We might want to say something that, recognizing to provide comprehensive primary care is a team approach, and there are lots of different ways of contributing to primary care, under the rubric that there may be a mechanism to include people who add to the comprehensive quality of palliative and the contributions of each.

So primary care, but it is comprehensive. I mean, you see this in managed care companies or managed care situations where it is better to have the visiting nurse, and the doctor, and people, all in the aggregate, together.

I think maybe we have to think a little bit out of the box, which is stuff that we said at the very first meeting, we've got to think out of the box. Maybe we need to think about the definition of primary care, not primary care practitioners but the comprehensive quality of primary care, which involves a lot of different kinds of practitioners.

MS. LARSON: That was my intent. We have an excellent example that is given by the Institute of Medicine in 1996. It is superb. It goes into detail

about the collaborative team, et cetera.

DR. GORDON: George, and then Conchita, and then let's come to a close.

DR. BERNIER: I guess we are dealing with two issues, the 1.5 and the 1.6. The 1.5, we passed?

MS. LARSON: Yes.

DR. BERNIER: The 1.6, I think there are just lots and lots of ways of looking at it. I know we had had some very long talks about it, and it seems to me that we could go into the demonstration projects or their equivalent without destroying what seems to be a really good process that has gone on so far.

I think everybody is tired, but I would like to urge that the group very strongly consider supporting the idea of having expanded loan programs and then the No. 1.6, to look at that as the opportunity to really test how students from various backgrounds are able to contribute to the well-being of the patient.

DR. PAZ: Coming from a state that is mostly under-doctored, and we do occasionally, rarely, get National Health Service Corps primary physicians, the fear would be that they would send an alternative

therapist or a practitioner in place of a physician. I would probably support it if we could include that team approach in the wording.

DR. GORDON: Tieraona, go ahead.

DR. LOW DOG: I just wondered if in the text we could expand upon the notion of team approaches, referencing back to the 1996 study that really talked about this -- the way we are moving in medicine, anyway, is co-management -- and really explore that within the text, so that it sets the stage when we talk about a feasibility study. If you want to include in the language about teams or whatever. This would set the foundation for the recommendation.

DR. GORDON: Joe.

DR. FINS: Maybe the most time-effective way is if a few of us over dinner take a pad out, and we just try to work this out.

DR. GORDON: Julia, did you want to say something?

MS. SCOTT: I guess I just want to say I support the recommendation for a feasibility study to see if there is anything, or any way, that roles could be

expanded and other students can be accepted. It doesn't say that we are training people to take the place of, or anything.

DR. GORDON: Linnea, will you bring it to a close?

MS. LARSON: I like the the action item as it stands, and I think that it can have a rationale in the text that makes reference to the 1996 description of the Institute of Medicine that says, this is what we see and this is what is needed. So that is a rationale.

DR. GORDON: So let me tell you what I am hearing. What I am hearing is that everyone, with the exception of Joe -- and Joe may as well, Joe Fins -- feels good about the feasibility study if the groundwork is laid to discuss teamwork, to discuss the issues, to discuss that this is not replacement in the text. We still have to come back to the original recommendation.

So let's proceed with that in mind, and it would be wonderful if you all wanted to gather and pull some of that together.

DR. LOW DOG: We can revisit this in the morning?

DR. GORDON: We can revisit it in the morning if you would like, yes.

Let's move ahead. Yes, Linnea.

MS. LARSON: Did we settle on the recommendation? I have a solution. Are we still going through the action items?

DR. GORDON: We have one hour and 10 minutes until 7:00, in which time we need to finish both this section and CAM Central. So let's move forward with the recommendations.

We are now on No. 1.7 on page 19, the action item. Is everybody with me on this? "The Department of Health and Human Services, and other federal departments and agencies, should convene conferences of the leaders of CAM, conventional health, public health, evolving health professions, and the public, of educational institutions, and of appropriate organizations to facilitate establishment of CAM education and training. Subsequently, the guidelines should be made available to the states and professions for their consideration."

Comments about this. Does this action item feel comfortable?

DR. FINS: Can I be out of character for a minute, and say I like it?

DR. GORDON: All right.

Are we okay with this?

PARTICIPANTS [En masse]: Yes.

DR. GORDON: Thank you. No. 1.8: "Demonstration projects of residencies in post-graduate training for appropriately educated and trained CAM practitioners should be conducted to determine the feasibility of such programs and their impact on clinical competency, quality of health care, and collaboration with conventional providers."

DR. FINS: I thought, last time, we talked about "post-graduate training programs," and left "residency" out because "residency" entangled us with something, I don't remember anymore, about GME monies. We just decided as a compromise. So we struck "residency in post-graduate training programs for." I thought we had compromised on it, "demonstration projects."

DR. GORDON: You said "post-graduate training," but struck "residency"?

DR. FINS: Yes. "Demonstration projects and

post-graduate training programs for appropriately educated and trained," to avoid a morass with GME funding.

DR. GORDON: How does that sound? Joe, speak up, please.

DR. PIZZORNO: Because we are training people to be primary care providers in many of our professions, we really need the residencies. So if we want to do demonstration projects, that's fine, but this is something that is critical.

I know the naturopathic profession, the chiropractic profession, and now the acupuncture profession, we are all adopting residency programs. This is something that we need to enhance our clinical training.

So if you want to do a demonstration project, that's fine, but I think we should be there.

DR. GORDON: Joe, can you explain the difference between post-graduate training and residency, why that word is particularly important to you?

DR. PIZZORNO: I don't know.

[Laughter.]

DR. PIZZORNO: We call them "residencies" because that is what we are doing.

DR. GORDON: "Residencies" used to mean that you were in residence in the place, so you would sleep over in the hospital. I mean, I believe that is where it came from.

DR. PIZZORNO: Well, we do have several programs that are like that at hospitals right now. I know the chiropractors do, and I know the naturopathics do.

DR. GORDON: Other comments? George, did you want to make a comment about this?

DR. BERNIER: You were saying what residents are. Most physicians, after four years of medical school, have three years of training. If they are going to go into a sub-specialty of the given area, that is an additional two, three, four years. So, it is really a time thing. You have to have a significant base of people to be able to fill out in a guaranteed way the residency slots, and that is, really, a very difficult thing to do unless you have got the manpower. I think that the big problem was that was discussed at that

meeting was that the manpower just wasn't going to be there to fill out the slots.

DR. GORDON: Joe, go ahead.

DR. FINS: I think part of it is that a residency implies the same issue, that accredited residencies are eligible for GME monies. So, if you have not evolved to an accredited residency program, you are not eligible.

On page 20, lines 25 and 26, the text says that these projects would be distinct from current GME education funding streams, which are a major source of funding for hospitals and really supports residency training programs, indirectly the care of the under-served throughout the country.

DR. GORDON: I'm sorry. Where are you?

DR. FINS: On page 20, lines 25 and 26. Page 20, lines 25 and 26.

So, I do not want to imperil GME funding streams because hospitals are already strapped with the Balanced Budget Act, and to somehow take money away from that to do this would really, I think, hurt inner city hospitals and the under-served.

So, the issue of calling these things residencies links it up with that. Post-graduate training programs, really, is what we are talking about because some of these programs will not have yet evolved into residencies. Residency is something more concretized, and post-graduate training programs are not necessarily eligible for GME funding because they are not accredited in the same way.

DR. GORDON: Tieraona.

DR. LOW DOG: Well, I hate to go back a step, but I had thought we had actually discussed a feasibility study because part of what we were looking at was which CAM practitioners. Some CAM practitioners may be at a place where even potentially residencies may be appropriate. Others, residencies wouldn't even be appropriate but post-graduate training might be more appropriate. Some, it may just be continuing education is all they need to really keep up.

So, I thought we had actually talked about stepping back to look at all of this so that we can address the next step instead of just jumping into a demonstration project because you haven't even defined

which ones and who and for how long or anything else. Feasibility studies would at least look at all of those things and determine which groups of people may be ready for that next step or not.

DR. GORDON: Joe K.

DR. KACZMARCZYK: That is the intent, and I think, as you suggested, if it is stated as "feasibility studies of" blah blah blah, I think it would accomplish what everyone hopes it would.

DR. GORDON: Joe Fins has asked Joe K. to fill in the "blah-blah-blah."

DR. KACZMARCZYK: I think that is filler at this time, B-L-A-H.

[Laughter.]

DR. KACZMARCZYK: I think, seriously, if you just restate it, so that it reads: "Feasibility studies of residencies and post-graduate training for appropriately educated and trained CAM practitioners should be conducted to determine."

Then you could go into the types of practitioners in their settings and their impact on clinical competency, quality of health care, and

collaboration with conventional providers.

DR. FINS: I think that we should really stress right there that this is distinct from GME sources of funding. It is in the text.

DR. LOW DOG: In the text I would suggest that we clearly state that if these feasibility studies show that certain groups may be ready for that, that we should say in the text that additional funding, separate additional funding, should be provided for this.

It should be clearly stated in there based on whatever happens with the feasibility so we are not taking away funds from the GME but additional funds would be set aside. You would have to have a new pot to take from.

DR. FINS: If it demonstrated the value-added.

DR. LOW DOG: Exactly. Which may or may not happen.

DR. GORDON: Joe, do you want to come back to us with the wording, the precise wording, tomorrow morning? Would you do that, Joe K.?

DR. KACZMARCZYK: Yes.

DR. GORDON: Great. Thank you.

Let's move on. Is that okay with everybody? Good.

No. 1.9, page 22: "All practitioners who provide CAM services and products should consider completing appropriate CAM continuing education programs to enhance and protect the public's safety."

Joe.

DR. PIZZORNO: I don't like the "consider" there.

DR. GORDON: I don't, either; "should complete."

DR. FINS: This links up the licensure stuff later on. I mean, for ongoing certification as a condition of that sort of thing practitioners should meet appropriate CME program guidelines. I mean, Charlotte, and I think Effie, were talking about their CME with acupuncture hours. We were talking about this during the break.

So the issue people have is requirements, and I think we should encourage that as part of what it means to be a trained professional.

DR. GORDON: I would also add something else,

and I am adding this partly in consideration of a conversation I had with Dean. So let me read it to you, because I think it is an important note. I know it will be an important element for him. I think it is fair enough.

"All practitioners who provide CAM services and products should complete appropriate CAM continuing education programs, dash, which would include critical evaluations of the discipline and approach to enhance and protect the public's health and safety."

So if I am doing my continuing ed in acupuncture, I would also get somebody telling me, well, what do the studies look like, and what do we know now, and what did we know three months ago, and where are we in the practice. I think it would make him feel somewhat more comfortable about some of these other disciplines.

DR. KACZMARCZYK: You spoke so quickly that no one got that except for Linnea.

DR. GORDON: Sorry, what's that?

DR. KACZMARCZYK: Could you repeat the clause?

DR. GORDON: Sure. Read it again?

DR. KACZMARCZYK: Yes, please.

DR. GORDON: "All practitioners who provide CAM services and products should complete appropriate CAM continuing education programs, which would include critical evaluations of the discipline or approach," -- dashes around that -- "which would include critical evaluations of the discipline or approach," dash, "to enhance and protect the public's health and safety."

DR. FINS: Take "all" out.

DR. GORDON: Take "all" out. Okay, fine. Is that okay? Everybody okay with it? Great.

Yes, Linnea?

MS. LARSON: Let's go back.

DR. GORDON: Are you ready to go back to the initial recommendation? We are back on page 1.

MS. LARSON: How does this sound? "The education and training of complementary and alternative medicine practitioners and conventional practitioners should be designed to ensure public safety," comma, "improve health," comma, "increase the availability of qualified and knowledgeable CAM and conventional practitioners, and enhance the collaboration between them."

DR. PIZZORNO: Good.

DR. GORDON: How does that sound? You want to read it once more so everybody can get it? Because we will want it up or down now. We will revise and so forth.

MS. LARSON: "The education and training of complementary and alternative medicine practitioners and conventional health care practitioners should be designed to ensure public safety," comma, "improve health," comma, "increase the availability of qualified and knowledgeable CAM practitioners and conventional practitioners, and enhance collaboration between them."

DR. GORDON: Charlotte.

SISTER KERR: I think it's great. Even though we are saying "conventional" and "CAM," should we say "among them"?

DR. GORDON: Julia, do you have a question or comment?

She's saying "among" as opposed to "between." Are we okay with this? Let me see heads.

Joe, you okay?

DR. FINS: I guess. Yes, it sounds fine.

DR. GORDON: I want to check in with everybody. Is this one okay? This is very important. This frames all the action items that follow.

[No response.]

DR. GORDON: Thank you. Thank you very much.

Is there anything else in the text that we need to address here that we have not addressed in our discussions?

DR. FINS: We still have to write No. 1.6, or whatever.

DR. GORDON: Well, we have the No. 1.6, we have the textual justification that has to be written.

MS. LARSON: I understood he didn't want it in the action statement, though, that has to be worked on further.

DR. GORDON: I'm sorry?

MS. LARSON: I understood Joe to say that perhaps in the context it might be good but he may want to say something in the action statement as well.

DR. GORDON: All right.

MS. LARSON: So that has to be re-looked at.

DR. GORDON: We can bring that back tomorrow.

Who is going to be working on that?

Joe and Linnea, and Joe.

DR. FINS: It may be Tieraona, too.

DR. GORDON: Tieraona, okay.

DR. FINS: And George.

DR. GORDON: You guys have got to have time to eat, though, too.

DR. FINS: Yes.

DR. GORDON: George, you are going to be involved in it.

All right. Anything in the text that needs to be addressed. Joe.

DR. PIZZORNO: Joe K., this is for you. This is on page 20, line 4, and says, "In outpatient clinics that are not affiliated with any hospitals," two of the residency programs are affiliated with hospitals.

DR. KACZMARCZYK: I have the total of three naturopathic residencies. There are 40 slots. At National College there are 27 positions. Three are outpatient, three are hospital, one is hospital-affiliated outpatient. Twenty-one of those are first-year residencies, six of those are second-year.

At Bastyr, there is a total of eight. All eight are outpatient. Six are first year, two are in the second year. At Southwest College, there are five total. They are described as outpatient but they have hospital rotations at Maricopa County. Four of those are first-year, two are -- excuse me, one is second-year.

So we looked at that and decided the best way to summarize it succinctly was as it is written there.

DR. GORDON: Suggestion.

DR. PIZZORNO: Thank you for the good summary of the residencies. I agree, they are primarily outpatient residencies, but the point I am trying to make is there are a couple of them that are at hospitals. I think that should be stated, that's all.

DR. GORDON: Other issues. Tom.

MR. CHAPPELL: I just would like to know if we should be stating dentists interested in oral-body systemic health is one of the alternative modalities. Of course, it is a very significant new piece of information and emerging work in dentistry, and yet in the modalities where we described the modalities, we never mentioned dentists in CAM.

DR. GORDON: Where would you put it, Tom or Don?

MR. CHAPPELL: I'm looking first at page 2. It says, "In a study of allopathic medical schools with no" blobbity blah. It talks about 10 CAM modalities. Now, that is referring to a specific study, but again, the dentist is not mentioned there. Or, the chart going back to the Research section where we had the different modalities. It is the dentist interested in oral-body systemic health. It is a huge piece of research.

DR. GORDON: Joe, do you have any comments on the Education section here with dentists?

DR. KACZMARCZYK: Dentists are mentioned along with the other conventional health care professionals in allied health in two sections. Or, I shouldn't say two sections. In two different areas in the text when the language tried to be more inclusive because it is saying, this should be not be restricted to just medical education. This needs to be expanded to all the conventional health care, including but not limited to, and you can go on and on and on.

DR. GORDON: Joe, a question for you. In the

statistics on CAM teaching in medical schools, is there a similar survey of dental schools that has been done?

DR. KACZMARCZYK: I am not aware of any.

DR. GORDON: I don't know of any, either.

DR. KACZMARCZYK: I am not aware of any.

DR. GORDON: Tom.

MR. CHAPPELL: What was the question?

DR. GORDON: The question was, is there a similar survey of CAM teaching in dental schools.

MR. CHAPPELL: I happen to know of some that are considering changing their curricula very much in the near term. We will get Don to accelerate that information.

DR. GORDON: Don, do you want to address that?

MR. CHAPPELL: Do I want to address it?

DR. GORDON: No, did Don want to. I thought Don might have something to add.

DR. WARREN: At this time I am not aware of any dental school that has a CAM program active. The biggest thing they have is the "Scope Manual on Nutrition," which is about 28 pages, and that is it.

MR. CHAPPELL: I am aware of one school.

DR. WARREN: Is it active now?

MR. CHAPPELL: It is not active yet, but they are in the process.

DR. WARREN: Good.

DR. GORDON: So, the question is, how do you want to address this.

MR. CHAPPELL: When you look at the amount of money that is going to be spent in research oral cavity/body systemic health, it is amazing. I mean, the body of knowledge is already there.

DR. GORDON: We are talking about the Education section. Do we have a place where we want to address it here, right now?

MR. CHAPPELL: That is why I raised the question. I don't want to see us lose the opportunity to be inclusive of this new field. It is major.

DR. GORDON: I am asking a specific question. Where do we want to address this, and how.

MR. CHAPPELL: Joe, where do you think we should put it?

DR. KACZMARCZYK: At this time I do not know.

MR. CHAPPELL: Well, can we sleep on it?

DR. GORDON: Tom, I think if you could find a place or places in the text specifically where you think it might need to be addressed, it would be helpful to us and then we could take that up tomorrow, okay?

Joe.

DR. FINS: A couple of things. I have a bunch of things I am just going to ramble through. I don't think any of it is major but just little stuff.

Page 1, we mentioned national guidelines are needed for education and training. I think that we have talked about having national guidelines are kind of problematic, imposing them on the medical schools here. When Jerry and I were doing the Education thing before it switched, we were very clear that just core elements of competencies but not guidelines that will be imposed upon the schools. So I would try to address that.

I mean, we need to establish there are curricular elements needed for CAM education and training, or something like that. In other words, not to impose guidelines from some central office.

DR. GORDON: I think you are right. Even if we wanted to, it is much too early. We haven't established

the groundwork, especially in this opening portion.

DR. FINS: The next thing is on pages 4 and 5, bottom of 4 and the top of 5, I really found this kind of in the advocacy tone, that we want to give medical students the opportunity to personally experience CAM and self-care. I mean it is like saying, we want medical students to experience a colon cystectomy so they can have the experience of surgery.

DR. GORDON: Joe, let me respond to this. I feel this is an absolutely crucial element of CAM education, that we are talking about self-care. We are not talking about surgery. You cannot teach self-care unless you experience it. You can teach surgery without having had surgery. I think there is a fundamental difference. I don't think, I know it is of fundamental importance.

DR. FINS: It has an element of proselytizing CAM.

DR. GORDON: I think it can be worded, perhaps, differently, but I think the element is that there are certain things that you can't be taught simply as academic subjects. They have to be learned in order to

be able to teach self-care. This is a long argument, but I feel extraordinarily strongly about this, that you cannot teach self-care without learning it yourself.

DR. LOW DOG: But perhaps, then, the language should be more specific about self-care instead of CAM.

DR. GORDON: Fine. That's fine.

DR. LOW DOG: Maybe even some specificities inside parentheses what that means.

DR. FINS: Moving on, a few more things. On page 13, line 20. Well, there is a "G" there, "bringing."

I am not sure. A lot of these entities are not necessarily funding sources. They are more sort of professional associations, so I don't know if any of them are actually funding sources.

DR. GORDON: Fair enough. That one okay, people?

DR. KACZMARCZYK: Excuse me. The intent was to bring together funding sources and organizations such as. It is funding sources plus these organizations.

DR. FINS: Say, "organizations with funding sources."

DR. GORDON: "Funding sources together with organizations," right, Joe?

DR. KACZMARCZYK: Yes. That is the intent.

DR. FINS: Good.

DR. GORDON: I have got one question, and I asked this before and I am still not clear on this, Joe K. On the third line on page 15, the point you are making about exclusive participation, it just isn't coming across clearly. What are you trying to tell us?

DR. KACZMARCZYK: The point that I am endeavoring to make here is that this particular program, that is NHSC, is not terribly effective when it meets only 10 to 15 percent of the identified need.

DR. GORDON: Now, is that because students are not applying for it or because there are not enough slots?

DR. KACZMARCZYK: There are, apparently, a host of reasons for this, and I would not presume to speak at this time for NHSC, but it would appear as if number one is that the demand far exceeds the supply. Two, there are so many administrative impediments. For example, the particular geographic area has to be designated as a

health professional shortage area, which has its own set of requirements that it becomes rather difficult to meet all of these requirements, and then the profession has to be named in the legislation and those individuals have to meet certain criteria, and there is a competitive award process, and it goes on and on and on and on.

DR. GORDON: What I am saying is that the idea of exclusive participation leads us off in the wrong direction. What you are really saying is that because of a variety of impediments the NHSC cannot fulfill its primary care function or can only fulfill 12 to 15 percent of the spots. Is that right?

DR. KACZMARCZYK: In short, yes.

DR. GORDON: Tieraona.

DR. LOW DOG: Are we still on text? Are we working through the text?

DR. GORDON: We are still on text, yes.

DR. LOW DOG: I had some problems reading through this text. I know it is the end of the day, but Joe, I think we could tighten it up a bit. Basically, we say that 72.5 percent of medical schools teach CAM. That's 91 out of 125, but more needs to be done. I mean,

so part of it doesn't seem to flow very well from what we are trying to say and get across.

DR. GORDON: Tieraona, why don't you suggest a better way to do it.

DR. LOW DOG: Well, I actually have moved the paragraphs around on my computer and changed it around a little bit. Maybe we could just print it off and see how people like it. I think it just reads easier. I think there are ways to manipulate the paragraphs around so they flow nicer.

DR. KACZMARCZYK: These have been manipulated so many times that they have fingerprints on them. Most recently, they were manipulated by copy editing.

DR. LOW DOG: Then, on page 3, I don't know why we talked about things like, "while many CAM courses are taught," lines 16 through 18, "are taught either from an advocacy or neutral view, some believe that all CAM courses should be taught critically." Well, of course. I mean, I don't know why we would even say that. Of course they should be taught critically. I mean, just like any other course. I don't understand that statement.

DR. GORDON: So, how would you reword it?

DR. LOW DOG: I mean, I guess you have to include something, but it just seems like of course you would teach or we would hope that you would teach the course critically. It shouldn't be from an advocacy view. I mean, it should just be taught critically the way you would expect any subject to be.

DR. GORDON: So, would you like to say that, "and all CAM courses should be taught critically" or something like that?

DR. LOW DOG: Or, "as all conventional courses should be taught." They should all be taught critically. Otherwise, I don't really understand what it means.

DR. KACZMARCZYK: Excuse me. That particular reference was from Wallace Sampson.

DR. LOW DOG: Sampson, I know.

DR. KACZMARCZYK: That is why it was included.

DR. LOW DOG: Well, in all due deference, but --

DR. GORDON: But it is not "some believe."

DR. LOW DOG: What I am saying is, we should all believe that. We should all say that they should be

taught critically, and all classes should.

DR. GORDON: Do we have agreement on that? You are sort of quoting Sampson's assessment, right? We want our assessment, and our assessment is that all CAM courses need to be taught critically, is that correct?

DR. LOW DOG: Of course it should be.

DR. GORDON: "Like all conventional courses."

DR. LOW DOG: Right. Let's see. I did most of this on my computer.

DR. GORDON: Tieraona, if there specific editorial suggestions for tightening, maybe you can get together with Joe --

DR. LOW DOG: With Joe.

DR. GORDON: -- and work on that.

DR. LOW DOG: I would be glad to.

DR. GORDON: Any other text issues?

DR. LOW DOG: Oh, one other one. I didn't know why we, on page 18, line 13, "For physicians practicing medical acupuncture which confused," and I know that means "not to be confused," "which should not be confused or equated with traditional Chinese acupuncture." I don't know why that whole sentence is in there, why that

whole little place between the parentheses.

It seems somewhat inflammatory to me because, for physicians practicing medical acupuncture, the American Board is the administrative board. I don't know that we need the, "which shouldn't be confused or equated with." I would leave it out. I think there are places in here that are like that. They are a bit inflammatory.

That was 13 through 15 on page 18.

DR. GORDON: Page 18, line 14.

So, Tieraona, I agree with you on this. Are there other inflammatory places or unnecessarily inflammatory places?

DR. LOW DOG: There are two places like that.

DR. GORDON: Where somebody is being singled out and where a kind of negative statement is being made, is that what you are saying?

DR. KACZMARCZYK: The intent was not negative. It was mentioned as an illustration.

DR. LOW DOG: With all due respect, though, listening to all those people that sat at those tables over there, people will read that as an inflammatory statement.

DR. KACZMARCZYK: So it needs to be made less?

DR. GORDON: I would just eliminate it.

DR. LOW DOG: I would just leave that part out.

DR. GORDON: Just eliminate that one. Are we okay with that?

[No response.]

DR. GORDON: Are there any others like that? Tieraona, if there are others?

DR. LOW DOG: [Off mike.]

DR. GORDON: So, the general principle is that we are trying to make positive statements, and unless it is absolutely necessary, we don't have to make all these distinctions. Is that the general principle?

DR. LOW DOG: Yes.

DR. GORDON: With me? Buford, with me? Don? It is a good thing you're with me because you're up next.

Joe, anything else that we should be looking at that we need to think about and you can see? We're okay, we're fine? We're cool here? Great.

Thank you, thank you very much. Thank you, Joe K.

Yes, Tom.

MR. CHAPPELL: I have those edits completed, if you would like to hear them.

DR. GORDON: I'm sorry?

MR. CHAPPELL: I have the dental edits, if you would like to hear them. There are three locations in the text that you asked me to work on. I have done it. Do you want it?

DR. GORDON: I just want to make sure we get through CAM Central, and we want to end by 7:00, which is 37 minutes from now, or approximately. It takes two minutes. Then maybe, if we are still conscious, we can come back and Tom can present us with that history.

Shall we break for three minutes? Five minutes. A five-minute break. We will come back, and we will go to CAM Central. Thank you.

[Break.]

Coordinating and Centralizing Federal CAM Activities

DR. GORDON: Don is present and accounted for. We will do the same thing that we did with the other sections. I will read the recommendations, then we will go back and look at the recommendations first, and then we will look at the text. Let's say that this is the

only one that has had a unanimous consensus up to this point.

Recommendation: "The President, Secretary of Health and Human Services, or Congress, should create an office to coordinate and facilitate integration of safe and effective complementary and alternative health practices and products into the nation's health care system."

I will read the three action items, and then we will go over the whole thing.

Action Item 1.1: "The office should be established at the highest possible and most appropriate federal level with sufficient staff and budget to meet its responsibilities."

No. 1.2: "The office should charter an advisory council with members from both the private and public sectors to guide and advise the office about its activities.

We will go through them, and then we will go back over them.

No. 1.3: "The office's responsibilities should include but not be limited to coordinating federal CAM

activities; serving as a federal CAM policy liaison with conventional health care and CAM professionals, organizations, institutions, and commercial ventures; planning, facilitating and convening conferences, workshops, and advisory groups; acting as a centralized federal point of contact regarding CAM for the public, CAM practitioners, conventional health care providers, and the media; and facilitating implementation of the Commission's recommendations and actions."

As Don has pointed out, we had unanimous agreement on this before. So let's start with the recommendation and see if we still have agreement. Any comments on this?

David, and Linnea.

DR. BRESLER: My first thought when I saw this report was that it was bass ackwards and that wellness was in the front of it and CAM Central was in the end. I think that this is one of the single most important recommendations that comes out of all of our work because it represents the next step of where we are going.

I'm thinking from several points of view, including introducing this to the media, that this ought

to be our number one hit. It ought to be right after the introduction. We ought to really feature this as one of the prime recommendations that we make because it is very easy to justify why. When people ask us what you guys have done for the last two years, we have really looked at how to centralize this within the federal government. I think that could be a great accomplishment.

DR. GORDON: Linnea, and Effie.

MS. LARSON: I don't have at this time worked out a No. 1.4, but I do have the beginnings of a second sentence of the text that then would tie into an action item. Can I elaborate a little bit?

DR. GORDON: Do you want to give us a hint, or do you want to just come back to it?

MS. LARSON: I think that the second sentence should have to do with the full range of CAM perspectives are part of the decision-making dialogue that guides this office and policy and implementation activity. That should be the second sentence, and you should excise the stuff about HIV and attention deficit, et cetera.

DR. GORDON: Wait. I'm sorry. I don't understand where we are. In the text or in the

recommendation?

MS. LARSON: I was making a statement that I actually think that there should be a No. 1.4 action item that I have not come up, but it would be related to this idea that I just articulated. The idea would actually follow the first sentence of the text, okay?

DR. GORDON: Can you articulate this in the next 15 minutes or so? Write it down.

MS. LARSON: Yes, I hope to.

DR. GORDON: Great. Thank you. We will come back to you, then.

Effie, you had something you wanted to say.

DR. CHOW: I wanted to underscore what David said, and this is something that was said before, about that this is one of the central important things and it should be up in front. It is the only thing that everybody has come to an agreement on. Within the text itself, then, it said that one of the most key issues or key functions of this CAM Central is to facilitate the follow-up of the implementation of the Commission's recommendations and actions, and it is the last line in the whole recommendation. That should be first, too, as

well. We tend to put last the most important thing.

DR. GORDON: So, you are suggesting that the last line of No. 1.3 should be earlier in the action steps?

DR. CHOW: Yes, because it is stated in the body that one of the most pressing --

DR. GORDON: Where would you put it?

DR. CHOW: I would put it, probably, in No. 1.3, and right at the first, as the responsibility.

DR. GORDON: Don, do you or Joe want to address why you did it the way you did it?

DR. WARREN: I think what we were talking more about, when we put the implementation of the Commission's recommendation actions back at the very end of this, is we didn't want to seem like we were really being self-serving. We want to do these other things and in addition to that also implement all these things.

I am really glad you all want to put this the first in the report. I think it is neat, but that is not the charge that we have and I think we need to address our charge first and then follow it up with other things.

DR. GORDON: Thank you. Joe, did you want to

add anything to that, or Steve?

DR. KACZMARCZYK: I agree with what Don said. Those responsibilities are laid out in a very deliberate sequence. There is a logic to that sequence, and Steve would agree to that because we have talked about that at length.

DR. GORDON: It is important to reiterate so everybody is on the same page with this, we understand the reasoning why it has been done this way.

Steve.

DR. GROFT: If there is an office -- it is almost a given that it is going to occur -- I think the other activities there in No. 1.3 need an emphasis to say that this is what the office should do. What we are missing is not an office to implement the recommendations, even though it is, but we really need some group to coordinate the federal activities and the rest of the other activities before we get to the implementation. Again, if the group feels that we should be moving that up?

DR. GORDON: I think it is important, Steve, that this is articulated very clearly why we are doing

it, and then we can discuss other ways to approach it.

DR. GROFT: I think that was it, that we felt that the other activities really needed the emphasis and that once the office is created, it is a given that they would be responsible for overseeing the recommendations and the other activities.

DR. GORDON: Effie, and Charlotte.

DR. CHOW: I appreciate the explanation. However, I don't think the development of a CAM office is to serve ourselves because this is what has come up from the other groups, too, from the Georgetown group and previously. There should be a central coordination office.

DR. GORDON: I am not sure what you are saying.

DR. GROFT: I don't disagree with that at all, Effie. I am in agreement. I just think what I was referring to was really the implementation, that statement about the implementation of the Commission's recommendations.

DR. GORDON: Charlotte, and then Tom.

SISTER KERR: I missed the first few minutes and I had a little lag in my thinking, so I apologize if

you all did more of this than I am aware of. This goes just to the general, basic introduction of how we identified three areas where this office could go: executive, DHHS, et cetera. For myself at this point without any further information, I have felt that we should say where we think it should go rather than leave it up.

My question, then, is we don't do that, from what I can see, in the final draft here. I really don't think it should go in the White House because it changes with the administration. Also, whatever the other office we had, surgeon general.

So, my request is, do we, as a group, want to consider actually giving a recommendation so that we really hold it. As we say, the public stressed the importance of creating a sustainable environment, so I would like to really look at that again.

DR. GORDON: Don, do you want to address that?

DR. WARREN: I believe that with the wording and the appropriations for next year that we can assume at this point that it is going to be in the Secretary's office, Department of Health and Human Services, in one

part of it.

DR. GORDON: Yes, but it is not worded that way. It is really worded as several options.

DR. GROFT: I think in wording this we were trying to be consistent with what the administration had advised on some other recently formed commissions in which they said to express options if we could not come to an agreement.

I think we also wanted to give the administration the opportunity to identify where they felt it would be most appropriate. Again, I think the text talks so much about DHHS somewhere there, but again, I think it was just to give them the options.

DR. WARREN: When we wrote this, we didn't know about the wording. Now, should we, since we know about the wording, eliminate the other options? Or, should we give the branch and the Secretary a chance to put it where they wish, give them the option, don't hem them into a corner?

DR. GORDON: That is a question that is on the table. This relates both to the recommendation and to Action No. 1.1. Let's have some discussion about it.

You have raised the question.

Tom, and Joe. Tom has had his hand up for a bit. Yes, go ahead.

MR. CHAPPELL: I wanted to address the order of the presentation of this recommendation.

DR. GORDON: Can we just focus on one issue, because we have been all over the map. So, if we can focus on this first issue now and then we can come back to the order, okay?

So, the issue that we are talking about is, should we make a specific recommendation about the location of the office. Let's try to focus on this.

Joe, you wanted to say something about that?

DR. KACZMARCZYK: The way I see it is that if you provide a list of options that is consistent with the information that Steve described, but also, and more importantly, increases the likelihood of the creation of this office.

DR. GORDON: Effie.

DR. CHOW: I think I agree that giving them the option that we can always set priorities, and they will set their own priorities anyway, but offering our

preference.

DR. GORDON: You would like to offer a preference?

DR. CHOW: Yes.

DR. GORDON: What would your preference be?

DR. CHOW: One is that it should be in the President's office, and with Congress, right away, taking action to put it through Congress.

DR. GORDON: That it would be at the Secretary's office? Where should it be, though?

DR. CHOW: In the President's office.

DR. GORDON: In the White House?

DR. CHOW: In the White House, yes, and then Congress right away take action to legislate it into official being, so there is longevity.

DR. GORDON: Other comments about this.

DR. CHOW: Well, can I just add, because it was set up at the President's level, and we are one of the few commissions out of the 200 commissions that have been appointed by the President, by executive order -- I'm sorry?

DR. PAZ: It was a different president.

DR. CHOW: Well, but still, it is there, and I think we should operate at a optimistic level.

DR. GORDON: So there is a specific recommendation. You are making the recommendation that we say where it should be and that we say in particular that it should be part of the White House, right?

DR. CHOW: With Congress taking action to make it permanent. I am saying, offer the other option, too.

DR. GORDON: Congress has already taken an action. Steve, do you want to clarify what Congress has already said? It is important to see what the lay of the land is. If we are making recommendations into the wind, we have to know that.

DR. GROFT: In the appropriations language that came from the House-Senate Conference Committee, there was language that the committee urged the Secretary, or encouraged the Secretary of HHS, to establish an office or an activity within the Department to coordinate CAM activities. I can get the specific language for you.

DR. GORDON: That is basically the gist of it?

DR. GROFT: Right.

DR. GORDON: So already there is legislation

saying put it within the department. So, let's continue with the discussion. Yes. I'm sorry. Joe.

DR. KACZMARCZYK: The specific language was, "The Conferees urge the Secretary of the Department of Health and Human Services to form a coordinating unit to review the commission's report and implement ways of improving coordination of the department's many CAM-related activities," end of quote.

DR. GORDON: Don.

DR. WARREN: Let me say, we are not trying to name this entity, either. We are just calling it, as they say, a "unit." They will probably put whatever name they want to on it.

DR. GORDON: Other comments about this issue. Do we want to recommend -- yes, Charlotte -- where it should be?

SISTER KERR: Well, I am just making my comment further. I am continuing to be open, but my sense is that this is even being recommended because of Senator Harkin, who is doing this. I think if we felt clear that we should go ahead and be congruent with that, which is to say HHS. I do think, even though I don't know and I

assume and I think great things about the administration, that it is more consistent to leave it in the Department of Health and Human Services, which is what I hear you having as a value, Effie, which perhaps either I or you are not as clear of where will it be the most consistent. It sounds like HHS.

I think what we would have, even though we want to be permissive and inclusive and all of this, and respectful, that it is okay for us to say, we looked at all of it and here is where we came down as a committee. I think it is a clear energy force, if we feel that way, if we are all conscious of HHS, the language is in, we know what we are doing, it will happen.

DR. GORDON: Steve wanted to say something.

DR. GROFT: I don't know if you recall the preceding sentence. It said, "The Conferees understand the White House Commission on Complementary and Alternative Medicine Policy will release its final report early in 2002." So, that was the preceding sentence. Then, "The Conferees urge the Secretary."

So, I think we could construct language, as we have done in others, stating that we are encouraged, the

Commission was encouraged, by the language included in the appropriations bill for DHHS and we agree that an office should be established within DHHS. Or, if we want to retain the options, any way I think is okay. I think, get one, though.

DR. GORDON: Yes, Tieraona.

DR. LOW DOG: I would agree with Charlotte. I think that if you have already got the momentum and there has already been recommendations going on the table that you should move with that and be grateful.

DR. GORDON: We have had a couple of recommendations. I don't know how you feel at this point, Effie, but there have been a couple of recommendations to go with the direction that Congress is moving in and recommend that it be at the level of the secretary of HHS.

Is that correct?

DR. CHOW: I just heard that today. I mean, what you are reporting now.

DR. GORDON: No, I understand.

DR. CHOW: I just heard that today, so certainly, I believe in going with where the action is.

DR. GORDON: So, should we make that specific recommendation? Don.

DR. WARREN: These things are in the text here. I think we need to give the options just in case one falls through. That is my own personal belief.

DR. GORDON: All three options that you listed?

DR. WARREN: Yes.

DR. WARREN: If the group says one, then we will do one.

MR. CHAPPELL: I agree with that, and if we want to add a paragraph in that section where we list the three options, we just add a couple of sentences indicating that we are aware of the current legislation. That would be fine, but I like the idea of leaving the three options.

DR. GORDON: David.

DR. BRESLER: I, of course, go the other way. I think it should be at the White House because my concern is that it is going to end up in somebody's drawer somewhere and nothing is going to happen.

I would be okay to go with HHS if there were some language in it that would say that we want to put it

in the area where it is going to get the most support and where this work is going to continue, wherever that tends to be.

We have had this discussion and we have spent a lot of time talking about the advantages of all these different options, and again, I would like to see it go where it has got the greatest likelihood of continuing.

DR. GORDON: So we have some differences of opinions.

Julia.

MS. SCOTT: I want to weigh in on the other side of not putting it in the White House, dependent upon whatever administration is there. I think we have seen some pretty significant offices just about disbanded with the change of the administration: AIDS and many of the women's programs.

I think it makes sense -- we are talking about the health of the nation -- to have it attached to the organization that is charged with the agenda for the health of the nation. So, I think, maybe as a part of what Tom said about putting it in the text, that it could be placed in several places, but I do feel as a

Commission we could come out and strongly recommend that it be in HHS.

The reality is, it could be changed in Congress. I mean, if they wanted to change it, they could.

DR. GORDON: I would just like to say something as a long-time Washington resident. The trend is very much in the direction of it going to HHS. HHS is getting ready for it. I don't think the White House wants it. There is no great interest in it right now. They have a lot of other things on their mind. I don't think it is realistic.

DR. BRESLER: So, Jim, let me ask you, then, one of the concerns that we had is it is going on in agencies way outside of HHS: in Agriculture, in Energy, and some of these other government agencies. Is there some way that we can acknowledge that and say that it needs to be coordinated beyond the department?

DR. GORDON: I think that is there in the text. I am pretty sure that that has been made clear, that HHS is the location for it and the place from which coordination will take place. Steve, you have been

around as long as I have, and Joe has been around for a while, and others, too. Isn't that your sense of where it is headed and what is happening?

DR. GROFT: That appears to be the case.

DR. GORDON: So, I think that we can't ensure anything. I am just going to put out my synthesis of what I am hearing. I think it is fair enough to put the three possible locations, talk about the advantages and disadvantages of each, and then, perhaps, come down on the side of the location of the highest level of HHS.

The problem is, the White House is incredibly vulnerable to change. The surgeon general has variable power, depending on who is the surgeon general and who is the president. HHS is always going to be there. If there had been tremendous enthusiasm in the administration, I would say, great, let's try to get it at the White House, but that is not what we have at this point.

DR. BRESLER: How about at the Supreme Court?

[Laughter.]

DR. GORDON: So, let me make that as a suggestion, that we put down, maybe, a little bit more on

the advantages and disadvantages, we talk about the legislation, and we say that we feel that it appears to us that HHS would be an appropriate home for this. Does this feel okay, Wayne? You know the scene, too.

DR. JONAS: Yes, I agree. I mean, there are pros and cons to all this, but the pros of putting it at HHS versus the White House are much greater than the cons. To me, it is a non-issue.

I think, certainly, when you describe the roles, the down side in HHS is that it has less jurisdiction over some of the other federal agencies that we are targeting. However, if you put in some of the roles that this specifically is to look at the other federal agencies, it is going to do that anyway. It is much more likely, given the current climate, that there would be appropriations to actually allow it to do something in there.

DR. GORDON: Joe, yes.

DR. FINS: I kind of agree. I think it will be less prone to ideological influences in Health and Human Services, and I think that would be for the long-term probably better.

DR. GORDON: So, do we have agreement on this? Great.

There are a couple of other issues that have been raised. Tom, do you have another issue?

MR. CHAPPELL: On the order.

DR. GORDON: Right. Thank you.

MR. CHAPPELL: I heard the explanation of why you don't feel placing it in the front of the report is appropriate, but I would argue that I do think we have the license to put this where we want. I like the boldness of this right up front. It is very provocative. Not provocative, it is bold and it is crisp, and it suggests something very important that they are about to read. It lends importance to the whole rest of the report.

DR. GORDON: So this is a discussion about the placement of this whole section on CAM Central. Other comments on this. Sorry. Julia, and Joe.

MS. SCOTT: I'm sorry. This kind of throws me. I thought we were going to go through the action steps first.

DR. GORDON: Thank you.

MS. SCOTT: Then we can talk about the placement.

DR. GORDON: Fair enough. Joe, do you want to say something?

MR. CHAPPELL: I think on the placement issue, I mean I think --

DR. GORDON: Wait. Let's not talk about the placement issue now. Let's go through the action steps -- I think this is a better order -- and then come back to the placement issue.

DR. GROFT: Tom, when I spoke about the placement, I was really referring to Action No. 1.3 and the discussion of the facilitating implementation of the Commission's recommendations. I wasn't talking about the positioning of the recommendation itself and this section, so just to clarify that. We are still open. We will talk about that in a little bit.

DR. GORDON: So, let's go through the action items. Thank you, Julia, for bringing us back. Then we can talk about the placement of this section, okay?

So Action No. 1.1, I am assuming that we are putting in there "HHS," right? We are being specific in

Action Item No. 1.1. We have that agreement?

[No response.]

DR. GORDON: No. 1.2. Any issues on No. 1.2?

Yes, Joe.

DR. PIZZORNO: To the advisory body, I think we should specify that it includes CAM and conventional medicine practitioners.

DR. GORDON: How would you have it read, Joe?

DR. PIZZORNO: No. 1.2, it says, "with members from both the private and public sectors, comma, including CAM and conventional practitioners to guide and advise."

DR. FINS: On page 4. You say this on page 4, line 6 to 13.

DR. GORDON: But he is questioning whether it should be in the action item and the recommendation. Your suggestion is, it should be. Yes, Don.

DR. WARREN: Another thing, the word "stakeholders" in here, I think we need to change that to "interested parties in CAM," which would include practitioners.

DR. GORDON: That is not in the action item?

DR. WARREN: No.

DR. GORDON: So, can we deal with Joe's addition to the Action Item No. 1.2? Are we in agreement on that? Tieraona.

DR. LOW DOG: I guess my only thing there is if you are going to start listing who you are going to have, then that is an incomplete list. I mean, that is the only thing, is that including CAM and conventional practitioners, I mean it would also be researchers and scientists.

DR. GORDON: Right.

DR. LOW DOG: I mean, so I guess I am not clear if we have explained this in the text, why it does need to be in the action item, because it is also an incomplete list, then. That is just a question.

DR. GORDON: Joe, can you explain why you feel it is important to have it in the action item?

DR. PIZZORNO: Because I believe that they are the two most critical on the list, and I want to make sure that they are specifically included.

DR. GORDON: Effie, and Tom.

DR. CHOW: I think what is critical should go

into the action line because a lot of people don't go and look at the text. I think it should be in there, too.

DR. GORDON: You agree with Joe?

DR. CHOW: Yes.

DR. GORDON: Tom.

MR. CHAPPELL: I guess I would leave this makeup of the advisory council to the office, the newly formed office. This particular group was not made up of CAM practitioners and conventional doctors, and we did pretty well.

DR. GORDON: In part. I think that the way the recommendation reads would be "including conventional and CAM practitioners as well as members of the public and private sector."

MR. CHAPPELL: I see.

DR. GORDON: It is not exclusive.

MR. CHAPPELL: I see.

DR. GORDON: That is what you had in mind.

DR. LOW DOG: I'm sorry, but I guess if you are going to say what is critical, I think in an advisory council like this it is very important that you would have rigorous scientists on here as well advising.

So I am not sure that I think this is the most critical aspect of this advisory council, so my only question is, can this be really discussed well in the text about how there needs to be a well thought of group and what we would envision this to be. I don't think it would just be the practitioners that are your critical aspect on this advisory council.

DR. GORDON: Joe.

DR. PIZZORNO: Tieraona, I agree with you. The challenge is the experience we already have with the NIH. It started out with some CAM people being on it. They virtually all got eliminated. We had to put legislation into Congress to require that they be on the advisory board. So, unless we are really specific that CAM professionals must be included, they will just get left out for one reason or another. Just practical experience.

DR. GORDON: Are we okay, then, with including that? We are not saying it is restricted to them, we are just indicating the importance of including those two groups. Okay? Great.

No. 1.3. How are we with the content and the

order? Don, do you want to say something?

DR. WARREN: Well, all these five parts of this No. 1.3 were designed to give us the broadest maximum efficiency or effectiveness in this office, and I think they ought to stay the way they are.

DR. GORDON: Are we okay with this? Or, are there comments or corrections or critiques of this? Joe, please.

DR. FINS: We are not talking about the text? I am not sure. What are we doing?

PARTICIPANT: We are talking about the actions.

DR. FINS: Okay, then.

DR. GORDON: I would like to get agreement, if we can, on this and then look at the text and then look at No. 1.4.

DR. CHOW: I still think that "facilitating implementation of the Commission's recommendation and action" should be up front there.

DR. GORDON: Can we have a discussion about that? Does anybody want to make any comments on that? Effie is suggesting that the last part be the first in No. 1.3. Yes, David.

DR. BRESLER: Again, there may be some issues in which we don't reach consensus or have quite different opinions in our recommendations. Again, putting this up front, we can say that it could also continue to explore areas that the Commission was not able to complete or was not able to resolve.

DR. FINS: I think having No. 3 last, I mean it is there. Putting it first looks like we are trying to perpetuate ourselves. I think it is more modest to say there should be an office, there should be an advisory body, and they should do all these things and also consider the implementation of these recommendations. I mean, it is a little more prudential and a little more like we did our thing, we sunsetted, this is the next process.

DR. GORDON: George.

DR. BERNIER: Yes, I would agree with that. I don't think it is our responsibility or our privilege to name the committee.

DR. GROFT: I actually tend to agree that it is better to have it last. It is pretty clear what we want to have happen.

DR. GORDON: For me, this is one of the issues that is clear in making statements to the press. It is an important issue, and it is already happening. So I don't think we need to belabor it. If it weren't happening, I might want to push it more, but since there is already a congressional mandate for it to happen, I feel much more comfortable being kind of relaxed about it.

Steve, you are a long-time observer of the scene.

DR. GROFT: To me, the significant point is to create an office and then things get done. Without creating an office, you don't have that focus of activity. What the placement is, it's not really that important to me.

I mean, as a person in the government, I just look for language that enables me to go and work in a particular area that needs to be worked on. You do what you can do in the time, and there is a time and place that you are able to facilitate the implementation of these activities.

DR. GORDON: Thank you, Steve. Effie, and then

Joe.

DR. CHOW: I think it has been misunderstood. I didn't mean put 1.3 up to 1.1. I'm just talking about the reorder of the activities in 1.3

DR. GORDON: Oh, I see.

DR. CHOW: Within 1.3, the implementation.

DR. GROFT: I think you want to move up the "and facilitating implementation of the Commission's recommendations and actions" to within No. 1.3, up to the beginning.

DR. CHOW: No.

DR. GORDON: No, no, no. She is saying moving all of 1.3.

DR. GROFT: Oh, okay. Then I misunderstood it, too.

DR. CHOW: I don't mean that. That is what you people are thinking I said.

MS. SCOTT: What she means is, she wanted to take that last sentence and put it as part of the first sentence of No. 1.3.

DR. CHOW: No. 1.3.

MS. SCOTT: "The office's responsibilities

should include facilitating the implementation of the Commission's recommendations and actions," and then continuing on with, "serving as a federal CAM policy liaison."

DR. GORDON: So that is a suggestion. What is the response? Do we want it the way it is? Do we want to put "facilitating implementation of the Commission's recommendations" first in this order?

Let's get a show of hands. This should be a simple up-and-down. Do we want "facilitating implementation of the Commission's recommendations and actions" to be the first item in No. 1.3? How many would like that?

[Show of hands.]

DR. GORDON: How many would like it to be the last item?

[Show of hands.]

DR. GORDON: The majority says it is the last item. I mean, we all want it there, it's just a question of placement.

Is there a No. 1.4 that you have for us?

MS. LARSON: I can't do it.

DR. GORDON: Linnea was looking for a No. 1.4.

MS. LARSON: I can't do it.

DR. GORDON: Yes, Joe, go ahead.

DR. FINS: Just a couple things. I don't remember, on page 1, that parents of children with ADHD, these various folks specifically talked about the need to coordinate an effort. If that is there, that's fine.

DR. GORDON: No, what they primarily talked about, they wanted more information, they weren't able to get information, they weren't able to get the government to pay, they couldn't figure out who in the government to deal with.

DR. FINS: It has been deleted? Let me just say one more thing. On page 4, when we are talking about who is going to be on the committee or this advisory thing, I agree with it being in HHS. I think that is a good idea.

I just raise this as an issue, really, for the government aficionados here, whether or not we want to say something about this body having some representation from the Office of the Domestic Policy advisor.

DR. GORDON: I think that is a great idea.

DR. FINS: As a way of reaching out to other federal agencies that are domestic but not in HHS.

DR. GORDON: I think that is a really important addition, and there may be several agencies that we want to list in here.

Do we have a sense of agreement on that? Because all we have here is HHS agencies, and we may want to give a couple of examples. So, we are in accord with that? I would say Department of Defense, VA. I mean, those are the clear ones.

PARTICIPANT: Education.

DR. GORDON: Good. So we will put that in.

Joe K., are we okay with that? Okay.

I'm sorry. Tom, and Tieraona.

MR. CHAPPELL: I am sensitive to the fact that we are guests for dinner tonight at a private home, and I feel a real strong obligation to adjourn right now.

DR. GORDON: So if there are any other textual issues, we will take them up first thing tomorrow morning, and then we will take up Tom's dental concerns.

[Laughter.]

DR. GORDON: Will we have Access and Delivery

first? Or, do you want to put Access off? Access first? Put it off. So we will do Information first, at 7:00.

I apologize, but I am concerned. I do not want to leave us hanging at 3:00 or any other time. I want us to complete our work, so we begin at 7:00 tomorrow morning promptly. Thank you all very much.

[Applause.]

[Whereupon, at 7:16 p.m., the meeting was recessed to reconvene the following day, Friday, February 22, 2002 at 7:00 a.m.]

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CERTIFICATION

This is to certify that the attached proceedings

BEFORE: White House Commission on Complementary and Alternative Medicine Policy

HELD: February 21-22, 2002

were held as herein appears and that this is the official transcript thereof for the file of the Department or Commission.

DEBORAH TALLMAN, Court Reporter