. I was just hurrying you through because I think we got the point that you are making.

Tom.

MR. CHAPPELL: Well, I think prevalence of use is an important indicator to understand the CAM movement and that efficacy is, in the final analysis, in the eyes of the beholder. You could give me a medicine that you say works in the lab, but if it doesn't work for me, it doesn't work for me.

So I think prevalence of use is a highly viable monitor and benchmark.

DR. GORDON: What I would like to do is to come back to that issue, not deal with that right now, but

come back to that one in order and deal with it as we go along, prevalence versus efficacy.

MR. CHAPPELL: Prevalence versus -- okay, prevalence versus proven.

DR. GORDON: So let's come back to that. What I would like to do is if these are the basic issues here, is to go through them one by one and have a discussion about them, and get a direction for the resolution of each one of these.

SISTER KERR: Jim, one of the things that I feel clear about, although I don't know how to necessarily articulate it clearly or have the response clearly, and my brother Wayne over here, I have often asked him to help us with this, one of the things that I feel we could potentially do today and in this report is collapse -- what I hear we are beginning to do is collapse into this research issue.

If you look at Dean's e-mail, you will see what he is saying. When we get into the evidence, and Wayne just made a comment I thought was good -- we were in the evidence rut. For myself, ever since we began the commission, I was always wanting this clarification on

research because even the most honorable person who knows there is issues in research wants to defend the public, wants to do the right thing, and we say, well, we need more research.

We all agree on that. But then we just collapse into this one model, and this conversation about paradigm and pluralism in research, I think we haven't really clarified that.

My own bias is a clarity, a statement about this actually give us the jumping off point for being the most visionary we could possibly be and bold, because we don't know how to still have the same honor of defending the people and speak about research in a way that allows us to be diverse and include things like CAM.

Let me acknowledge I am not being very clear and I am going to ask Wayne to help me out on this, but there is a clarity for me about the vision that is possible when we broaden this understanding, but speak it clearly about the potential of new paradigms in research, and because Wayne has volunteered to help me -- go ahead, Wayne.

DR. GORDON: Let me just ask both you and Wayne

whether this discussion is appropriate for this section or for the Research Section.

SISTER KERR: Let me speak first while I am bringing it up now. To me, my listening is that everyone has spoken to research in the last, I would say, 80 percent of the comments in some form, and that is why again I am trying to bring it up in a vision statement actually.

DR. JONAS: Well, I hesitate a little bit to get us out of the rut because it is not our rut. We didn't dig the hole. It is a rut that the entire country and the community has been involved in for a long, long time and will continue to be involved in, so I think we need to clarify the issues around that, and I think that can be done in the Research Section if we could then reflect back in some of these areas to those how it relates to research, then, I think that is important.

I think the way to deal with that in a section like this, which is not about research, is to try to come up with what has been suggested around the table, a nice, balanced tone, a tone that acknowledges the tremendous advances in conventional medicine that have really

revolutionized health care around the world, that acknowledges some of the limitations of those and some of the reasons that the public is looking for alternatives, and then some of the potential contributions and concerns that there are about that, and that is how we should do that and try to get away from whether any of the statements are based completely on research or not completely on research.

I think if we have a balanced tone on that, then, we won't fall into the rut in a section that really is not about addressing that, so that would just be my suggestion.

DR. LOW DOG: I just want to make sure that we are very clear that I think that this is a problem in the report, though, where we talk about prevalence and consumer-driven movements.

The 2001 Gallup poll was very interesting when you look at consumers' beliefs, just every-day Americans' beliefs in paranormal activity, you know, the amount of people who believe in astrology, you know, 40 percent of people believing in haunted houses and ghosts and witches, and things like that.

So beliefs and what we believe are one aspect of this, and prevalence, you know, the prevalence of people eating high-fat foods and smoking, and things like that, are very, very high, as well, but I am not sure we would advocate for them.

The last comment is I would have to say that I think that because Western medicine or conventional medicine has not found answers for all of the health problems or even something deeper that many people may be looking for, I am not sure that it is also going to found in CAM.

I think the reason for evidence is before we just bring on more things, that may or may not be the answer to these problems, there needs to be some evidence before we take it into the system that it is actually going to do something.

So I think prevalence and proof, I think that we have to address safety issues around prevalence because people are using things, so we need to make sure they are safe. I don't want to restrict their access to it as far as if you want to do it, but I think that before you begin to make public policies about what you

are going to integrate into a system, there needs to be more evidence.

DR. GORDON: What I would like to do is address the issues as they come up in this chapter, having heard the general perspectives, and begin to move through this because otherwise we are not going to be able to get through the report.

Joe.

DR. FINS: There was a survey in the late nineties about how people dealt with pain, and one of the things that was really clear about it was how people endured a lot of pain, wouldn't go to doctors to get pain control because they didn't want to cede the locus of control to a provider.

Part of that is consumer driven, but part of it is the fear that if I go to the doctor, I am really sick, if I need a stronger prescriptive medicine, there may be something wrong. I think part of what is going on here is the psychology and the sociology.

This is not necessarily the promotion of wellness side for people who are sick, and how we engage in all kinds of denial to avoid the encounter which might

break bad news to us.

So I think that there are multifactorial reasons why we seek to promote our own wellness and to maintain control. Being ill, requiring a healer's presence whether it's a physician or a CAM provider, or whoever, is a ceding of certain kinds of control.

So I would like a little more about the vulnerability, the sociology of illness here that captures why people might seek refuge in things that are less threatening.

MR. SWYERS: Joe, I just want to add that in the case of CAM, the surveys show that most people that are using it are the sicker people who have already been to the doctor, so they have already gotten the bad news, so they are looking for more options.

DR. FINS: That brings up the issue of palliative care, and I think one of the failings of conventional medicine is its failure to adequately integrate palliative care.

People can go to the CAM provider because we are a death-denying society and say I am looking for the heroic cure, when, in fact, they might be better served

by the wonderful services provided by the local hospice.

DR. GORDON: I would like to move through the list. We can raise these issues as they come up.

Ken, can we begin with the first of the issues?

DR. FISHER: [Off mike.]

DR. GORDON: On that issue raised by Tom, basically noting in the history that these were aspects of the movement in the direction of CAM, do we have agreement on this, that this is something that should be mentioned as part of the history of the movement?

MR. CHAPPELL: Ken, the natural foods business had nothing to do with taste. It had to do with nutrition.

[Laughter.]

DR. FISHER: Yes.

MR. CHAPPELL: It wasn't a culinary interest, it was a nutritional health fundamental, "I might live longer" issue.

DR. FISHER: I was just checking to make sure you all were listening to what I am saying.

[Laughter.]

DR. FISHER: Plus means that you want it added.

DR. GORDON: This is part of the background. The other thing that I would add, that I have written in a previous critique, is that, in fact, long before Americans were using the words "complementary and alternative," they were using the word "holistic," and I think that the accurate history needs to be "holistic" first and with a little description of what was going on among holistic physicians and nurses, and then "complementary and alternative" after that. Okay.

The second issue and, Ken, the political challenges to CAM?

DR. FISHER: This was Joe Pizzorno's comment about the political challenges to CAM then and now.

DR. GORDON: Joe, do you want to say what you feel is necessary to put in here given the fact that we want our tone to be fair and not be raising old battles that can't be solved?

DR. PIZZORNO: Well, first, this is a History Section, so we are not raising old battles, we are just simply stating what was, I think that has to be said, and I think we also have to say that there is still opposition amongst state medical boards to the licensing

of CAM practitioners, this being the fact. This is not us getting into an argument, the statement of facts, it is happening right now.

DR. GORDON: Let's discuss this one. We have discussion. Tierona.

DR. LOW DOG: I think that you can't have the conversation about the political aspect of blocking licensure without the discussion that a number of these CAM practices have not been shown to be scientifically based. It is a problem that we are having a hard time getting around, because it does impact the political system.

So I think that it is both. It is both parts of it. It is an entrenched system that doesn't want to let go and doesn't want to relinquish power, and that is there, there is no question.

There is also the flip side of that, which many of these are based on vitalistic sort of notions that may have been more relevant 100 years ago, may not be as relevant today, may be, but maybe not, and are not scientifically based.

DR. PIZZORNO: I just want to say,

Tierona, I agree with you. We don't want to say we are opening the doors to anything, but I think we have to deal with the political realities.

I think we should clearly mention the antitrust case that the chiropractors won against AMA, because that's clearly demonstrated it was based on economic realities, not on scientific realities. This is a matter of court record.

DR. GORDON: Other thoughts about this? Linnea.

MS. LARSON: I think this requires a little bit deeper thinking here. Joe Pizzorno, the doors are open to everything. Okay? But we do not legitimize through positive sanctions certain things. Okay.

That could be how you put that in the history. That is how we get confused on access and delivery, et cetera. So making claims that there is nothing, that is not true.

DR. GORDON: So how do you suggest framing this discussion? I think that is what we are looking for right now. Both Tierona and Joe seem to agree that it is important. The question is how to frame it in this

context. It's Linnea, Effie, Joe, and then David.

MS. LARSON: I just had a brain-block moment. David, you can have it.

DR. CHOW: I think we are still looking at a medical model when we talk about licensing, even though we don't say it is. When you say we can only license something if it's scientifically proven, I think the Indians are very smart, the Chinese are not so smart.

We are moving over the border and sacrificing our total approach, which is like taking acupuncture into separate entities.

DR. GORDON: Effie, I would like everyone to focus, though, on this particular issue. We are not dealing with licensure here, we are dealing with the historical question.

Forgive me if anybody feels I am being rude, I am really trying to get everyone to focus as closely as possible on the issue at hand, and the issue here is how do we deal with some of the historical and present conflicts between Western medicine and some of the other disciplines that are looking either for legitimatization or looking for licensure.

DR. CHOW: Well, the politics that Joe mentioned, Tierona brought up licensing, that you can't deal with the politics without mentioning about licensing, and I think with licensing, we have got to talk about then the fact that some cannot be licensed in the usual manner.

That is why I am bringing out the difference between the Indians. Perhaps their licensing is through the acceptance of the elders themselves, and by nobody else.

DR. GORDON: If I am following you correctly, you are saying that for a number of traditional forms of healing, that they lie outside of this kind of discourse.

DR. CHOW: Yes, this is my point.

DR. GORDON: Thank you.

Joe is next, then David and Wayne.

DR. FINS: I had asked I think at the very first or second meeting that we commission a historian to write the history of the movement, and I think now we know why that would have been a good idea.

I think what we need to do is appreciate that history is a mosaic of lots of different perspectives,

and what is written by one school might be different than another. I think the way we handle this perhaps is to cite scholars, not opinions.

You know, this scholar in his work or her work suggests that it was economically driven. Others suggested that it was a response to hucksterism. Others, you know, it was the rise of the scientific model and the NIH, and just diversion of funds.

I don't think the Commission can or should take sides on who was right or who was wrong but rather, just to explore the issues in a very balanced kind of way, and if people could supply -- maybe, Joe, if you can supply Jim with scholarly references of real historians, and then there are other sources, we can just kind of have a balanced treatment of it.

I think scholarship is really what is needed here, it is not a commentary, it's a scholarly take on it.

DR. GORDON: Thank you, Joe.

David, Wayne, and then Joe Pizzorno I think again.

DR. BRESLER: To take the balanced notion a

little further, I mean those of us in the early days know what the resistance was like. In 1972, it was 17 submissions to the Medical Review Board at UCLA before we got an acupuncture protocol approved.

So we could go ahead and list all these kinds of things, but in the spirit of balance and the spirit of keeping it positive, the fact is that they did approve it and that these changes did occur, and I think we can address some of the obstacles, but also address some of the ways that those obstacles were overcome and how basically, everybody is coming together to begin to facilitate this type of research now. Keep it in a positive.

DR. GORDON: Thank you, David.

Wayne.

DR. JONAS: I think we do need to describe what has been often very rocky and contentious political debates, which sometimes includes science, but most of the time does not, and we also need to emphasize the tremendous advances in science and conventional medicine that largely overwhelmed some of the alternative perspectives including the perspective of holism in which

there was minor movements that then kind of got buried, and this is now a resurgence of those, in fact, the third time in this country that they have come back in a prominent way.

I think a description of that is important. I mean I am not saying anything anybody else has not already said, but I think the balance in the tone, I think is important in this area, but on the other hand, there are continued political battles that are ongoing right now that are continued extensions of the history of this.

So we at least need to have an accurate description of those types of things.

DR. GORDON: So, Wayne, would you include those continuing battles, and if so, how would you address them?

DR. JONAS: I think in the History Section we need to describe them and then simply reference that there are continuing battles, because actually in the body of the report, that is when we get into the meat of trying to address some of those issues, so I don't think those need to be described in the History Section, but I

do think we think we need to acknowledge the fact that there is this, and has been, an ongoing kind of power struggle and political issues that involve practitioners of various types and the public and policymakers, and this type of thing.

DR. PIZZORNO: Well, thank you to the Commissioners. I think this was a very balanced conversation, and Joe Fins, I think we have full agreement, just we want to just kind of matter of factly say this is what happened, not take sides, but not also use as a door to open up anything coming into the system either, because clearly, they are having problems with inappropriate practitioners that we don't want to have practice, but there has also been a problem there has been an economic drive to some of the things that have happened.

So let's just be as objective about it as we can. It makes sense.

DR. GORDON: Are we agreed then, is this a fair representation? I am wondering, Wayne, if I can ask you, since you have worked on this section, if you could help to draft some of these historical issues. Work with Jim.

DR. JONAS: Jim has actually seen a number of the scholarly descriptions of this area. Again, the opinions even in those are quite diverse. Sure, I would be happy to help.

DR. FINS: Maybe a way of casting the History Section here is to simply state that the history of the rise of modern medicine in the last hundred years and the concomitant sort of fall and then resurgence of CAM is a complicated story. It is informed by current political pressures, and it sort of feeds on itself.

Anyone who is to engage in reform needs to be aware of this past and understand the continuing tensions that exist, but not take a stand, and then list different perspectives. I think I heard economic pressures, the rise of science, and then again I think education is another theme, and the Flexner Report needs to be mentioned and what that did for sort of the standardization of medicine.

The Kenneth Ludimer book, "Time to Heal," is a wonderful source for this history. It just came out, and it does mention some of these things, and I think it is a wonderful volume.

DR. GORDON: Do we have a sense of agreement and a sense of direction for Jim and perhaps with Wayne consulting and working with him on this? Good. Let's move on to the next one, Ken, please.

DR. FISHER: At the risk of being shot down, I would suggest that Item No. 7 is what you have sort of bridged over to Item No. 2 in terms of the success of conventional medicine, public health interventions, and the same. You have sort of talked about those in the same voice.

So then with that success in mind, I would suggest that in addition, the discussion of Oriental medicine also belongs up with additional topics, and if you will buy that one, then, I would suggest that the issue of mind-body medicine and Item No. 9 all refer to the accuracy and completeness of the table on page 2.

DR. GORDON: Ken, let me get clear. You are saying that No. 7 needs to be brought in as part of No. 2, and that that discussion needs to be woven together. Is everybody comfortable with that? Joe, are you comfortable with that?

DR. FINS: Yes, I think it is part of that

history story.

DR. GORDON: Great.

Wayne.

DR. JONAS: I agree with what you are saying, and there is actually a fairly detailed taxonomy of CAM already laid out.

DR. GORDON: That is the next topic. That is what we are coming to right now.

DR. JONAS: This relates to the table.

DR. GORDON: We are not on the table yet. We are talking about the evolution of conventional medicine going together with a discussion of the CAM/conventional medicine struggles. So that is all part of the history.

The next part does have to do with the table, so please feel free to comment on that. It has to do with Oriental medicine, mind-body medicine, et cetera.

DR. BRESLER: Oriental medicine goes with Restin --

DR. GORDON: What you are saying is that part of the rise of CAM has to do with the interest in Chinese medicine in particular after the Restin article.

DR. BRESLER: It just goes up with additional

topics.

MR. SWYERS: That is the James Restin article in the New York Times.

DR. GORDON: So that is part of the history, just the way the history of holistic medicine is part of the history.

The next issue has to do with the table. These are the points that Ming brought up, and that you brought up, too, and Wayne's suggestion was that we might look to the original table, the OAM and now NCCAM tables for the categories. Wayne, do you want to say more about that?

DR. JONAS: I would suggest that. I mean it has been worked on for many years, it is now kind of standard usage, and it's not perfect, but I think it would be useful to substitute that.

MR. SWYERS: It's on the NCCAM website, too, if anyone wants to look at it.

DR. JONAS: I would do that.

DR. FINS: Just to briefly go back to the History Section as just a caveat, I think whatever we write, we need to say that a full comprehensive historical treatment of this complicated subject is way

beyond the scope of this report, but suffice it to say, you know, and that readers are directed to, and maybe the bibliography for additional scholarly sources.

But I think we want to be very clear, and not attempting to be historians or scholars, because we are only going to briefly treat it to set up the current context.

DR. GORDON: Back to the table and the use of the NCCAM/OAM table.

DR. TIAN: I have one suggestion. I think it was very good mention, medicine system or medicine. We should say medicine, therapy, and the product. These three things are different, so we should not put them together even from the original table from NIH, the definition was not quite clear. We need to adjust a little bit at least the wording, make this better.

DR. GORDON: So these are different points of view, yours and Wayne's.

DR. TIAN: No. I would suggest to add my suggestion because basically, we are still using NIH, that listed all of them, because this table does not include everything. As I remember last time, we had a

reference. That table includes 33 medicines and the therapies if I remember the number.

Now, we cut some of them. Must be a reason. We have to say why not including those or even mentioned in the paper, NIH definition of CAM.

DR. GORDON: Wayne, do you want to address this?

DR. JONAS: I think the distinction between system, modality, product, and practice, et cetera, actually perhaps -- I don't know if this is adequate -- but in the footnote under the table, there is actually a specific discussion of that.

What happened in the classification is that systems became an entire category in which they talked about traditional systems, and they threw everything in. Well, in that one category are all the modalities, practices, products, et cetera, et cetera, if you were to simply look at the details of that.

Then, some of them were broken out and put into different categories primarily because these are ones that allowed Western folks to kind of get a grasp on aspects of it, like acupuncture, for example.

So, yes, that exists in the current system, and it is kind an inadequate dissection, but it is a dissection that I think is accepted.

I think if we use this reference on the bottom and explain this, and perhaps you would want it up in the text, but in a sense I like it set off. I think this, hopefully, would get at this issue of the system.

I am not sure if we want to modify that other than just describe the issue that comes even with the NCCAM definition.

DR. TIAN: I have no objection. I just wanted to mention that the medicine is medicine, therapy is therapy, and the product is product. The definition should be different.

DR. GORDON: Okay. Are we okay? Let's move on to the next issue.

DR. FINS: I think Ming's point is there is something there that is really important, and I think maybe stick with the table that was in the NCCAM iteration, but maybe say in the discussion that sometimes there are confusions that exist because we conflate all these things.

You might have practitioners who are multiply skilled, therapies that could be considered as being part of several different systems, and it is not so clear, and that what we might want to argue for -- and we don't do a great job of it in the report, though -- is that any policy that exists regarding CAM has to be very clear and specific about what we are talking about.

So definitional clarity, you know, any of us around the table is in favor of CAM at large. There are dimensions that we are against, and there are parts that we are for. So I think this might be a good place to talk about the need for diagnostic and definitional precision.

DR. GORDON: I think that is what Wayne was saying also, that some of that work has been done.

DR. FINS: Yes, but we didn't say it.

DR. GORDON: And that would be said. Is everyone okay with this? Good. Let's move on then.

Mind-body medicine. I have a paragraph, just a basic description of mine-body medicine, which I will give to Jim. Mind-body medicine is a separate. Was there more?

DR. FISHER: Well, yes, you need to clarify that, I think, because the discussion suggested that all of the different modalities would be associated with the development of a more comprehensive table and explanation.

DR. GORDON: In the NCCAM definitions, mind-body medicine is a category, and it's in there. I am not sure what you are saying. We are going to use those tables. We are going to use their definitions.

DR. FISHER: I guess what I am saying is that I am unclear. It was mentioned as a specific modality, but also so was holistic medicine, organic foods, Oriental medicine, but they all sort of subsume in a table.

DR. GORDON: Let me try to clarify. There is a table that discusses the modalities, the approaches, the systems as they are laid out by NCCAM. There is agreement that we are going to use that table with the addendum that Joe is speaking of.

There is a specific question in terms of the history of the development that relates to holism, relates to Oriental medicine, that is a separate consideration.

Joe.

DR. FINS: The other thing that goes with this, I think is sort of the rise of the psychoanalytic movement especially in the postwar period, and psychiatry, you know, the sort of inside-oriented psychotherapy was really in many ways a precursor, and I turn to you and David about linking up that history with this story, because in many ways, those are antecedents to some of the mind-body concerns and the therapeutic obsession that we all have.

DR. BRESLER: The early TM work, the biofeedback work, all those things should be mentioned.

DR. GORDON: I think the issue, though, is we have limitations of space, and I think we can mention it, otherwise, you are going to get into a whole complicated history which goes back much further. It goes back to Jung and other folks, as well.

MR. SWYERS: Jim, we also have a major time limitation, too.

DR. GORDON: Let's move on. I think commonalities of conventional medicine and CAM, have we addressed that sufficiently in the way we are taking up

No. 7? In terms of the history, commonalities in CAM, do you want to re-specify what you meant, Joe, and say whether or not you feel this is covered?

DR. FINS: I think we are talking about the Common Characteristics Section. We want to be a little less dichotomous, you know, those are them, and this is conventional, because there is that whole bio-psychosocial movement in medicine, and the primary care movement, in and of itself, was a counterculture movement in medicine, and the resurgence of family practice out of general practice.

All these things are whole body, kind of whole person, nonreductionistic approaches. We also might want to say that in some states even, which maybe it will come up later, is that at least in New York State, I think that the reimbursement that the state gives to residency training programs has a multiplier effect if it's a primary care program.

DR. GORDON: What you are saying in this section is to indicate some of the commonalities of primary care and the CAM world view.

DR. FINS: And I also would add more recently,

the palliative care movement, which is totally total person, and not only person, but the patient and the family approach.

DR. GORDON: Is everybody clear on what Joe is asking for, and in agreement?

DR. PIZZORNO: I think actually, Joe is asking for a new section, which may be a good idea. I think this one is about commonality of CAM systems within different CAM systems, not with conventional medicine.

So if you want to add another section about commonality with conventional medicine, that is probably a good idea, but that is different from what this section is supposed to be doing. This is within the CAM systems, between the CAM systems, not between CAM and conventional. It's page 3.

DR. FINS: You know what might be a nice way to bring this chapter together in a kind of concord kind of way, you know, we start with the history initially, and, you know, how we all didn't quite get along, all the tensions and all those perspectives, and then talk about the various CAM systems, but in a sense, there may be more commonalities than the history would have suggested,

and that gets us into more of an integrative theme.

So if history, what is now Common Characteristics of CAM Systems, and then Shared Characteristics, then a move towards --

DR. PIZZORNO: Another section.

DR. FINS: A new section, I agree with Joe. It's a way of trying to bring the history back together.

DR. GORDON: Linnea.

MS. LARSON: I believe Wayne provided a few months ago some kind of visual aid. Didn't you do another one, Wayne? That was one of the suggestions about six, seven months ago.

DR. JONAS: I put one in, and then I think, Joe, you modified it to make it more clear.

DR. FINS: We should bring that back.

MR. SWYERS: We have made several stabs at Vin diagrams. I think it would take a whole subcommittee a week to come up with one that everyone could agree on. I think language might be a little easier way to deal with it.

DR. GORDON: I want to get a sense, if we can, of agreement here. What is being suggested is that there

be another section, albeit a brief section, that talks about some of the commonalities between some of the developments within Western medicine and some of the development and the ancient history of CAM perspectives.

MR. SWYERS: Actually, I would like to suggest a section on convergence, how they are converging. I had made a feeble attempt to do this in an earlier draft that I could resurrect, but I think that is a better way to do it.

DR. GORDON: Are we agreed on this now? Wayne, go ahead.

DR. JONAS: I agree, I think that is good, however, what I would like to do is I would like to not just add it, I would like to substitute it for this section on common characteristics of CAM, because whoever wrote that I think should be taken out and shot, I think it's terrible, and we should eliminate that.

MR. SWYERS: Actually, Wayne wrote some of it.

DR. JONAS: I wrote most of it. That's why I can say that.

[Laughter.]

DR. JONAS: I did write almost all of that

section, and I think we should eliminate it, frankly, and we should substitute something along the lines of what we are talking about right now, which is the commonalities.

Within that, we can embed some of the reasons people have classified things as CAM or not CAM, which could be a very short thing, rather than trying to describe the details.

DR. GORDON: With or without gunpoint, would you undertake the job?

DR. JONAS: I won't write the common characteristics, I think Joe should do that, but I would be willing to put in the paragraph saying here is why things have been classified as complementary medicine, the reasons that have been given, very briefly describe that.

MR. CHAPPELL: I am wondering if it isn't more helpful to create that list of common interests as the interests of the consumer. I have the term "patient centered," but if we list these things as the longer list today of patient expectations or patient interests, then, neither camp has ownership and then you simply say that CAM has been early in some of these responses, and

conventional medicine is also responding with its own, but it takes away the competition and conflict, and places the subject at the center with the consumer driving it.

That is the way I would rather see this section structured than either/or.

DR. GORDON: Joe, we need to move ahead very quickly. We have a lot to cover. So I would like to get to some kind of closure with this.

Joe.

DR. PIZZORNO: Actually, Wayne, I don't think that person should be shot. I like what is in here because the idea is what is a commonality within the CAM systems, and I think this sums up pretty well, but I think we can do that commonality with conventional, we can bring in the parts that are appropriate, too, but I think that part of this is who are these CAM people, what is it about them, and that does this.

If you remove this, then, we have actually lost our only effort to try and define who this group is, so I really think we need to keep this.

DR. GORDON: Joe.

DR. FINS: One of the things that might be a helpful distinction for Jim, and I think it is on point with what Tom was saying, that one of the major differences might be a means versus ends kind of thing. If the best of conventional medicine is to enable people to achieve their goals and to give them wellness, and to treat their illness, we might use a scientific means to get there.

The distinction between how we got there versus what the goal is might be a way to have that convergence. I like convergence because, indeed, patients or consumers going back and forth are in their own persons converging these different streams.

But I think distinguishing means and ends interventions and goals is a way to perhaps reach some convergence, admittedly acknowledging that some of the goals may still be different, and that is where the Vin diagram is not a complete overlay.

MR. SWYERS: I would like to suggest a potential solution. We could save this common characteristics, but boil it down into a paragraph or two, put that up with the definitions and description,

and then have this history flow into a convergence section, because I think it does flow into that more than it does the way it is structured now.

DR. GORDON: Is that acceptable, agreeable to people? Okay.

Charlotte, go ahead.

SISTER KERR: My comment is just that I have been listening for the emphasis of this. I am not saying it is lacking, and it is probably in another chapter more, but when we talk about the chapter to talk about convergence and separateness and evolution, I just want to request that we are sure we have some of the philosophical developments, that we emphasize that, that we actually are moving into things like ecological paradigms, the re-enchantment of the earth, the understanding that the universe is an organism, that there are probability patterns of interconnectedness.

To me, this has influence and informs how we are moving, and I never quite get comfortable feeling we have acknowledged that, because, to me, it also is why we have this issue that goes on with research, just like the concept again of pluralism.

These are concepts that come out of real evolution of consciousness that is trying to go on. So I am really requesting that we emphasize that.

DR. GORDON: One suggestion I would have, Charlotte, I think that that aspect, that emerging world view really comes under the rubric of holism, that is, holism is one way to describe some of what you are talking about.

So in the history of the development of holism, you could address some of these other sort of philosophical, cultural, spiritual issues.

DR. JONAS: Exactly, and that forms the foundation for the commonalities that we are talking about and some of the characteristics we want to see emphasized.

DR. GORDON: Jim, are you, as the man who discovered China used to say, perfectly clear?

MR. SWYERS: Maybe. No, actually, I think I am seeing the light here, the light at the end of the tunnel starting to come through.

DR. GORDON: It is important that either you are clear or that you get clear, because we are depending

-- and this is true in working with all of the staff -- we don't have much time, so what needs to go out next to the Commissioners has to be as full and accurate a reflection of the discussion here as possible.

MR. SWYERS: I think between Wayne and I working together and working with you, we will be able to answer all of these concerns. I don't think we will have much of a problem doing that. There is going to be a little more adjustment problems and seeing how it all fits together, but that is always a problem.

DR. GORDON: Linnea, what?

MS. LARSON: I can provide you technical assistance, too.

DR. JONAS: May I mention just one other thing? There are some very nice things written about how research has evolved because of unconventional approaches, and I think you are familiar with those, but there is also a book that has just been published by the Hastings Center called "Pluralism in Medicine."

It is specifically on complementary and alternative medicine, and there are some very nice things written about the historical issues and some of the

topics we have talked about, so we can get you a copy.

MR. SWYERS: I think if you look back to some of my earlier drafts, I did touch on some of these issues, so I can back. I mean we are not going to have to start from scratch to do this. So it's there, it is just a matter of pulling it all together.

DR. GORDON: Let's move ahead. Ken, we are on No. 6, I believe.

DR. FISHER: Well, I am going to try another ploy since I had two successes and one failure, and that is, the issue of the rise of diagnostic clarity and the rise of pluralism really are a neutral and balanced part of No. 2 on political challenges.

DR. FINS: History. History.

DR. FISHER: On history, yes, thank you, Joe. So that leads us down to No. 8, which you have already identified as general aspects throughout the entire document. If you agree to that, then, we move to No. 10.

DR. GORDON: What I would like to do is talk about No. 8 here and get some clarification of the concerns that people have about CAM rhetoric in this section, so that we can deal with them and make sure we

are all on the same page.

Joe.

DR. FINS: I think the issue of prevalence is important vis-a-vis public interest, so I think if there was no prevalence, we wouldn't be here. That addresses Tom's emphasis, I think, on that. I want to just distinguish the difference, that prevalence should not be in any way equated with efficacy or demonstration of safety or efficacy.

There are things that are prevalent, like smoking, which is dangerous, and it is effective in promoting lung cancer and heart disease. So the fact that people do it does not mean it is initially endorsed.

So I think we can deal with some of these overreaching statements that somehow say that people perceive it to be efficacious, I mean it has meaning to them, and it is used, but it should not be presumed because it is used, that it is effective.

We actually later on say that we need to demonstrate safety and efficacy, and we do come back to research, and the rut in that ground is, you know, it is a $20 billion endeavor with the NIH funding.

I mean Congress, as a body, and the country, as a while, has invested itself in research to great effect, so I don't think we want to go against that. I think the balance here rhetorically is to say it is being used, people really value, it's important in their lives, but as yet, that does not in and of itself mean that it is safe or effective, and what we want to do is strive to have mechanisms that will that use more beneficial and less dangerous.

DR. GORDON: This is an issue, Joe, I think you will agree that this is both No. 8 and No. 10 that we are talking about. The specific is under No. 10, prevalence versus efficacy, but it also relates to No. 8, which has to do with rhetoric.

DR. FINS: The parity thing is a different issue, I think, which is 10.

DR. GORDON: No, we haven't discussed parity yet. No. 10 is also prevalence of use, efficacy of treatment.

Let's have comments. What Joe is addressing is an issue that has to do with rhetoric, making a clear distinction between prevalence and efficacy with no

implication that prevalence implies efficacy.

Tom.

MR. CHAPPELL: Joe, I think prevalence needs to still be held up for accountability of safety. It is not either/or, I think it is prevalence and accountability. I think if we start to use the word "accountability," you know, I am not saying CAM is accountable to conventional medicine, I am saying CAM is accountable to public health and the authorities of public health, which is the government, so I think prevalence which is supported by an accountability to safety and efficacy is the point.

DR. GORDON: Jim.

MR. SWYERS: I think a potential solution here is that we could keep the information on prevalence and usage, but add the caveat that Joe is talking about as a transition paragraph, then, that leads us into the safety and efficacy part, and then we can take a look at that language and make sure that that has been done.

DR. GORDON: I would add to that I think this really is here, this is about prevalence. Efficacy will come in, in terms of discussing research, it will come in, in discussing cost-benefit studies. It may come in,

in terms of access and delivery, other sections.

I think here you are describing what the landscape is, and not saying necessarily that these things work.

DR. FINS: The problem is as it is read. I know what we intend to do, but you don't have prevalence for the conventional interventions, and this is not conventional medicine, I admit that, but I am concerned that if we simply have a little caveat that prevalence is not to be equated with efficacy or safety, that it will be a one- or two-line thing, and then we go back and we create the same impression.

So I just urge you to be editorially careful.

MR. SWYERS: Well, I would ask if you could help us with that language.

DR. FINS: It's on the record, I think.

DR. GORDON: Joe, one simple thing, for example, is the study that is quoted, and this is the way I would quote it, the M.D. Anderson study, if you eliminate spirituality, the figure is 69 percent, and 100 percent of those people are using conventional therapy.

DR. FINS: But it is a matter of scope. See,

that's the thing. I mean if somebody has gone through two years of chemotherapy, and let's hope they have done well, and they have had surgery and radiation, and their has been unfortunately dominated by that therapeutic endeavor, and they are taking vitamins once a day, the percentages, you say, well, were they using conventional, were they use complementary, it looks like there is parity.

So we are not capturing the qualitative, the qualitative difference in the investment, the experience, and that is what gets somewhat misrepresented here.

DR. GORDON: Is that clear, Jim? It is not clear. What is not clear?

MR. SWYERS: I think it is important to present this kind of information, but how to present it in a way that it is not perceived as stating that CAM is somehow efficacious to these people, I am not quite sure how we can do that without going into the kind of language that Joe was talking about, saying that we have to emphasize that this doesn't mean that because people perceive --

DR. GORDON: Are these responses to the question that Jim is raising? Joe Pizzorno, and then

Tom.

DR. PIZZORNO: I fully concur with Joe's point that we don't want to imply that prevalence is indication of safety or efficacy. I think the purpose of putting prevalence is to show why the work we are doing is so important, because, indeed, a lot of these things are being used. The medical practitioners don't know they are being used, and they can clearly impact the efficacy of the therapies being used and the safety of those therapies.

So, clearly, the fact that they are being used is what is important, not whether they are safe and efficacious.

DR. GORDON: Tom.

MR. CHAPPELL: I think the Historical Section needs to deal with prevalence, and it needs to also deal with the current concerns for safety and efficacy, so I think it is sequential and it all leads right into the rest of the report.

DR. GORDON: Jim, how are you having heard these two pieces?

MR. SWYERS: I think we can improve on it, but

I think it will take people like Joe to look at the language and make sure that we have done it properly.

DR. GORDON: What is emerging here is that on certain sections, it is clear that commissioner input will simplify the process and make it much more likely to succeed. So I am wondering if we can rely on Joe, for example, for you to lend some help here.

DR. FINS: I totally endorse that involvement, but I am very concerned about the logistics of this, the time frame, our availability, when we are going to get these documents, and I think that we haven't even gotten to a single recommendation yet, and there is a massive amount of work to do.

I think we need to just, as they say, take a time out, and get a sense of just the game plan, because it is not enough that I am on-board, and then Tom has got to have a look at it and make sure that we haven't, you know, in moving in one direction, offended another commissioner's perspective.

DR. GORDON: Which we will. What I want to do is over lunch we are going to discuss some of the logistics of this. I want to move through this section,

finish this section, then go to lunch, and then talk about how we are going to work on recommendations and the rest of it over lunch, and then manifest it this afternoon as we get into the sections with recommendations.

MR. SWYERS: Jim, could I ask a quick question? Is the feeling we need to enhance the prevalence, but that it needs to be presented in a very delicate manner, in an objective manner?

DR. FINS: I think prevalence is why we are here, but I think the way it is currently drafted, it would suggest greater efficacy based on those good prevalence numbers, that has yet to be proven, and it's oppositional, too.

MR. SWYERS: So, would it be better if we prefaced the information on prevalence with those kinds of caveats rather than as an afterthought? Would that be better?

DR. FINS: Not to recapitulate what we said, but on page 7, line 7, it is because conventional medicine was slow on developing adequate treatments da-da-da, all these other things happened, and they are

responding to a need that conventional medicine did not meet, and that is the kind of setup that sets this whole thing in opposition.

MR. SWYERS: I have agreed we are going to address those kinds of things, those kinds of concerns.

DR. GORDON: Any other issues on the rhetoric? Yes, Veronica.

MS. GUTIERREZ: Before we get too far away from safety and efficacy, as it relates to CAM, I would like to say there is probably many people in this room that feel that there are questions about safety and efficacy in drugs and surgery, as well, so if we are going to discuss safety and efficacy, I would like to have it put in perspective of that is an assumption that we will use in addressing all approaches to health and disease.

DR. GORDON: Any response from other Commissioners?

MS. LARSON: I don't understand what you just said, Veronica. Could you repeat it, please?

MS. GUTIERREZ: We are talking about safety and efficacy. There is no drug that you take that doesn't have some safety factors and risks. The same for

surgery, you go under general anesthesia, there are risks. So we need to address the whole picture and not put CAM aside as a separate concern.

DR. GORDON: Any comments? Effie, you had your hand up.

DR. CHOW: A simple one.

DR. GORDON: On this particular document that Veronica has raised?

DR. CHOW: No, I agree with her.

DR. GORDON: You agree with her. This is something that has been sort of around since we began, how do we deal with issues of safety and efficacy with regard to both CAM and to conventional approaches, do we need to make a general statement, which we do in the Research Section? I think very clearly, we say the same standards. Do we need to make a statement in this section is the question Veronica is raising, about same standards for conventional medicine as for CAM.

Tierona.

DR. LOW DOG: The concept is very good, but yet if you have been in a car accident, and you are going in for emergent surgery to save your life, although there is

risk of anesthesia and there is risk from the surgery, the necessity of that intervention is high.

When you are talking about health promotion, and taking dietary supplements or vitamins and herbs that may or may not promote your health, may not contain what they are supposed to contain, may be adulterated, contaminated, et cetera, that is a very different risk-benefit.

So, I think that safety and efficacy is very important, and all health care providers should choose the least toxic, but efficacious treatment for the particular condition. I think if we make those kinds of statements, that that is where we should be moving, the least toxic, but efficacious, realizing that sometimes for it to be efficacious, there may be greater risk.

DR. GORDON: My question on the floor is do we need to make that kind of statement in this section, and if so, how.

DR. FINS: To add to Tierona's point, if you go to page 12, lines 16 through 18, the ethical doctrine that Tierona is referring to is proportionality and risk-benefit ratios.

So, we will assume a huge risk if there is a greater benefit, and we will not be accepting any risk if there is no benefit, and yet, if you look at line 16, "despite evidence that CAM systems, approaches, and products are effective," okay, you have categorically said that it is effective, we have not studied safety, when, in fact, we haven't proven efficacy at any kind of -- I mean if a well person takes a supplement that they did not need, that is yet to be proven to be safe, and has a bad outcome, even if the incidence of that is very low, it is an unacceptable situation.

That is what I think we are trying to say.

DR. GORDON: Joe, I hear you, but how would you deal with this issue? I understand what you are saying about those sentences being inappropriate, and how would you deal with the issue that Veronica raised? Would you talk about a doctrine of proportionality, or would you just let it go in this section, not include it here?

DR. FINS: I think what we need to say is that risk and -- and I just said it, and it's on the tape -- but risks and benefits have to be understood in their relationship to each other, and that's true for every

intervention that we do.

DR. GORDON: Understood. I am asking you, does that need to be said in this section or not? That is the question on the table right now.

DR. FINS: I think again the Blendon paper that we keep on citing suggests that the American public, not the people who testified here, but the people who were randomly selected, who did not select themselves, to show up at commission hearings, which is a selection bias, they want more regulation because they want safety.

DR. GORDON: I understand.

DR. FINS: So, if we are taking the consumer mantra and what the American public wants, and we are being responsive to their needs, then safety is part of the reality.

It is also true, I should just say, and you could say also the IOM report crosses the quality chasm and to err is human are also massively concerned about error and bad outcomes in the conventional side.

DR. GORDON: Please, come back to my question. Should it be in this section?

DR. FINS: Yes, I think it is a major driving

force for why we are here.

DR. GORDON: Good. Thank you.

Effie.

DR. CHOW: On rhetoric --

DR. GORDON: I want to talk about rhetoric, but I want to get some kind of clarity on this. Joe and Veronica agree, and Tierona agrees, that there needs to be a general statement about issues related across the board to benefits versus risks here in interventions.

Is this something that the Commission feels is appropriate in this section? I just want to get that nailed down, so speak, pinned down, and then have people come back to the rhetoric.

MR. CHAPPELL: On this point, I would like to see this common standard that Veronica is talking about addressed from the point of view of the accountability to public safety, that whatever system is employed, that that system, by nature of government authority, the government holds every system accountable for safety and efficacy.

DR. GORDON: Is everybody agreed on this? Tierona.

DR. LOW DOG: You even have under the crossing the quality chasm, No. 6, safety as a system property, and it talks about patients should be safe from injury caused by the care system, and I think you could just take that and add a few sentences around it that talk about that, and include it, and I don't think we have to have a lot more.

DR. GORDON: Thank you. We are in agreement on this? Good.

Julia.

MS. SCOTT: I just felt this whole discussion, addressing Joe's and other people's concern about balance would mean that we would point, as an example, we would point out if there was imbalance in one system and another as we are trying to get to convergence.

I mean clearly you can't just talk about what is lacking in safety and efficacy in CAM, without saying that there are also these things. This is the dilemma, there are also these things in other systems.

DR. FINS: Maybe one way to do that is to say that there has been a concern about safety in two IOM reports, and that concern for safety with respect to

conventional medicine really transcends the genre and should be applied to CAM, as well.

DR. GORDON: Thank you, Joe.

Let's move on. I think we have it. Jim, we have it?

MR. SWYERS: Yes.

DR. GORDON: Effie, you had a question about rhetoric. Any other issues about rhetoric? Rhetoric is still very much on the table. We have heard some of the concerns. Do you have any others, Linnea, anyone else?

DR. CHOW: I just want to make one point here, is that we talk about rhetoric, but we do have some statistics in here that talk about the success of CAM over conventional medicine, and the one that people keep referring back to is page 7, partly because conventional medicine has been slow in developing, but the page before, it gives an example about chronic lower back pain, not very effective, and if you look through, there are indications of studies.

So, I think if you think a statement is rhetoric and an overall statement, should look back on what is stated as statistics given here. I don't think

this is rhetoric as it has been put out to be, again, modifying that.

DR. GORDON: I am trying to understand exactly what you are saying. Are you saying that the lines 12 through 15, because they are based on data, are not rhetoric, but it looks like -- maybe this is my interpolation -- line 7 on page 7, for example is rhetoric?

DR. CHOW: I am saying that that has been pointed out as being rhetoric, and I think different parts in the section are stated as being rhetoric without reference back to the fact that there have been some statistics given.

They said, "For many chronic conditions" -- page 6, line 11 -- "For many chronic conditions, conventional medicine," et cetera, "provide only modest gains," and it gave an example, not going into many examples.

DR. GORDON: I would say that there is a difference between the two statements, that that statement on page 6, first of all, there is significant evidence to back it up. The statement on page 7, though,

it is sort of an attribution almost of intention, which I think is unfair. It is not that conventional medicine hasn't been trying to find better solutions, it is just that there have been limitations in the solutions they have come up with.

So, I think that is an example of rhetoric.

MR. SWYERS: Jim, I think we can just say "because of the slow pace."

DR. CHOW: It doesn't say it is incapable.

[Simultaneous comments.]

DR. GORDON: One at a time.

DR. PIZZORNO: I have some wording for that, that I think would work well, and that is simply say, "Because of the growing incidence of chronic degenerative disease." That way, we say there is more of it, we are not assigning blame, but it is driving the public to looking for more solutions.

DR. GORDON: Thank you, Joe.

DR. LOW DOG: I just also want to be careful when we have cited things, such as hypertension, heart disease, and diabetes, and even arthritis now, talking about only modest gains, and being careful, again using

references that are 20 and 30 years old.

I think the last 10 years have been really phenomenal at new drug therapies that we have, which is not to suggest that there is not an incredible role potentially for CAM therapies in here, but I think that is another form of rhetoric that is also just not reflective of where we are today with current therapy.

DR. FINS: You have, like on page 12, lines 1 and 2, it's an oxymoron, "confirmed the potential benefits." If it's a benefit, it has been confirmed; if it's potential, it is yet to be confirmed. Anybody who reads this from sort of a sophisticated point of view, heart disease, it looks like it is like a 9th grade biology report, heart disease. I mean there are all kinds of heart diseases.

There is no specificity here, and in a sense, you are hurting your argument by giving this as evidence of efficacy.

DR. LOW DOG: The thing on heart disease was reduced or modified fat diet, so maybe it would be better just to put -- that that is what the Hooper paper is actually on. We need to be careful when you are talking

about -- the reason we have added potential benefits is because the back pain and headache were not conclusive in their findings.

Then, depression with St. John's wort, the Little and Parsons was glucosamine. So, maybe actually saying glucosamine for arthritis, reduced or modified fat diet for heart disease, so it is a little more specific in there.

DR. GORDON: I like that very much. We are okay? Great. Thank you, Tierona.

Joe.

DR. FINS: Even that reference that he just gave us, dates back to Framingham. It is not CAM. Reducing fat in your diet is a public health intervention. It has been Healthy People going back 2000, et cetera, and it is not CAM. So, to allege that it is -- it's a category error.

MR. SWYERS: These are all Cochrane systematic reviews in the Cochrane's CAM library.

DR. FINS: That is how they have categorized it, but the question is --

DR. GORDON: I think we have whole categories,

some would call it CAM, some would call it conventional. I don't think we can arrogate it totally to CAM, and then there is the whole argument about how low a fat diet, the argument that Dean has versus extremely low fat diet versus not so low fat diet.

DR. FINS: But you are using this as evidence base. You know, the sentence that precedes this is the CAM approach.

DR. GORDON: Why not say specifically what the approaches are, and not label them CAM or not CAM? So, the benefits of nutrition and exercise is here. The benefits of glucosamine is there. The benefits of whatever it may be, St. John's wort is there.

Is that a way to --

DR. FINS: This is an important distinction. I mean we are talking about glucosamine, we are talking about St. John's wort. Those things, I think are understood as complementary and alternative. But I am not sure that diet and exercise and fat reduction in your diet is CAM.

I mean there are lots of mainstream cardiologists and epidemiologists from the public health

arena who would see that as part of conventional practice.

DR. GORDON: Why not just say these lifestyle changes, and don't call them CAM, just call them what they are.

DR. FINS: Then, you can't use it as evidence of the benefit of CAM.

DR. GORDON: What we are interested in is trying to promote the larger perspective, Joe, as I see, is what is healthy for the American people. If diet and lifestyle --

DR. FINS: We don't disagree that that is a good thing. What I am disagreeing with is how it is being used as a justification here in the efficacy, but we will see how it turns out in the next draft.

DR. GORDON: I think it is partly a question, as long as it is not seen -- well, this is a long discussion, I don't want to get into the whole discussion.

DR. LOW DOG: I think the point we are going to keep coming back to it, though, is that because of the overlap that exists between complementary and alternative

medicine and conventional medicine, there is going to be this sort of conflict, that CAM is co-opting things or otherwise.

I think we are going to have to address this at some point. I know there is a number of Ph.D.'s or clinical nutritionists who have been sort of pounding the pavement, doing a lot of this research for 30 years, long time, who may have felt like they were CAM looking at how they were viewed, but they are very much within the conventional setting.

I think that we are going to have to address this somewhere, and it is one of -- like the CAM rhetoric, it is something that is sort of throughout the document that we are going to need to come up with some language for.

DR. GORDON: I agree. Maybe one of the ways, though, is in this section on convergence, that part of the convergence has to do, not just with bio-psychosocial approach, but with the emphasis on nutrition, exercise, and stress management, not just as ancillary, but as primary therapeutic interventions. That is a difference.

I think that the world view, the more holistic

world view has pushed these ahead and helped to make them more powerful, but they are not exclusive to CAM, and it is a place where they do converge, and maybe if we can talk about the convergence in a way that is thoughtful, that will help lay the groundwork, so we won't be mired in disputes.

DR. LOW DOG: Let me just throw out this here. To say that a reduced or modified fat diet is CAM, you are also going to have the other parts of CAM that are also under CAM, that believe that it is a high-fat, high-protein diet, that is most beneficial.

So, within the umbrella of CAM, you have very diverging opinions about nutrition, and one would have to really argue that much of this research that has been done on reduced or modified fat diets have really been done through the conventional research, and that right now, CAM nutrition is kind of all over the board.

What most of us would agree is a healthy diet is not shared by all people that fall under the rubric of CAM.

DR. FINS: Brown and Goldstein won a Nobel Prize for characterizing cholesterol and fats. So this

is mainstream science, this is not CAM. But I do think what we need to say here is that CAM, as a public movement, has mobilized people's adherence to healthy lifestyle.

In other words, CAM doesn't get credit for the lipoprotein (a) receptor. It gets credit for people thinking about I shouldn't have another steak, I should eat 2 percent fat-free milk or something. It's a sociological influence perhaps that takes the best of science and mobilizes healthy behavior. That is where it is a win/win for both sides.

DR. GORDON: Are we comfortable with this? Okay, great. Let's move on. Jim, are you clear, perfectly clear?

MR. SWYERS: Yes.

DR. GORDON: Ken, where are we now?

DR. FISHER: Well, Issue No. 11. Making a suggestion, Issue No. 11 is going to come up under Research, so maybe it should be discussed there. No. 12, the Sociology of Illness, I don't know whether you have discussed or not.

DR. JONAS: First of all, we already addressed

one issue, which is the importance of saying how modern research in conventional medicine did, in fact, cause a great rise in the interest and use of it, and that complementary medicine then was kind of pushed underground with that. I think that is what this is addressing.

Maybe I already said this, I apologize if I did, but I think there is some very good evidence that looking at these areas has allowed us to develop new methodologies and have evolved research.

So in the historical section, a reference and maybe a sentence or two on how the evolution of research methods has occurred because of the exploration of unconventional types of practices, blinding randomization, et cetera, for example, have evolved, and then were eventually brought into the mainstream because they were first used looking at complementary medicine, and this type of thing is continuing now in terms of trying to come up with standards.

DR. GORDON: So, history, part of that history is the history of the development of research you are saying?

DR. JONAS: Correct.

DR. GORDON: Is everybody okay with that? Is that being included? Okay. Ken, do we have anything?

DR. FISHER: Number 12.

DR. GORDON: Number 12. Sociology of Illness. Tierona.

DR. LOW DOG: I don't really know what it means exactly, what it was intended for, but when I read through some of the prevalence data here, I am also struck by cancer, HIV, pretty severe illnesses, and maybe this is part of the sociology of it, but why, when you are confronted with something that is very terrifying, why, people may be exploring lots and lots of way, I am going to cover all of my bases, I don't know if it is going to work or not, the studies haven't been done, but I am going to incorporate it into my belief system.

I think there is a tremendous amount of fear and frustration when people are confronted with these life-threatening illnesses, and that may be a part of this. I am not sure we have really captured that in this document.

DR. GORDON: So, a kind of framing the

discussion of prevalence with the discussion of what the psychology is of people who are using these therapies.

Tom.

MR. CHAPPELL: Actually, it doesn't feel right to me. I am glad Joe has returned, because Joe brought this subject up. When Joe was making the point, I didn't agree with it.

I think prevalence is simply a function of what consumers feel they need, and they seek out solutions. I don't think it has anything to do with whether they feel comfortable about finding out the truth from their conventional medical doctor. I just don't buy that premise at all.

They are solution seekers. That was Joe's premise. I don't buy that premise, these are solution seekers, and that is why prevalence has occurred, and I think this runs the risk of sending us into an area that is really highly interpretive and irrelevant. I would strike it.

DR. LOW DOG: Keep the prevalence, but not try to explain why, just to leave the data.

MR. CHAPPELL: Yes.

DR. FINS: I think it's probably best to strike it, but I do think maybe a kind of glancing mention to why -- I think this is why we really needed a sociology, sort of historical overview at the beginning, because people seek out these things for all sorts of reasons, and empowerment. I mean people made allusions to the feminist movement, the civil rights movement, the rights movements of the sixties.

People are empowered, and a lot of people have written about the empowerment movements. This is a kind of empowerment. It also gives people access to the fruits of science on their own terms.

I think there are also people who seek out, and we heard about desperately ill people seeking out CAM interventions because they are unwilling to give up. So, I think there are all kinds of reasons why people do this.

Ultimately, the bottom line is it becomes -- the markets reflect these individual needs in the aggregate. It's a complicated story, maybe it's too complicated to get into here.

DR. GORDON: It's getting to be time for lunch.

I want to see where we are with this particular issue, and this is the last issue on this chapter, and I would like to come to closure here, go to lunch, and then we will come back and begin with the other sections afterwards.

Effie.

DR. CHOW: I believe in the cautiousness and the quality and all of that about efficacious and safety, and all that. One thing we haven't really emphasized, and we have watered it down, is that people really do look to CAM, and they have been getting better.

In my work, I work with thousands of people, not just my own work, but with other practitioners. This is part of my life. I would say I see 1,000 people every month in contact somehow, input to me, et cetera. People seek it, not just to feel a little bit better, or just seeking like out of desperation.

Partly from desperation, but they are having side effects from drugs, and they are tired of not having the personal attention, and not having anybody to talk to, and we have said some of these things, but I think we keep watering this part down because we worry about

efficacy and safety.

So, cancer patients have gotten better because they have sought megavitamins and supplements, and all this, so we need a balance on that, that we really say very clearly that -- and there has not been -- there have been studies. Dean Ornish's study is one example, but there are some other studies, but there is not enough funding that is put in, so it goes back to research.

But I don't think we should diminish the fact that prevalence -- prevalence of usage means people are happy. If it increases, they cannot because they are getting side effects from taking these things.

DR. LOW DOG: I would just have to disagree with that. I think if we are going to scratch comments about reasons why are things, we need to do that, and I actually think that is probably appropriate, because nobody can really guess the reason why people use and turn, unless it was directly part of the survey and part of the research. We would just be speculating then.

I am not sure. Obviously, people are getting something from what they use, but again, I think we are over-speculating, so I would resist from using anecdotes

and resist from putting more into the prevalence than what it is, because we have not mentioned the driving influence of the marketplace.

There is a tremendous amount of advertising. There is a tremendous amount of misleading advertising out there as we heard from the FTC. That drives the use of products and services.

I think if we want to just keep it short and sweet, we list the prevalence, we don't try to get into the reasons for why people or this movement is moving, because it's multifactorial, but to leave it kind of as it is with just the qualifier that prevalence we are not say indicates efficacy.

DR. GORDON: Joe.

DR. FINS: It cuts both ways. It is just sort, you know, why people do what they do, and we do lose something, because I think some of the changes in conventional medicine, the rise of managed care, the change in the doctor-patient relationship, the decline of the family practitioner, specialization, the impersonal quality of the medical encounter has led many people to the complementary and alternative practitioner.

Both sides are responsible for all this, but I think it is so complicated, to do it justice would require a full report, and it opens up, as Dean would say if he were here, all kinds of red flags that we just don't need to navigate. The prevalence does speak for itself.

DR. GORDON: Charlotte.

SISTER KERR: I hesitate to speak, and I will, and I would like my fellow commissioners to listen, because I think I am really just again speaking back to my bias for how to proceed in general in terms of a philosophical basis and world view, because I feel when we get into these issues, again back to research, that it is true, and this is why I ask you to listen.

If we speak out of a shifting consciousness in the population and a different world view, we do begin to evolve, and I know -- I guess we don't have the research for this -- in what therapies we choose.

I will give you a clinical example. If a woman has a vaginal yeast infection, and the world view is one of cause and effect, reductionistic, you say why in the world would you not use Diflucan, you get rid of it, it

is gone, that's it. There is no consequences.

You perhaps might say, if you have a different world view of relationship and ecological, you might say I am going to look at the pH balance, I am going to look at my food, I am going to look at probiotics, I am going to think about what is my relationship to myself and to everything else.

It is the same reason as an acupuncturist, when I see research with osteoarthritis of the knee, and I put a study that the needle goes in the same place for everybody, I have absolutely no way to relate to that as an acupuncturist, because it's the valuing of the anthropological research, it's all the new models of research that, you know, God knows, Wayne has listened to me go on about this forever, and I frankly think this -- why we want to talk about convergence, we absolutely have a diversion because of shift in consciousness. Thank God.

I go nuts when I see Diflucan on Prime Time Network ads. I think it's the biggest women's issue going. So, when I hear, you know, the research models and the same bloody thing coming out, and it is probably

what I said two years ago, I just go, to me, it looks like a big compromise we are doing.

DR. GORDON: I think it's getting to be time for us to go to lunch. I would like to make a suggestion and see how this sits with people.

There is research evidence published in peer-reviewed journals that shows (a) that people are looking at these approaches when they have chronic illness, (b) that the world view of the practitioners is congruent -- this is Astin's research -- with the world view of the people who are looking for help, and (c) that people feel some sense of empowerment, as Joe suggests.

I would suggest that we can talk about those three as background issues without saying that they are defining, and that those three at least, and also the fourth issue has to do with more time spent, and I think that we are on safe ground as far as research goes if we say those things without saying necessarily that X, Y, or Z works, but at least these are clear reasons that are backed up by prevalence data and also backed up by the research data that has been done on motivation of people using these therapies.

David.

DR. BRESLER: I agree with you as long as prevalence data is suggestive and scientific data that is demonstrative, and as long as we keep that distinction.

DR. GORDON: It sounds great, but tell me what you mean.

DR. BRESLER: Well, prevalence data can suggest certain things. Controlled studies demonstrate that there is an effect there.

DR. GORDON: I am not saying there is an effect. I am saying that prevalence data demonstrates that people are using the therapies for specific conditions, that's all.

Is everybody okay with this way of approaching it without imputing other motives that we don't know about, I think it covers most of the bases that people are concerned about.

DR. LOW DOG: Right, because in the Research Section, one of the things that we requested research on because we found the data to not be very conclusive was why do people use and turn to alternative and complementary therapies, and what do they find

satisfactory and not satisfactory about it, and we dedicated a section on that, because we feel that this is an area that really does need to be explored more fully, but we felt that looking at the available research out there today, it is not very substantial.

DR. JONAS: I agree. I mean this is an issue, the issue of trying to get at values, and what are the values that motivate individuals can be investigated. That is all prevalence data, it is all extremely useful, it is all very important, and it has to be balanced and hopefully guide what you then study.

There are two different categories of research that really are looking at different questions, providing different types of information, and that is something that could be better clarified in the Research Section, but one could point to it.

DR. GORDON: That might be something to come back to when we come to the Research Section.

Tom.

MR. CHAPPELL: Jim, in the four points of motivation that you raised, I didn't hear you mention prevention or health maintenance, but I assumed in that

topic of congruence.

DR. GORDON: I think that in order to bring that one out, we need to present the data on it. This is one of Linnea's concerns. The date on health promotion is not in here in this section on that. Unless we present that data here, we cannot mention it here.

If we present that data, and pull some of that data from the Wellness Section back, then, I think we can fairly mention it. So, that is a task, Jim, for you and Corinne perhaps to look at and see if we can do some of that.

DR. LOW DOG: So, on the Sociology of Illness, sort of what I have heard is that we are going to leave the prevalence data, we are not going to try to expand on a lot of the reasons why that people are using it, and we may something to the effect of, you know, the many reasons that people explore complementary and alternative medicines is not completely understood, but then you may want to quote world view, more time spent, some of those things that there is some data for, and then we will go through the prevalence, and we will leave it at that.

DR. FINS: And then maybe conclude by saying

that really to further direct public policy in this area, additional research is needed to understand all the reasons why people seek out these interventions, and this will be addressed in the Research Section, which sets it up later on, the demography of CAM use.

DR. GORDON: Thank you. We have come through the first two sections. We are going to take a break for lunch. I want to introduce to the Commissioners, Tripp Fair, Bill Fair's son, who is here.

We welcome you, Tripp. It is great to see you. Please come have lunch with us. We will be eating lunch in the next room.

We are going to take an hour break for lunch, and then we will be back, and we will start with Research this afternoon at 1:20.

I apologize to those who came expecting Research in the morning. We are moving ahead with deliberate speed.

Thank you, everybody.

[Lunch recess taken at 12:20 p.m.]

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