used separately, there is no difference.

MR. CHAPPELL: There is only one world view in this statement at the present time, the way it is stated, and that is CAM needs to integrate into the conventional health care system, and I don't think that that is our vision.

DR. GORDON: I don't think that that is part of our world view.

MR. CHAPPELL: It is not, but I am just talking about this sentence.

DR. GORDON: It is talking repeatedly about integration and collaboration.

MR. CHAPPELL: Right, and so I would like the language combed.

MR. CHAPPELL: If everybody understands this principle, that we are talking about collaboration, and the point is well taken, and not just integration, can we move on because we are already at 3:30?

Linnea.

MS. LARSON: I know we already settled this. I just wanted to add one little tweak to the last one on 9. "Public and private resources should be used to support,

conduct, collate, and update systematic reviews of the peer-reviewed research literature on the safety and efficacy and cost-benefit of CAM practices and products."

DR. GORDON: Okay, everybody? Please nod your heads. We are talking about text here. General comments on the text.

DR. JONAS: Prior to the first recommendation is what I consider the heart of the research discussion, the text. I mean there are other things spread throughout, but I think these are some of the key issues.

I have a number of fairly minor edits, I think wording changes that I don't need to go over in detail, because a lot of them are fairly minor. However, there are a few things that I think I am obligated to at least say about because they may have some meaning differences.

DR. GORDON: Okay.

DR. JONAS: There are a couple of things that I think need to be added. I think the way the definition of CAM is co-opted by all parties to decide what research is being done or not being done, and where dollars go is extremely important.

The CAM community will co-opt things that are

traditional, that are conventional medical aspects, and say, oh, this is actually CAM all along. The conventional community will then co-opt standard things that they have been doing all along, and say, oh, now it is a supplement, so it's CAM, and this type of thing.

That has major consequences for the shift of research funding dollars and prioritization. So, I think we should describe that issue at least, so that people are aware that this is there, and that therefore the need for prioritization process.

So, that links us back to the actual recommendation where we say the IOM and others should -- but primarily the IOM -- should establish prioritization and definitional criteria.

So, I would like to add that in.

DR. GORDON: Is everybody with Wayne on that, or any questions about what he is saying?

MS. POLLEN: Yes.

DR. GORDON: Are we all right with that?

MS. POLLEN: I am not. I am not quite sure I know where Wayne -- Wayne, where were you with that?

DR. JONAS: Well, I was going to stick it under

No. 1, somewhere under No. 1.

MS. POLLEN: No. 1, you mean Recommendation 1?

DR. JONAS: No, under text No. 1, Research Support under Current CAM Research Activities. Probably I would do it on the third page, maybe line 18 or something in there, but we can find a place, because it is really a topic that is not addressed at all in here.

MS. POLLEN: And that is again the same issue which you brought up for the recommendation, which was the proportionality issue?

DR. JONAS: Well, it relates to the prioritization issue.

MS. POLLEN: Prioritization.

DR. JONAS: Yes.

DR. GORDON: Are you going to want to say anything about criteria for prioritization?

DR. JONAS: Well, yes, I would like to, but I think that those issues can be left to -- if that occurs, if the IOM says all right, we are going to do our process for looking at the prioritization, which, by the way, they have already said they would do, they developed a whole plan for doing it, in fact, then, that can be

addressed at that time.

I do think that to talk about the definitional issues as a way in which, without prioritization process, all sides begin to co-opt research dollars, and therefore, don't allow you to do proportionality estimates on these areas, should be at least stated in there as a challenge that justifies then this.

I would like to least say something about the definitional issues in terms of how that influences. I do think that a statement about -- I don't think the federal government should be expected to fund all things that are non-patentable, that is impossible, and some statement in there to that effect.

We have said that we think that they should fund more that is not patentable, but I think it should be clear that we are not going to rely on the federal government to do this, we need to be aware of that, that this is going a token in many ways.

MS. POLLEN: A bridge there could be that because the need is now, the federal government has to do what is necessary, but at the same time, there needs to be stimulation for the private sector.

DR. JONAS: Exactly, and we have that.

MS. POLLEN: And eventually, there will be less federal and more private.

DR. JONAS: I agree. We should make that clear in the text.

DR. GORDON: You can't lose the thrust that the federal government needs to step out and do it now, Wayne.

DR. JONAS: No, I agree. I am not saying not to do it. I just think that we should be aware that it is never going to be able to do it all, and we shouldn't be expecting that this should be the sole source.

On No. 3, in terms of the whole person, I think we also ought to add a little bit more emphasis on whole systems, whole persons and whole systems, and we have talked about that, it is fairly easy, the importance of looking at whole systems, and that is actually being done.

MS. POLLEN: Wayne, whole systems is picked up under Expanding Areas of Scientific Inquiry.

DR. JONAS: I saw that, and I thought it was weak in that area, but we could expand it in that area,

too, if you wanted to. I would like to have something about it under Whole Persons and Whole Systems. I think there ought to be something to emphasize that, and maybe it's a rearrangement of what is in there.

DR. GORDON: Are we all right on this, as well? Good. Go ahead, Wayne.

DR. JONAS: I think that we should put something in about the need to really look at research methodology for two purposes, one of which is to come up with standards that are applicable to complementary and alternative medicine, and this is probably the most problematic area, and let me explain what I mean.

The way I would phrase it is that we need to come up with creative methodologies, "innovative," you could use, et cetera, et cetera, to address areas that don't fit currently into a neat little bundle in terms of standard approaches.

For example, what if you never come up with an active ingredient, or you don't know what the active ingredients are in an herbal product, then, you will never be able to just plug it into a drug trial.

You can approximate it, but you can never just

plug it in like you would do a drug trial.

DR. GORDON: You would put that under No. 5?

DR. JONAS: Yes, I would put that under No. 5 exactly. Another area is behavioral medicine and mind-body types of techniques that involve learning. It doesn't mean you can't do good research on it, but it means that there need to be creative ways of addressing this, and this then backs up one of the recommendations that will go under No. 4, which is that the NIH should focus on development of creative methodologies that are specifically applicable to CAM in those areas.

There is a number of other minor things. I don't think that they are that important. I could actually put that also under Pluralism.

DR. GORDON: So, these are some changes, and, Wayne, you are going to be working on these with Gerri, is that right?

DR. JONAS: Yes.

DR. GORDON: Don had an issue, and then Joe.

DR. WARREN: Page 1, line 6. Instead of saying, "Cost effectiveness of CAM treatments," let's change that to "CAM care, and to discover the basic

mechanisms underlying this care," instead of these treatments. Not all of CAM is treatments, but it is care, though.

DR. GORDON: Is that okay with people? Let me see a show of hands. Okay.

DR. FINS: I think on page 3, to strengthen the argument here, lines 11 to 17, it would be helpful just to have percent success rates and how that compares with the other institutes.

DR. GORDON: Percent success rates?

DR. FINS: Scores, you know, people with certain scores and what percent rates, because if they are high scored, and as Steve said, they are in single digits, and other institutes are in double digits, then, that makes --

DR. GORDON: Can we get that information, Gerri, you think? Some of it may be a little hard.

MS. POLLEN: It may be very difficult to get that at this point.

DR. GORDON: We could probably get the NCCAM information, but not so easy to get the information from the other institutes.

MS. POLLEN: That's right.

DR. FINS: It is not a "must do," but I think it is worthy of an effort.

I just want to echo on page 4, lines 15 and 17, I think we have to really tread very carefully about the patent issue, intellectual property issue. We just have a couple of lines here, and I think it is better to just lay out why funding is necessary versus a resolution.

I think all this, the technology transfer, these are very complicated issues, and I think it is simply enough to say that there is a public health need, the kind of what we talked about with the recommendation, to protect the public. This is not always amenable to private funding for a variety of reasons including patentability, intellectual transfer of innovation, et cetera, and not get as much into it.

DR. GORDON: Let me make sure that everybody understands and that Gerri in particular understands, that everybody understands and agrees, and that Gerri understands.

DR. LOW DOG: Part of what I am hearing, though, is also that we don't have to come up with all

the answers for how these things are going to be implemented, that we can pose the problems and the reasons why they exist, and then we are making recommendations for people to try to figure out how to incentivize it.

We don't have to create the answers. We may come up with the wrong ones. I think that is what I am hearing.

DR. FINS: We haven't heard testimony and we haven't studied it in depth to make cogent suggestions about the resolution --

DR. GORDON: Joe, can you give a sense, maybe a clearer sense because people are a little confused of what you would like in place of that?

DR. FINS: I would say lines 15 through 18 or so, like we are making recommendations about tax incentives, market exclusivity, and resolution of intellectual property issues.

I think it is a little too prescriptive based on the nature of the testimony we heard, the expertise around this table, and the fact that there is a depth of scholarship in this area that we haven't even begun to

tap.

So, I think it is better to posit the problem than to try to fix it. I know you are saying "might consider," but it still comes across as too --

DR. GORDON: David.

DR. BRESLER: Actually, at the New York meeting, there were representatives of Wall Street there that some of us had a chance to talk to for a while about what was going on, they attended our hearings.

These were some of the things that they had suggested could stimulate interest in them getting involved in investing in this. I don't think it is prescriptive. I think these are action-oriented recommendations that we are going to make. I would vote to keep them in.

DR. GORDON: Julia.

MS. SCOTT: I agree that we should keep them in. They are not prescriptive. They are suggestions of ways in which it might be done. I think the other thing we need to keep in mind is, you know, you send up a policy recommendation to Congress. It takes on a life of its own, and they are going to whittle it down and change

it, you know, to do the minimum, many of us think.

So, we don't need to do that for ourselves. I think it is great to highlight pitfalls that might happen, but I don't think we need to cut it down or be that prescriptive, which I don't think we are in this case.

DR. FINS: I think it is an area of great interest and promise, and I just would editorially just tinker with it a little bit.

On page 5, I think that there is an element here about this going back to the very first introductory section about respect for the whole person, and I think we want to say something here about convergence and shared, you know, concerns about the broader bio-psychosocial model, not to say that only CAM is concerned about health and the whole person, going back to what we agreed to this morning.

DR. GORDON: How is everybody with that, okay?

DR. FINS: We agreed on it this morning, it is just consistent, I think.

DR. GORDON: I just wanted to make sure.

DR. FINS: On page 7, the expanding area of

scientific inquiry. I am reminded what Marcia Angell said, "Science is science," and I agree that there is a need for novel approaches.

You would use language like "novel approaches that maintain rigor," that maybe employ the social sciences, as well as the biological sciences, but this seems like a kind of a swipe at science, you know, "moderate reductionistic expertise," which I am not always a proponent of reductionism myself, so I find myself sort of out of place arguing for reductionism, but reductionism has its place at times.

I think we want to maintain the rigor of science here. We shouldn't develop a methodology that generates an answer that we want, but methodology that is rigorous.

DR. JONAS: Would you like a word change somewhere on this, on page 7? Do you want to get rid of "modern reductionistic expertise," or maybe make it approaches or something like this?

I think maybe the way it is expressed is perhaps a little unclear in the sense that what we want is we want to look at whole systems.

I think people are doing that. In fact, even conventional research, they are doing that, and perhaps we are talking about kind of objective measurements or something like this.

MS. POLLEN: Aren't we talking about bringing together both approaches?

DR. GORDON: Joe's point is that science is science, and Wayne's point is yes, science is science, and there are many kinds of science that need to be used. I don't think there is a contradiction, and I think that his approach will resolve it.

DR. JONAS: I am just wondering, are there some wording changes in this particular section that you would feel more comfortable with?

DR. FINS: I think a lot of us feel that, for example, acupuncture might one day be explainable through the biological sciences, through imaging studies. There is already some preliminary evidence that the neuroreceptors in the brain light up when acupuncture is done.

So, I don't think we want to necessarily foster the sense that because we don't have the science to

explain it now, that science one day could not necessarily explain it.

On line 16, Wayne, the spectrum includes areas of challenge, biological scientific concepts, and assumptions. So, you are challenging the scientific method, the scientific paradigm with some of these issues.

Some of these things are not studyable by science. Some of these things are not scientific questions, like spirituality, that is a different kind of question.

DR. JONAS: Perhaps the word is materialistic, challenge materialistic assumptions.

DR. FINS: I would say current biological and scientific assumptions. I think current would help a lot.

DR. JONAS: Current.

DR. FINS: How about our current state of knowledge, because I mean current state of knowledge about biological and scientific concepts and assumptions, but we are not challenging the scientific method. We are just challenging -- it is challenging the current state

of scientific knowledge. I can live with that if you guys can live with it.

DR. GORDON: I would like to live with it, and I would like to move on.

DR. FINS: I am done.

DR. GORDON: Any other issues here? We are now done with this section. We are going to take 10-minute break and then we will come back and look at Education and Training. Thank you, everybody.

[Break.]

Open Discussion: Education and Training

DR. GORDON: We are going to begin. The plan is as follows. We are going to begin with Education and Training, and then we are going to go to CAM Central, because some Commissioners are going to be working on Access and Delivery overnight.

Speaking of overnight, we are staying here until 7:00, and we will start again -- unless we pick up the pace, we are staying here until 7:00, and we start again at 7:00 tomorrow morning.

MS. SCOTT: Wait a minute. You need to say that again when the rest of the people are here.

DR. GORDON: I will. Let's get started. I will make the announcement again when they come back, but let's get started on Education and Training.

We are going to proceed the same way we did with consent. Yes? Okay. Julia is nodding her head. I want to see other heads, signs of consciousness. Good.

The first recommendation. "The education and training of CAM and conventional practitioners should be improved to ensure public safety and to increase the availability of qualified CAM practitioners and knowledgeable conventional practitioners."

That is on page 1. The first action item is on page 7.

DR. LOW DOG: I just want to say, as a general comment, the formatting should be consistent.

DR. GORDON: Is that okay with everybody? Consistency of format. Is that okay with all the staff, is everybody tuned in on this one? Okay.

DR. KACZMARCZYK: It was that way previously.

DR. GORDON: Are we agreed? The implication, Joe, is that the commissioners then decided they wanted a different format? We need to make sure that, as

commissioners, we agree with Tierona's suggestion that we want the same format for every section.

COMMISSION MEMBERS: Yes.

DR. GORDON: Great. There is the first recommendation and then action item. The first action item is page 7. The second is page 9. Third is page 10, and so on. You have to look through the whole text.

DR. GROFT: I think what we tried to do here was meet the suggestion that we put the action item close to the language in the text itself. I think that is why they are separated.

DR. WARREN: On Recommendation 1, line 25, page 1, it says, "should be improved." That implies deficiency. Could we put in there, instead of "improved," put "structured" as a recommendation? It says, "conventional practitioners should be improved." I would like to change "improved" to "structured."

Recommendation 1, page 1, line 25, fourth word, change from "improved" to "structured."

DR. GORDON: Should be structured to ensure, I see.

DR. WARREN: Basically, we are talking about

education and training.

DR. GORDON: Because the way it is now implies that it is not in good shape across the board.

DR. JONAS: What about "facilitated"?

DR. WARREN: No. Should be facilitated, education and training should be facilitated to ensure public safety? No.

DR. GORDON: How about designed?

DR. WARREN: I will take "designed." It makes sense, but "facilitate" doesn't really turn me on.

DR. GORDON: What is on the floor right now?

DR. LOW DOG: The Recommendation 1 on page 1. "The education and training of CAM and conventional practitioners should be designed to ensure public safety."

DR. GORDON: So, we are okay with "designed"?

COMMISSION MEMBERS: Yes.

DR. GORDON: Other issues and recommendations?

DR. PIZZORNO: Would you go back to why "improved" is not accurate because "designed" implies they are not designed to do this, or using "structured" means they are not structured to do this currently.

DR. WARREN: To me, it seems like when you say "improved," implies that it is worse than could be. It is, we know that, but I don't know, I like something a little more positive. "Improved" has more of a negative connotation to me.

DR. PIZZORNO: How about "enhanced"?

DR. WARREN: We will take bids on this. I move we accept this with the word "improved" changed to "designed," and accepted as written.

DR. GORDON: Okay. Julia.

MS. SCOTT: I have a problem with the second part of that sentence, "to increase the availability of qualified CAM practitioners and knowledgeable conventional practitioners." So conventional don't have to be qualified? I don't understand.

DR. LOW DOG: Could it be partly that some of these practitioners may not be licensed, so we are using the word "qualified," because some of them may not be licensed practitioners, and conventional practitioners pretty much, by definition, have to have licensure. I think that was maybe the reason "qualified" was chosen instead of using "licensed."

DR. GORDON: I thought of another word, which might be "scientifically-grounded CAM practitioners." I am open to other possibilities.

What we are talking about here, I think we need to look at the action items, and the action items, there is something about them I think that may not quite fit with the overall recommendation, because the action items are largely for CAM professionals to learn more about Western scientific methods, and for Western professionals to learn more about CAM approaches, so that is why I am trying to balance the overall recommendation.

Tierona.

DR. LOW DOG: I have a more fundamental challenge on this section here, which is because we are using the term "CAM," that it is just then all-embracing. I am not sure how much yoga instructors, how much Western science they really have to have. I am not sure how much Reiki therapists or polarity.

I think there is all these different levels, and so what we have just done is scientifically-grounded CAM practitioners, and yet there is a big spectrum of those.

DR. GORDON: How would you reconceptualize this recommendation in this section given what you are talking about, given that wide spectrum?

DR. LOW DOG: Well, I don't mind the recommendation as it stands. I think the text needs work, but when you say that the education should be designed to ensure public safety, that sort of means that each group, you are going to look at what their necessity is of how much they need to know of this, and then to increase the availability of a qualified CAM practitioner, that, you are just saying if he or she is a yoga teacher, that they are qualified to teach yoga, but that may not be the same requirement as somebody else, so I am fine with it.

DR. GORDON: So, you are okay with the current wording then?

DR. LOW DOG: Yes.

DR. GORDON: Linnea.

MS. LARSON: I don't have anything else really to offer than I do think that there really is an embedded assumption here, that that which we have now has not provided an assurance of public safety, and that actually

what we are asking for is a recognition that public safety, in what we think of as two worlds, is the most important thing. That is the recognition.

After that recognition is that whatever action items come will be to design to improve public safety. But there is an implication in here, whether we substitute designed, enhanced, or whatever, that public safety has not existed.

I think it is simply just I can't get my mind around the right words.

DR. GORDON: What is your position about the statement you just made? Do you think we ought to be focusing more in the text on public safety? I heard what you said, but I am not sure what the implication is.

MS. LARSON: The implication is that we need to have a better crafted recommendation. It is not within the text, it is a better crafted recommendation. At this minute, I don't have it at the top of my head.

DR. GORDON: Okay.

MS. LARSON: It is simply the systems that have existed for education have always included some level of public safety. What we are asking at some level is to

set up that qualified or licensed increases perhaps the public safety. That is another of the implications.

DR. GORDON: Charlotte.

SISTER KERR: I just pretend I don't know anything, and I look at Recommendation 1, and I see it as just a big run-on sentence, and it is just not clear, just to start there. I would say Recommendation 1. "The education and training of CAM and conventional practitioners should be" -- let's just say -- "designed to ensure public safety."

What I can't even help us with is what the heck we are trying to say in the second part. Are we saying the education and training of CAM and conventional practitioners should increase the availability of quality CAM practitioners -- period? Are we saying that? And then are we saying da-da-da should be to increase knowledgeable conventional practitioners? If we are saying that, that's all crazy.

DR. GORDON: Is what? I'm sorry.

SISTER KERR: It is not even a statement to me that is clear. Is that what we are saying? Is it basically three sentences, that education and training

should increase the availability of qualified CAM practitioners?

DR. GORDON: I think you are right. It is a little confusing, because it is two different thoughts. One is increasing availability, and the other is ensuring public safety, and it may have somewhat different mechanisms.

SISTER KERR: I think someone should say in just third grade language what are we saying. We know the first one, we have got that, we want designed to ensure public safety. Now, what do we want to say?

DR. GORDON: Joe K., do you have a comment on this?

DR. KACZMARCZYK: As I recall, the work group wanted to express two different views or ideas. Number one was the overriding emphasis on public safety. Number two was increasing the availability of both qualified CAM practitioners and knowledgeable conventional practitioners. That was the intent of the work group as I recall it.

Joe Pizzorno.

DR. PIZZORNO: I would like to suggest a slight

reword here. I think that is what we are talking about. "The education and training of CAM and conventional practitioners should be designed to ensure public safety and improve health." I think that gets what we are trying to do.

DR. GORDON: So, basically, you are eliminating the second thought because it is confusing and confounding, I assume.

SISTER KERR: It would be a very important recommendation if we want to say, we want to recommend that the number of qualified complementary practitioners be increased. I mean that is very dramatic and specific, but is that just the recommendation? No specificity, no whatever.

DR. GORDON: I have Tierona, I have Joe, and I have George Bernier. I'm sorry, go ahead, George, in his role as co-chair of this committee.

DR. BERNIER: Another way of expressing those three ideas together would be to say, "The education and training of CAM and conventional practitioners should be strengthened to ensure public safety and to increase the availability of both CAM qualified practitioners and of

knowledgeable conventional practitioners."

I think it was a pretty strong feeling of the committee that it was important to include both the CAM physicians and the conventional.

DR. GORDON: Tierona.

DR. LOW DOG: I agree that we need rewording, but when I read this, it is not to increase actually sort of let's bring on thousands more people, but actually, of the people that are already out there, to increase their knowledge base, so that those that are out there or those that are in training will have increased knowledge relevant to what they are practicing -- I mean that is part of it, too -- relevant to what their role is going to be and their scope, but your whole argument in this text is that conventional professionals need to know more about complementary and alternative medicine, so that they are more knowledgeable about what is out there.

The other argument was -- and I do have some caveats there -- that depending upon what your scope of practice is as a complementary and alternative medicine practitioner, that you have an understanding of Western sciences, and so that if we have this sort of cross-

training, that that will somehow enhance the public safety.

When I read this, I am not getting that we are going to increase the absolute number, but what we are doing, we are making more knowledgeable practitioners of both CAM providers and conventional providers.

DR. GORDON: I just want to check. Is that the intention, Joe, of this? If we are agreed on the intention, we can work on the wording.

DR. PIZZORNO: Let me try again. "The education and training of CAM and conventional practitioners should be designed to ensure public safety, improve health, and increase the availability of qualified and knowledgeable CAM and conventional practitioners."

SISTER KERR: I thought the ending was really good. I just had the question. You included "ensure public safety, improve health." You just feel that you want to amplify that?

DR. PIZZORNO: That's why we are doing it. We want the practitioner to be more effective in improving the health of the population.

SISTER KERR: And to increase the availability of qualified and knowledgeable CAM and conventional practitioners. If that is the intention, then, I think that is certainly clear.

DR. GORDON: Joe.

DR. FINS: I guess what is missing is the aspect of cross-training. It seems to me that if we could somehow capture in a preamble to this, you know, to promote the health of the American public as they make use of conventional and CAM modalities together and in isolation. You know, we recognize the need to improve the training of CAM and conventional practitioners.

DR. GORDON: What about just adding at the end, "and enhance collaboration among them?"

DR. FINS: But that is an access and delivery kind of thing.

DR. GORDON: I am not sure what you are looking for.

DR. FINS: I am saying that, again, the metaphor that I keep on thinking about is people going back and forth between two worlds, and we can't protect them in each of the worlds if we don't protect them as

they move back and forth in the transitions.

I think in order to meet the needs of the American citizenry as they make use of conventional and CAM modalities and treatments, together and in isolation, we need to have a work force that is appropriately trained with the interface.

I need to know something about acupuncture when my patients are visiting Effie, and she needs to perhaps know something about hepatitis B, so if a person comes in icteric, she will know to use universal precautions, and those kinds of issues.

DR. GORDON: My question to you is, does that need to be expressed in the recommendation, or can that be an action item?

MS. SCOTT: No, it doesn't, it's in the action item.

DR. GORDON: Was there anyone else before -- Julia is next.

MS. SCOTT: I was just going to say that a lot of what Joe is speaking to is in the specific actions. They are hard to find. I went to the Recommendation Section because they are all together.

In this one, it is labeled 1.2, but there are two, 1.2's on the recommendation page, so maybe in the text they will be separated out. They are? Okay. So, I guess it is 1.3.

DR. LOW DOG: Have we gotten consensus on this?

DR. GORDON: No, I don't think we have consensus. First of all, I would suggest that everybody look at the action items, and I know it requires a little paging through, and then see whether the recommendation, as stated and as amended, works with the action items or whether it doesn't.

MS. SCOTT: I would like to recommend that as Joe read the recommendation, it stand, and our other Joe's consideration of cross-training, et cetera, it is, I believe, covered in the action statements, as well as it is included in methodology when you teach. We can't do every detail of curriculum planning, and I think the spirit of that is definitely contained both in the recommendation and in the action.

DR. GORDON: Don?

DR. WARREN: Are we on action items now or what are we on?

DR. GORDON: I want everybody to look at the action items, so you know what they are, and you see how they go together with the recommendation, and then I would like a restatement of the recommendation for everyone's consideration. So, just a take a minute and look at the action items, if you would.

In this instance, all the action items go with one recommendation, so it is important to get the whole picture.

DR. LOW DOG: Maybe we should go through the action items.

DR. GORDON: The first action item is on page 7. "Conventional health professional schools, postgraduate training programs, and continuing education programs should develop core curricula of knowledge about CAM in conjunction with CAM experts and CAM institutions, so that conventional health professionals can discuss CAM with their patients and clients and guide them in the appropriate use of CAM."

Veronica.

MS. GUTIERREZ: I did e-mail a message about this. I thought the phrase "and guide them in the

appropriate use of CAM" resembled the gatekeeper mentality, and I would like to see the sentence end with "patients and clients."

That way we keep personal biases out of it.

DR. GORDON: Let's have any discussion about that recommendation.

Joe.

DR. FINS: I agree, it is really not about directing people, but maybe to maximize the benefits and minimize the risks. I would also take out this little parenthetical here, "in conjunction with CAM experts and CAM institutions."

That can be put in the text because all we are saying here is that these schools should develop a core curriculum about CAM, that would prepare -- prepare the conventional health practitioner or professional to discuss the risks and benefits of their patients' use --

DR. GORDON: We now have a suggestion, an amendment, and a second suggestion.

Tierona.

DR. LOW DOG: I also wish to take out "in conjunction with CAM experts and CAM institutions,"

because we also don't do the same when we talk about CAM education, we don't list in conjunction with conventional, so I think keeping parity there.

I just want to comment about the "guiding" them. I am not attached to that particular language, but there are a lot of people that are using CAM products that are not under the guidance of anybody.

They just go the health food store, they just purchase things, and nobody is giving them any kind of guidance, and I think it is to everybody, the chiropractors and the pharmacists and the dietitians and the doctor, I think everybody has to help guide folks, because a lot of what is being consumed out there is not being done through a CAM professional, it is just being purchased at a health food store or through multilevel marketing.

DR. GORDON: I want to come back to the second point that Joe raised, the "in conjunction with CAM experts and CAM institutions." At least a couple of people have said that should be stricken because it doesn't work both ways.

George.

DR. BERNIER: I think it was very clear with this group anyway that we felt it was critical for the CAM-accomplished individuals to be able to pass that education on to the conventional medical student, postgraduate, et cetera.

It seems to me we are running in two different directions here.

DR. FINS: I agree with that. I am just saying that it should be in the text, but not necessarily in the recommendation, like how you do it. I agree with the sentiment, but I think it goes into the text.

DR. GORDON: Is that okay, put that in the text, and not in the action item? I want to see heads. I want to see if that is all right. We are going to put in the text, and take out of the action item, the phrase, "in conjunction with CAM experts and CAM institution."

DR. KACZMARCZYK: It is already in the text.

DR. GORDON: Then, we take it out of the action. Fine.

Let's go back to the second point that was raised regarding the last clause here, "and guide them in the appropriate use of CAM." There have been a couple of

opinions expressed.

Other opinions on this one? My own opinion, in case you were wondering --

DR. FINS: You have been very judicious about sharing your opinion, and I really want to congratulate you for holding back. You have been great.

DR. GORDON: The reason that I think this could be important, and I am not totally wedded to it, but I think the concept is important because one of the main issues that I hear from patients, particularly patients with serious illness, is I want my doctor to help me figure out what to do, not just discuss CAM.

That is the first step. But they want to know, if they are going to see an oncologist, they would like that oncologist to refer them to somebody to give them more guidance about how to use these approaches, so that is why I felt it was important to put in here.

DR. PAZ: Well, you know, there is actually a fair amount of people who are not knowledgeable about CAM and their practices, so they do ask what would be appropriate. So, I think that would be very important to know.

DR. PIZZORNO: Veronica, was there other language you would suggest?

MS. GUTIERREZ: Language, no. If somebody felt that that was an issue, which is the other side of the scale, I suppose of what I am talking about, what I deal with in my office on a regular basis.

Perhaps there could be the discussion in the guidance relating to CAM, could be in the text of the document instead of the recommendation, and I will tell you my problem with "appropriate" use of CAM, it is just relating to chiropractic.

People have concepts of chiropractic that are as old as the profession itself, and we don't all twist necks, we don't all twist low backs, and we don't all apply force, but there are many, many medical doctors in our community that say, oh, don't go to a chiropractor, you know, you have got osteoporosis, or whatever.

Right at the present time, I don't think it is appropriate. Maybe it's a visionary thing that we can incorporate in the text.

DR. GORDON: Joe.

DR. FINS: The point here, it is coupled with

education, and that is why I want to use the word "prepare" them, that we should have these things to prepare these practitioners, so that they can discuss, but I think guidance is important.

It is not in any way meant to be like in a gatekeeper mode. It is really to have the heart-to-heart kind of conversation that allows patients to make informed -- maybe informed choices. Maybe that is the metaphor, "to prepare patients to make informed choices about therapeutic options."

DR. GORDON: Linnea.

MS. LARSON: I had a solution to the recommendation.

DR. GORDON: Okay. We will come back to it.

Joe.

DR. PIZZORNO: The majority of health care in this country is provided by medical doctors, and the majority of their patients are using CAM in one form or another, and the majority of them are doing it without guidance.

So, this is a problem that has to be addressed. I think one of the problems we have historically is we

don't trust the guidance they would get, because either they are not knowledgeable or they have biases, but we are about fixing that.

We need to fix this in a primary care environment, so people do get appropriate guidance, and that is why I was asking you for some other kind of wording we can use.

MS. GUTIERREZ: I like the phrase "informed choices," and perhaps the professionals can discuss CAM with their patients, and encourage all decisions be made out of informed choices, or something of that type. That is no problem.

DR. GORDON: Joe.

DR. FINS: Conventional health professional schools, postgraduate training programs, and continuing medical education programs should consider -- I mean that is the other issue -- should develop core curriculum about CAM to prepare conventional health professionals, so they can discuss CAM with their patients to help patients make informed choices about the use of CAM modalities, something like that.

DR. GORDON: So, you are crossing out the

"discuss," and you are saying to help patients and clients make informed choices.

DR. FINS: Yes, because it is a collaborative model, and it gets at Veronica's concern that we are kind of pushing them in one direction. The patient is making the choice, we are not making the choice.

DR. GORDON: It feels okay to me. Does it feel okay to everybody? Okay. Let's do it.

We are going to move on to Action Item 1.2.

For those who came late, after the break, we are going to be working until 7:00 tonight, and we are going to be starting at 7:00 tomorrow morning.

DR. FINS: This is part of new wellness effort.

DR. GORDON: After two hours of yoga the first thing in the morning.

MR. CHAPPELL: I would be available earlier than that, if you would like, tomorrow morning.

DR. GORDON: I have to take care of the animals and the fields first, so I can't get here until 7:00.

1.2. "All CAM education and training programs should develop curricula that reflect the fundamental elements of biomedical science and conventional practice

in order to ensure safe and beneficial care of patients."

Tierona.

DR. LOW DOG: This comes back to my earlier comment about we need to phrase this in a way that it is relevant to the practice, what they are doing, because again if you are doing yoga or Tai Chi or Reiki, I am not sure how much of this you need.

MS. LARSON: Same comment that I had.

DR. GORDON: Same comment. Okay. Good. Joe, do you have a suggestion about how to rephrase it?

DR. FINS: Yes.

DR. GORDON: Good. Please.

DR. FINS: So it is consistent with their scope of practice.

DR. LOW DOG: Conventional practice?

DR. FINS: [Off mike.] -- that reflect the fundamental elements of biomedical science and conventional practice consistent with the scope of their practice, their CAM practice.

DR. LOW DOG: Just their practice.

DR. GORDON: How about "develop curricula consistent with their practice?"

DR. FINS: Consistent with their scope of practice.

DR. GORDON: Scope of practice. That way, it is less clumsy. Okay? Are we all right with this one?

DR. FINS: "All CAM education and training programs should develop curricula consistent with the practitioner's scope of practice that reflects the fundamental elements of biomedical science and conventional practice in order to ensure safe and beneficial care of patients." We have an extra "practice" in there we can take out.

DR. GORDON: Tierona, you look troubled.

DR. LOW DOG: I just actually think it reads better when you put develop curricula that reflect the fundamental elements of biomedical science and conventional medicine or whatever relevant or consistent with their scope of practice because I think that is where it fits.

Or you can use conventional therapy, conventional medicine, you can put whatever you want, or just the elements of biomedical science.

DR. GORDON: Let's have someone state it,

please. Do you want to state it, Tierona, or, Joe, do you want to state it?

DR. LOW DOG: "All CAM education and training programs should develop curricula that reflect the fundamental elements of biomedical science and conventional medicine consistent with the practitioner's scope of practice in order to ensure safe and beneficial care of patients."

DR. KACZMARCZYK: Excuse me. Instead of "conventional medicine," I think it should be broader, "conventional health care."

DR. FINS: Instead of saying "consistent," say "relevant" now, "to the practitioner's scope of practice."

DR. LOW DOG: Can you put "in order to ensure patient safety" or something?

DR. GORDON: The question is do we have to add that last phrase, because that's in the recommendation.

DR. FINS: That's in the original recommendation, which we will get back to.

DR. GORDON: I just don't think we have to keep repeating that every time if it's in the original

recommendation.

Let's read it once more without that last phrase.

DR. LOW DOG: "All CAM education and training programs should develop curricula that reflect the fundamental elements of biomedical medicine and conventional health care relevant to the practitioner's scope of practice."

DR. GORDON: Don.

DR. WARREN: Did we change "biomedical science" to "biomedical medicine," which is what you just said?

DR. LOW DOG: Oh, is that what I said?

DR. WARREN: Yes.

DR. LOW DOG: I didn't mean to say that. I meant to say "science."

DR. WARREN: It should read, "All CAM education and training programs should develop curricula that reflect the fundamental elements of biomedical science and conventional health care consistent with the practitioner's scope of practice."

DR. GORDON: Relevant.

DR. FINS: One more delete stylistically.

Instead of saying "All," just say "CAM education and training programs."

DR. GORDON: "And foster collaboration between CAM and conventional students, practitioners, researchers, educators, institutions, and organizations."

Comments, additions, questions? Okay.

I just added one phrase, "To foster critical discussion and collaboration."

DR. FINS: No.

DR. GORDON: No, you don't like that?

DR. FINS: It is implied in there.

DR. GORDON: Fair enough. Are we okay with this? All right. Onward.

"Increased federal, state and private sector support should be made available to expand CAM faculty, curricula, and program development at accredited CAM and conventional institutions."

How are we with that? I added one little addition, which I will offer up. I would say, "Expand and critically evaluate." We don't need to put it in, I am just think it's important that we evaluate the efforts that we make in this direction.

DR. FINS: I think it is very important. I would endorse that strongly.

DR. GORDON: We are not really critically evaluating faculty.

DR. KACZMARCZYK: Well, it's faculty development, Jim, it's not faculty.

DR. GORDON: Faculty development, okay.

Is that okay, faculty development? All right.

MS. GUTIERREZ: If the institution is accredited, isn't that the job of the accrediting agency to critically evaluate faculty curricula?

DR. GORDON: My thought is that, for example, we have a grant at Georgetown to develop a CAM curriculum. A significant part of that grant is evaluating how well the curriculum works for the students.

I am just adding it. The reason I am adding it is because I think it says we are serious about this, this in not merely giving some money to folks. We really want to find out how it works. That is why I want to put it in there.

DR. FINS: Maybe there is another action item

here that is consistent with your insight here. Maybe support should be made available to accrediting bodies to critically evaluate.

I am saying like LCME, for example, we have no recommendations about LCME that go into, say, medical schools to accredit them. We have nothing about that, that I am aware of, in any of this, and the accrediting bodies, if they are going to accredit, say, a medical school's program in CAM education, so this is just on the conventional side, they are going to need some kind of guidance.

Now, maybe this is the next stage. Maybe George could comment on that.

DR. BERNIER: Actually, the LCME knows a lot more about what is happening in the CAM education process than I think we give them credit for. I can see that being over the next few years, a really key part of it, but I think at the moment, I would not add that last phrase.

DR. GORDON: 1.5, page 17. "The eligibility of CAM students for existing loan programs should be expanded."

MS. LARSON: I have a substitute recommendation that actually orients it to something that is doable. It is, "The Department of Health and Human Services should conduct a study to determine whether and in what ways and to what extent should eligibility be expanded to students of CAM."

So, it sets it up before we just willy-nilly, say, open everything up, and it gives direction to it. That is something that we need to discuss.

DR. GORDON: Joe.

DR. PIZZORNO: Aren't the chiropractors already included in the Heal Loan Program now?

DR. KACZMARCZYK: In the text, it states that chiropractic students are included in two loan programs, Heal and SDS, which is Scholarships for Disadvantaged Students.

DR. GORDON: Joe, expand on that a little. So, what is it saying and what is not being said?

DR. KACZMARCZYK: I don't understand your question.

DR. GORDON: You are saying two programs allow chiropractors in. In all states?

DR. KACZMARCZYK: These are federal programs.

DR. GORDON: And other programs do not allow chiropractors, is that right?

DR. KACZMARCZYK: Those, to the best of my knowledge, are the only programs that include CAM students.

DR. PIZZORNO: I think for those two programs, that students at accredited CAM institutions should be included, because that pretty much is going to limit it to those that have licensing standards. I think those are the ones that are accredited.

DR. GORDON: What is your position vis-a-vis Linnea's substitute?

DR. PIZZORNO: Since the doors already have been opened to those two programs for chiropractors, I think that any CAM student at an accredited institution should be eligible to those programs, but to open up other programs, I think we should go through this process that you discussed. I am kind of separating the two pieces.

DR. GORDON: Go ahead, Linnea.

MS. LARSON: So, you are saying, you limit it

to those programs, such as Scholarships for Disadvantaged Students and those from the Heal Program that already have scholarships and loans available for chiropractic students, and that you limit it also to those in accredited complementary and alternative medicine institutions, and then the rest of the programs that you would have feasibility studies for.

DR. PIZZORNO: Yes, I did, I agree.

DR. GORDON: Tierona.

DR. LOW DOG: These are loans, right, and you have got to pay them back. So, you have got to pay them back. Why is it even an issue? I just don't understand it. I mean if you are going to borrow money to get an education, whatever that education may be, if it's accredited, I just don't understand.

I think it is different when you are talking about loan forgiveness and primary care, and all that kind of stuff. This, to me, just speaks about loans and being able to get a low interest loan to go to school.

I would expect that whether you are going to be a teacher, or you are going to be a chiropractor, or whatever, so I just support that they should be expanded,

because they are loans, you are going to pay them back.

DR. WARREN: Aren't these loans federally guaranteed loans, so that if you decide not to pay them back, the Feds pick up the tab, and then they go after you.

MR. CHAPPELL: I am fine with the action as it is stated originally.

DR. FINS: I have a couple points. One is that chiropractic was singled out because it met a need. They went through with this process, said these folks are qualified for these loans because they fulfill a need.

I think Linnea's language that if other disciplines meet a certain need, then, maybe it's considerable as an option, but the one thing that I would -- and I am willing to kind of think about that -- the thing that I want to distinguish, though, is the National Health Services Corps scholarship, which has all kinds of associations with what is primary and underserved populations.

DR. GORDON: That's the next one.

DR. FINS: I think that is very different than the kind of language that Linnea had, you know, looking

at the viability of this without an endorsement of it.

DR. GORDON: I have a question, and this follows up what Tierona said, and Joe or others, Steve might be able to answer. If I can get a loan to go to school to study Serbo-Croat or to study becoming a beautician, why shouldn't I be able to get a loan to go to school to be a naturopathic physician?

I don't understand. I am sort of essentially saying the same thing Tierona is saying, reminding us that many of us may have gotten loans to go to college to study snowboarding or whatever it is we studied in college.

Charlotte.

SISTER KERR: I want to say my clarification of it, but in response to that, too, it may be that the committee should know more details to this, but what I wanted to say, I hear two options.

One would be the statement that Linnea made, which is that we do a study, and part two of that was what Joe said, that the professionals within accredited schools would be eligible, so that is A. B was to leave 1.5 as it was based on this philosophy that, hey, if you

want to go to school, you should be eligible.

If we go with B, which I am called B, 1.5 as it is, I think we should be very specific like the eligibility of CAM students should be included in existing loan and scholarship programs, period.

Now, the only C is whether or not there is some other information that we don't know, that is making this a big deal.

DR. GORDON: That is what I am trying to find out. Joe.

DR. KACZMARCZYK: It is not a big deal. The two loan programs that are referenced in the text, that is, Heal and the Scholarship for Disadvantaged Students are based on financial needs.

They are administered by the Bureau of Health Professions, Health Resources and Services Administration. They are included in legislation in Title 7, and it looks like in the 2003 budget, many of those programs are going to have significantly reduced funding.

Those programs are administered in part by the institutions, specifically, the SDS, so the money would

go from the federal government to the institution, and the institution would then actually implement and manage that particular program, and these are based on the financial need of the student.

DR. FINS: But also they have met certainly their professions.

DR. KACZMARCZYK: The profession is mentioned in the legislative language. Unless the profession is indicated specifically in the legislative language, a student of that profession cannot participate in either Heal or SDS, and the current legislative language specifies that chiropractic students are eligible for participation in Heal and SDS.

DR. GORDON: How does this relate to -- and maybe Joe Pizzorno can answer this, too -- how does this relate to ordinary loans that all students can get?

DR. PIZZORNO: Students at accredited CAM institutions are eligible for the same financial aid as colleges. The reason Heal exists and these others is because health care education is, at a graduate level, more expensive than the regular loan programs that are available. So, this basically adds to the loan limit

that students can get.

DR. GORDON: The first thing I would like to say that we need some of this background in here to understand why this is important and why this is even an issue, which is not immediately apparent to me or to Tierona.

Joe, go ahead.

DR. PIZZORNO: It is a problem because the students doing graduate education in CAM have tuition and room and board, and such, which is substantially in excess of the Stafford loan, which is what they are eligible for.

So, this is to put them on the same ground of getting more in debt as conventional medical practitioners.

DR. GORDON: So, there is a clarification.

Linnea.

MS. LARSON: I actually think that in the text, it is there. It just is not as clear as we want it. That is one of my suggestions. Actually, I have a visual aid of a grid, saying this is who is eligible, and this is how it works. I have actually written it out if

anybody wants it.

DR. GORDON: George.

DR. BERNIER: I just want to be sure that we are all looking at the same deck of cards. The students who are in the CAM programs are not eligible by the way the rules are written for the disbursal of HRSA loans or other ones that primary care physicians in the United States during their education can be fully funded through that, so it would require that the law be changed.

DR. FINS: And that means to designate those folks as primary care providers, which is, in my view, problematic, but my understanding from Joe here, is that this is a different pool of money that doesn't require the primary care designation, which is to me a critical distinction.

DR. GORDON: Can we have a recommendation for how to word this action item?

DR. LOW DOG: I just had another question, though, that I am still unclear about. Say it wasn't a health-related field, if I am going to go to law school, and it was going to be $20,000 for the year, and I didn't have anybody to help me, what funding would I go to for

that? I mean I just don't understand enough about the way loans work for these kinds of things to know what is available.

I guess I am an advocate for people being able to take out loans for education, and I just think that that is important because it is going to be paid back, so how do you make that available to people to get education, but I don't really know the extent of what is available out there and what other kinds of loans people could get.

If you are taking it away from a certain pot that doesn't have a lot of money, then, that is an issue that has to be considered. I just don't feel like I know enough about this to know where people are going to go get their -- where do people get their money?

DR. PAZ: One of the things to also think about is that with the loans, there is different amounts of interest rates of them, and some are much higher than others. Some of these federal ones have much lower interest rates than some of the others.

DR. TIAN: If I understand, I think that for CAM students, they do have it difficult to get a loan.

First of all, the school, for instance, either traditional Chinese medicine or acupuncture school, this school has to be nationally accredited, otherwise, you can't get a loan.

I think the point here is very important. We want to help those students they can get a loan, even that school may not be accredited now, may be in the future, but again it takes about three years, sometimes five years to get accredited, so I think that point is very important we should mention it.

DR. GORDON: Let's come back once again. We have the action item, we have Linnea's revision or alternate version or Joe's alternate --

DR. FINS: No, I don't have it. You see, I think this gets back to some fundamental issues about whether something is a profession, whether somebody is going to an accredited institution or not, whether there is an unlimited pool of money for loans, you know, if you said to me, you know, this money will prevent a respiratory therapist from going to school versus somebody to go to an unaccredited traditional Chinese medicine school, you know, those are tough choices.

DR. GORDON: I would like somebody to make a proposal. This is a very good discussion, and I think we are getting ready for a proposal here. We want to say something about loans, and I want to know, do we want to say what is written down here, do we want to say what Linnea said, or based on this discussion, do we want to say something else?

Tom.

MR. CHAPPELL: My recommendation is that this concern be dealt with in the copy of the text, and that the action remain as it is originally stated.

DR. GORDON: So that the action is the same as it is here.

MR. CHAPPELL: That's right.

DR. GORDON: And that the concerns be described in the text.

MR. CHAPPELL: Correct.

DR. GORDON: Linnea, do you want to respond or say whatever you have to say?

MS. LARSON: It's clarified if you look at the text with respect to loans and scholarships. It sets out there are these programs. The one that gets into the

issues about primary care is the National Health Service Corps. There is a rationale for this in the text. This is as it stands, and it is open enough.

The one that is the trickiest is the one that relates to the definition of primary care.

DR. GORDON: If that is the case, I would like to get final on this action item, and then move to that, that relates to primary care, which is the next action item.

DR. FINS: Linnea, do you still have your text somewhere, your original proposal?

MS. LARSON: 1.5 now has two parts to it.

DR. FINS: If we took Linnea's recommendation, we have here the way Tom has written in 1.5 now, it is "Existing Loan Programs," which would include all of them, all three categories. I think we might have agreement on Heal and SDS.

If we took Linnea's initial recommendation and said that they should conduct a study to determine whether, in what ways, to what extent eligibility should be expanded for Heal and SDS and accredited institutions.

The second question is the National Health

Service Corps, which is a separate issue, but I mean we might be able to agree to one, and not the other.

DR. GORDON: She said something a little different, Joe. I think what Linnea said was that chiropractors are getting the loans, all other CAM practitioners should get the loans, and that other loan areas should be explored and studied. You said it more nicely than that, though.

Go ahead, Linnea.

MS. LARSON: The text needs a little bit tightening up in terms of clarity of the programs. They are spelled out. There is an SDS program. There is a Heal program. There are some programs that only -- most of these programs. We are not talking here at all about the National Health Service Corps.

If this 1.5, as it stands, what Joe Pizzorno would like would be to add the portion of accredited, those who come from accredited schools. Then, we break it down into two separate recommendations. But the text can justify and has to be spelled out, because the text says this is what is available.

DR. GORDON: Can we have the wording on this,

please?

DR. PIZZORNO: Here is what I would like to suggest. "CAM students at accredited institutions should be eligible for Heal and SDS loans." So we just say just those programs just for accredited students.

MR. CHAPPELL: Then, who are we excluding?

DR. FINS: Those who don't go to accredited schools.

DR. PIZZORNO: And other loan and scholarship programs are not included. We are just doing just those two programs.

MS. LARSON: I think that is really good and clear, but what I feel unable to do in coming to closure to that is until I have that further discussion on the primary care and the other programs.

DR. GORDON: This is separate.

MS. LARSON: I know, but it may be limiting. I may want to include that in this recommendation.

DR. GORDON: Let's bracket this one. If we are agreed on this one, for now let's leave it at this, and then let's go on to No. 1.6.

Tom, are we okay with this one?

MR. CHAPPELL: I am not familiar enough with what schools we would be excluding that are not accredited.

DR. GORDON: Ming said schools that are not yet accredited or schools that never will be accredited.

DR. FINS: And students shouldn't go to those schools.

MR. CHAPPELL: And does the student loan program require accreditation anyway? Then, why are we editing the statement?

DR. PIZZORNO: Because if we don't say they have to go to accredited schools, that means all schools are open, and I believe we should not open loans to students in schools that aren't accredited because accreditation is our national standard to determine that schools have qualified faculty, good quality education, et cetera.

MR. CHAPPELL: I guess I would argue that we all have to start somewhere before we get accredited. In your experience, were you accredited on day 1 of year 1? Then, how do these people have a financial strategy that includes loans?

DR. PIZZORNO: It is part of the challenge for the student.

MR. CHAPPELL: It's not a scholarship, it's just a walk up the ladder, and these perfectly good -- and there will be new ones, and there will be more, they have a right for students to have eligibility for loans, as well, so, no, I don't agree with the edit at all.

DR. FINS: It seems to me it is unfair to the student to impose a burden of indebtedness to an entity, you know, based on an experience that doesn't give them a quality educational product, and schools should be able to get accredited.

MR. CHAPPELL: But they did get a quality experience at many of these schools that started before they were accredited. That is part of the chicken and the egg issue.

DR. GORDON: This is real difference of opinion. Let's hear some other thoughts about this, and see if there is some way we can reconcile it.

Joe, go ahead.

DR. PIZZORNO: Tom, having gone through this process, I am sympathetic to the challenge. As a

practical matter, I cannot envision the Department of Education accepting the responsibility to provide loans to schools that aren't accredited. It would open up the door to huge abuses of the system.

There has to be some way to determine which schools should have eligibility for loans and which ones shouldn't, and without some kind of standard, it's impossible.

DR. LOW DOG: I would just support that because part of even the accreditation process is just how you protect the students, you know, how are their grades done, it is this huge process, and the students really have no protection in unaccredited schools. It doesn't mean that they are not good, but I don't think we are ever going to get this passed, if it's not through an accredited school.

MR. CHAPPELL: I'll go along.

DR. GORDON: Thank you, everybody, on this one.

DR. WARREN: Who does the accrediting, is it a nationally accredited school or is it a state?

DR. GORDON: What does it say, Joe, in the Heal regulations?

DR. KACZMARCZYK: Department of Education.

DR. PIZZORNO: The Department of Education publishes a book of all the schools that are approved for accreditation.

DR. GORDON: Do you want to read that again, Joe?

DR. PIZZORNO: "CAM students at accredited institutions should be eligible for Heal and SDS loans."

DR. GORDON: Julia.

MS. SCOTT: I'm sorry, I got lost in all of that. I just want to make sure I got this. 1.5 now has two different sections, or there is one? There is one. Okay. So, what we are expecting is Joe's edit.

DR. GORDON: Just as he said it. Joe's revision of Linnea's edit, yes.

DR. GORDON: One of the nice things about this recommendation is it has specificity, and it makes very clear recommendation, and I think the fact that we make it accredited schools makes it very believable to the Department of Education, as well.

Let's move on to a more complex issue, 1.6, which I will read.

"The Department of Health and Human Services should conduct demonstration projects to determine the feasibility of CAM students participating in the National Health Service Corps Scholarship Program."

Tierona.

DR. LOW DOG: I would like to move that we take Linnea's recommendation from the last recommendation or action item or whatever, but just make it relevant for this, for the feasibility studies.

DR. GORDON: Somebody with a mike, read it.

DR. KACZMARCZYK: "The Department of Health and Human Services should conduct a study to determine whether and in what ways and to what extent should eligibility be expanded to students of CAM in the National Health Service Corps Scholarship."

DR. FINS: That would be 1.6?

DR. KACZMARCZYK: That would be 1.6, that is correct.

DR. GORDON: Let's discuss it. Tierona, go ahead.

DR. LOW DOG: I just wanted to finish my thought because I had thought, on our conference call for

this section, that it may have Maureen that had said that before you start doing a demonstration project or whatever, you need to actually have feasibility studies, and you need to sort of thing through the process.

I think it needs to go back a step from the demonstration project to this, and also to determine which CAM providers, if any, would be eligible for this.

So, I would propose that.

DR. GORDON: Other comments on this?

DR. KACZMARCZYK: Much of that is addressed in the text.

DR. GORDON: I'm sorry. What, Joe?

DR. KACZMARCZYK: Much of Tierona's concerns is addressed in the text.

DR. GORDON: Joe.

DR. PIZZORNO: I agree we need to do a study first. I think we also said that, and if feasible, then demonstration projects should go forward.

DR. FINS: The whole thing here, as I understand it, is to be part of this program, you have to be providing service after you have been trained as a primary care provider. That is the sine qua non for this

scholarship program.

I will not be convinced that these folks, even that small subset of people, are equivalent as primary care providers. With all due respect to what a naturopath would bring to the patient's well-being, that individual does not have the skill set of a family practitioner, an ob-gyn, a pediatrician or an internist.

The scope of training differs. The duration of training differs, and I think it puts the public at risk to say that these folks, who bring other things to the table, are primary care providers, especially when we are talking about underserved communities that would be the recipients of these individuals.

This loan program is predicated upon people paying back with their expertise to underserved communities. If you look at all the things that they are meant to do on page 16, these are not necessarily services that they are trained to provide.

DR. GORDON: Charlotte.

SISTER KERR: From what we have just said, with all respect, nobody is debating that right now, and also, as far as the state, I guess Washington, naturopaths have

been defined to be able to do primary care. So, the point is Linnea's proposal anyway is just saying we want to do studies, so it's an opinion.

But I want to say this just for a sense of history, if you look back in our History Section, page 5, Recent History of CAM, it is very interesting to note, "The vast majority of primary medical care in this country was provided by botanical healers, midwives, chiropractors, homeopaths, and an assortment of other lay healers."

Of course, it did progress, but, you know, it is just a point that we could discuss for a long time what the primary care is.

DR. LOW DOG: But, Joe, I guess I just want to ask the question, if we are talking about a feasibility study, which will evaluate all of this and determine if a direct entry midwife, who is licensed interstate, would be able to provide some women's health services in a community.

All we are saying, I think, is that somebody other than us should probably go away and look at this issue, and they may come back and say not yet, not now.

But is there a problem with the feasibility study, I guess?

DR. FINS: Should I respond or should I wait?

DR. GORDON: Why don't you respond.

DR. FINS: Congress just decided that chiropractic was not primary care, and primary care means something special. It is not to say that others don't provide first-person care, but it is a scope of practice and a kind of expertise.

I would much prefer some kind of consideration of alternative loan sources that do not somehow equate this with primary care. The fact that Washington State has done this doesn't mean that it's right. It might mean there was good lobbying or there was a constituency or whatever. It is not necessarily the way that the country should go.

MS. LARSON: I would actually like to have that recommendation read again, so it is very clear. It is about a feasibility study, and it says what, whether or not, and to whom this is extended.

Secondly, I would like to make a comment that I really do not know what this is. It is Senate Bill

something or other that is on the table right now that actually looks to expand -- what I was just talking about -- to include what I think has been a significant absence is behavioral scientists within this domain.

They are not considered primary care, but I can tell you that a physician or a nurse practitioner without the necessary behavioral science is crippled, and most of the community health centers do not have those services provided.

So, I am just saying this is all it is, is a feasibility study.

DR. KACZMARCZYK: The legislation you are referring is the NHSC reauthorization.

DR. GORDON: Veronica.

MS. GUTIERREZ: I was going to suggest amending the sentence at the end, the 1.6 remaining the way it is, and adding, "If this is found to be congruent with legislative intent," because at the time Title 7 was written, and I am not even sure when that is, medicine was the politically dominant health care model, and that has changed.

I know there are a lot of legislators that have

talked to our national organizations, and are willing to revisit the Title 7 the way it is defined.

So, rather than even proceeding with feasibility studies, and so forth, I am willing to go on the line and offer that this be done if it is found to be congruent with legislative intent, and if it is not, I am more than willing to give up the battle.

Secondly, I would like to say not opening the door for this opportunity is not congruent with even one of our guiding principles of the Commission.

DR. PIZZORNO: I have to say, Joe, I am surprised that you are objecting to this because I thought this was what you and I had worked out.

DR. FINS: That was something else.

DR. PIZZORNO: I'm sorry, I thought this was what we agreed to. We actually agreed to a demonstration project. We actually stepped back to do a feasibility study. I am actually quite confident in doing a feasibility study that will lead to a demonstration project, because we are already doing it in Washington State, and it is working great.

So, let's just make it a more formal process.

Let's do this.

DR. GORDON: Tierona.

DR. LOW DOG: Part of when you are talking about the feasibility study, it may address if this should be value added, if it should be done in conjunction, but I think that that is partly what is left to the feasibility study, is to actually try to address all of those issues.

I think this is a good compromise for a very sticky subject, I really do. I think the feasibility study, it is not saying let's go do it, it is saying let's look at all the available options and let's see what comes out of it.

That may be paring, it may be not a rural primary care. It may be saying inner city. I think that there are so many options that we just don't want to limit ourselves to it, but we want to just say feasibility studies because we don't know what would show up.

DR. GORDON: Joe K.

DR. KACZMARCZYK: I think this would be vastly improved if we took the words "demonstration projects,"

out and used "feasibility study."

DR. GORDON: We are discussing the amended version.

DR. KACZMARCZYK: I brought this up because the two other Joe's were going back to a previous issue about demonstration projects. So for clarity, let's just stick to the feasibility study, and not the previously discussed demonstration projects.

DR. FINS: I just want to see, Joe, because yes, that it was in conjunction. In other words, my real concern is value-added. I think you and I both agreed that we would both be uncomfortable having naturopaths designated in an isolated area as the only practitioner.

DR. PIZZORNO: We don't agree, because I have graduates out there doing that right now.

DR. GORDON: I think we are not talking about a demonstration project. We are talking about a feasibility study. What we are saying is, we are open to the possibility. We're not saying, let's do it. We're saying we are open to the possibility that this may have value. That's it.

DR. FINS: Why do we have to link the

possibility of value to a program that is exclusively for primary care providers? That's the question. Why don't we say that there needs to be another feasibility study to determine a new loan forgiveness scheme, or program, outside of the National Health Service Corps, because the National Health Service Corps is about primary care. It is not about other providers.

DR. GORDON: Joe, I practiced Chinese medicine for 25 years. In China, there are people who practice Chinese medicine who have a pretty good Western medical education as well, even though their licensure is Chinese medicine. I bet they would be quite good at doing primary care practice. I would love to see what it looks like. They are doing it in China.

So I'm just saying the possibility. Naturopathic medicine is expanding and growing in all kinds of ways. You deliver babies, don't you?

Naturopathic physicians deliver babies, they do minor surgery, they can give injections, they can do many, many things. I think we just don't know, and that's why I think it is fair to see in an open-minded way does this work or doesn't it work. That's where I

am.

DR. FINS: Why don't we study and see whether it works or not, and not link it to the question of loan forgiveness.

SISTER KERR: I have a sense you have a feeling that something will be lost in doing this rather than what is the opportunity in revisiting a definition of primary care and who could possibly help people. But, wait. There is the worry that there is a big pot of money and that it won't be enough because, first of all, what I have always been advised in legislation, just like in writing your home budget, you may say, "I need prescription glasses. I want to put that in the budget," and they come back and say, "Too bad. We can only afford the dime store."

So, if we look at the pot of this money for loans, it will be shared or one will be deleted or whatever, but we are not to have to worry about that. So, what is the concern for you, which is obviously very important?

DR. FINS: It is really not about the money because I think overall all these programs are under-

funded. So, we are really talking about the equivalence, the move towards equivalency between scopes of practice and training that are not commensurate.

SISTER KERR: In your definition. That is --

DR. FINS: Huh?

SISTER KERR: In your definition they are not commensurate.

DR. FINS: In my definition, and I think a lot of internists would have a hard time with that.

SISTER KERR: So then, that is the protection, but as Jim said, like acupuncture, for example, in Chinese medicine is primary care in China. The bottom line, millions of people, that is primary care. Acupuncture is a system of preventive medicine. We talked about using in sick care. I learned it as preventive.

DR. GORDON: Effie had her hand up, and Tieraona had her hand up.

DR. CHOW: I know we have gotten into debates like this before, and it comes down to definition. So many times we have gotten into trouble with all this debate because we don't have definition of primary care

other than the medical primary care.

So I don't know. I haven't heard anything further about the glossary definition.

DR. FINS: In the Public Health Service Act, Section 3.30 on the bottom of 15. It is not my definition, it is by statute.

DR. CHOW: I am not saying it is your definition. I am just saying that that is the traditional definition.

DR. GORDON: I think the issue, though -- excuse me for interrupting -- Joe, is if this is primary care, then, as defined, the question arises, can these other people provide it. That is an open question. I mean, at least that is the way I see it. I am not trying to convince you.

DR. FINS: This, to me, is, I think I can say without any kind of doubt, the most important issue for me. This may reflect a world view kind of thing, and I may have a hard time with it. However this turns out, you may want to go forward without me, and that is perfectly fine. I think the country will be served by an articulation of the issues, and hopefully, something

will, in a Hegelian sense, synergize out of it.

I just have a hard time with it and I have had a hard time expressing it to this group based on where people are coming from and what their own backgrounds are. I respect everybody's point of view. I respect barefoot doctors in China. I understand that, but I would not equate a barefoot doctor with a fully trained family practitioner and internist.

So I think this may be a discussion that we could continue at dinner at Ming's house but it may not be fruitful to continue it here. I say that with all humility.

DR. GORDON: I appreciate that. I just want to clarify one thing. I was not talking about barefoot doctors. I was talking about people who have been through the complete training in Chinese medicine who have also had significant Western medical training.

Barefoot doctors is a whole other category. I am talking about people with a very deep knowledge of Western science who happen not to be M.D.s but who happen to practice Chinese medicine.

This isn't, again, part of the discussion. I

shouldn't carry on. I'm supposed to cut discussion off, but I would suggest that if you go down this list, it is entirely possible the naturopathic physicians might do everything on this list of primary care. Just saying that as a possibility, I think we just don't know. That is where I am.

I will shut up now. Tieraona, Linnea, Tom, and let's close with Joe.

DR. LOW DOG: I need better clarification because when it said that NHSC scholarship programs are limited to U.S. citizens enrolled or accepted for enrollment in fully accredited U.S. allopathic or osteopathic medical schools, nurse practitioner, nurse midwifery P.A. schools, or dental schools, dentists are not primary care.

I guess my problem here is that I have no position at this moment. Rather, I believe that a naturopath, a midwife, a massage therapist, I have no opinion on whether they should be in this program or not, but I am fully willing to engage in a feasibility study where people will look at the issues with objectivity and try to figure out how do we maximize benefits for the

public.

Again, I just want to point out, when I read this, nurse midwifery programs, they do not teach people to do all of primary care. A nurse midwife out in a rural area does not do all of primary care. Neither does a dentist.

So I'm not sure if maybe I am just misunderstanding the NHSC. Maybe I just don't understand it enough.

DR. KACZMARCZYK: As the law is currently written, those are the health professions which are eligible for participation. The text originally said pilot program parenthetically after dentists. That is currently a pilot program.

DR. LOW DOG: Oh, that's a pilot program?

DR. KACZMARCZYK: Yes. That pilot program was removed in the editing because the document as a whole is too long, too verbose, and efforts were made, wherever possible, to abbreviate it.

DR. GORDON: Linnea, Tom, and George Bernier.

MS. LARSON: The only thing I would have to say is to second what Tieraona said and that all we are

looking at is simply the feasibility. That's it.

Also, if we look at 1996 Institute of Medicine Book on Primary Care and what they look at as a primary care team, that is different, okay? We are not excluding and saying there is equivalency.

Having worked in a community health center in which there were recipients of National Health Service Corps, I can tell you how devastating these areas are. We need people. We need, quote, behavioral science people in there. We're not asking that a substitute physician or whatever, we're asking for a feasibility study because we want to expand the possibilities, at least in my mind, for collaboration, for collaboration.

DR. GORDON: Tom.

MR. CHAPPELL: I support the language as we have been referring to the feasibility study because I think the consumer, whose interests we represent here, needs to have more opportunity to make the choice of primary care.

It has nothing to do with how many years of education that professional has had, it has to do with how confident the consumer will ultimately feel in

selecting a given practitioner for primary care based on their experience in working with that professional. We have got to open up the opportunity for that model, or various models, to be determined by the feasibility study.

DR. GORDON: Joe.

DR. PIZZORNO: Just real quickly, Joe, I look forward to this conversation continuing in the evening, but I want to assure you I don't consider a naturopathic doctor, a broadly trained chiropractor, a Chinese-trained Chinese medicine person to be the equivalent of a medical doctor. Clearly, they have different abilities and such.

However, I do maintain with a great degree of confidence, because I have done it, that in a primary care setting we have a lot to offer. We are not replacing you, but there are many places where what we have to offer is of great value. That door needs to be opened and understood.

DR. FINS: May I? Linnea said something that might be a way of tweaking this. I want to just suggest it but not commit to it, because I really need to see it in print.