DR. GORDON: Let me just say that I think --

DR. JONAS: One second. One could say "Appropriate practices found by the Healthy People Consortium to be useful for the 10 leading indicators should be incorporated."

DR. GORDON: What I would say, though, on the school issue is that I think that this is an issue in which Secretary Paige is quite interested, the Department of Education. I think it is one of the few issues in which we can really make a difference.

DR. ORNISH: We are saying the same thing. All that Wayne is saying, which I think is really smart, is that if I say "CAM practices that have been proven to improve nutrition," blah, blah, blah, you have to say, well, according to whom? That's all. And he is saying, according to them. I mean, you may assume or I may assume that something has been proven, but there has to be some standard of what do we look to to say that this has been proven or not, and you are just giving a mechanism.

DR. GORDON: Tieraona.

DR. ORNISH: I think we are all in agreement

about that.

DR. LOW DOG: I am willing to compromise on CAM practices in 1.1 because I didn't like it. I wanted, "Strategies should be developed that improve nutrition, promote exercise and teach stress management," because I am not convinced that a lot of our best evidence and our best techniques to do this are going to be found just under CAM. So if I am really interested in promoting the health of my kids in school, I am going to look for the best strategies out there, not just those that fall under CAM.

So I am willing to go with "CAM practices that have been proven," but you have to have somebody to do the evaluation, and I think before you start to implement things in kindergarten, you better be very sure that what you are putting in place is valid, scientifically valid, appropriate, period.

DR. GORDON: The question I have here is if something has already been proven --

DR. ORNISH: According to whom? That is the question.

DR. GORDON: Well, for example, it has been

proven that calorie-dense snacks are not particularly healthy for kids.

DR. LOW DOG: Right. That is not a CAM practice, either.

DR. GORDON: I understand. I understand. But what I am suggesting is this is one of the areas where -- and we make this very clear and I think that a lot of Joe Fins' points have addressed this very clearly, that there are many areas where CAM and conventional medicine or public health overlap. This is one of those, clearly one of those areas, and the issue here is do we want to begin to use proven strategies for improving nutrition, promoting exercise and teaching stress management with kids or not?

DR. ORNISH: Jim, the whole issue is proven according to whom? And what Wayne is outlining, which I think makes perfect sense to me, is a mechanism by saying that these are proven.

You could talk to somebody who might say, you know, sitting under a pyramid is proven because I have three patients who did and they got better. You know, we need some kind of way of saying what does that mean, that

they are proven?

DR. GORDON: Let me come back to something that Charlotte said earlier, is that in various portions, we have used safe and effective and we have not said who determines safety and efficacy. We have assumed that that has to do with published research in peer review journals. That is what I am talking about. There is a difference between setting up a whole other mechanism here -- let me just finish my sentence, and I have David first and then Tieraona -- setting up a whole separate mechanism here from what we have done in every other section in the report.

So I am not saying that we can't do that; I am saying I don't see the reason. If we are saying safe and -- I see the reason for the Healthy People in regard to those specific task forces that are addressing issues related to Healthy People. That makes sense to me. It may not make sense if we are talking about preventing -- you know, we are talking about promoting wellness, promoting better patterns of exercise in children. So I think there are two separate issues here and we are invoking a different standard here.

David and then Tieraona.

DR. BRESLER: Again, I see an opportunity here, and I think what Wayne is saying is right on target, but I think it could be expanded even more. In those areas that would not be appropriate to go through that review agency, maybe we can recommend funding for consensus conferences or other fairly well established ways that we do look at the status of things and make determinations as to where we stand.

DR. ORNISH: But he is saying why is this held to a different standard if we don't do that --

DR. BRESLER: I think we need to address that issue in all the safe and effective. I think we need to -- why not take that on and say very often the questions come up. There are some things that appear to be safe and effective, there are others that we need to do more research to determine it.

That affects all of our recommendations and maybe we need to address that issue directly and request funding to make those determinations either through Healthy People or through consensus conferences or in some other way. Maybe that is something we need to do.

DR. GORDON: That takes us back to the whole rest of the report, too, though. So I want to just point that out.

Tieraona.

DR. LOW DOG: It is not enough to have one study in one journal saying something works in one group of people when you are going to be making national guidelines or broad statements about that this should be implemented at the federal level for public policy. It requires more than a study, and somebody has got to do the evaluation before you say, in our national guidelines, we are suggesting this. It is a little bit different.

If you want to use glycocyamine for your arthritis, that has a different -- that has something different to me as a consumer, what you are willing to choose to take care of your arthritis. It is a very different issue when we start saying that we are going to make federal policies. And we are going to make claims about disease prevention? That is a very hard thing to prove, disease prevention. Health promotion. Improving nutrition. Promoting exercise. I think that you have to

have more thought and there needs to be a respected body that is going to take this on to evaluate what is out there.

DR. GORDON: Any other comments on this? Yes, Julia.

MS. SCOTT: I think first I would like to remind us that the Chair's admonition that we are spending too much time is clearly on Recommendation No. 1. I think we really have to pay more careful attention to the clock.

Having said that, I also agree with Wayne in terms of the recommendation. If our recommendation is that it needs to be evaluated, it seems to me that 1.1 needs to then describe the mechanism through which it would be evaluated and then everything else should be addressed.

I agree it is important to get the aspect of offering these kinds of things in a responsible way to children and whatever, but I do think a logical progression, if we recommend an evaluative body, that we then say who that body should be and then continue with the rest of the recommendation.

DR. GORDON: Okay. Other comments on this? Yes, Charlotte.

SISTER KERR: Just a question.

Corrine, where is it that we validate stress management so that we ended up listing it in our action? Is it in the text?

MS. AXELROD: When you say "validate," you just want to know if it is --

SISTER KERR: We obviously pulled that one out and I am just wondering where did we discuss it that we decided on that one. It is sort of, in my mind, a continuation of this evaluation conversation. I am just wondering what we did already responsibly so that we included that particular behavior.

DR. ORNISH: There are some studies looking at stress management in kids, and I think that, whether they are in this section or not, that we discussed them. But maybe we could just add that to there if they are not there already.

I want to just bring up the point that Jim mentioned, though, which I think is a really important one, and that is that I think the real issue is not how

come we need to specify here how they are going to be evaluated to be safe and effective, but to say we really need to be mindful of that throughout the report to come up with at least some general guidelines that can help people determine a mechanism for deciding what is the state of the evidence.

DR. GORDON: Wayne.

DR. JONAS: I do think that if you are going to make policy statements and say this should be implemented, that is different than many other areas of the report which are about professionalism, access, licensing, education, you know, which they are different. So I think especially in the areas we are going to determine, you know, what is proven and what should be established in a policy, you do need to have a process that involves a national body. Maybe this is not the right one, maybe we should put the Healthy People Consortium and other national groups to broaden it a little bit.

I think that even things that are already proven, they still need to be evaluated this way because they have to be looked at for their potential impact on

the top 10 leading indicators and in Healthy People 2002, so even the proven literature.

It isn't necessarily always safe and effective. I mean, some things are implemented because they are felt to be just logical and they make sense and we want to see them happen. So "appropriate" is probably a better term. Often it is based on whether they have been proven safe and effective, but that is part of what the national body would do.

DR. GORDON: Wayne, I am going to ask you if you could reword and reorder the action items for us, because I think we are at a stage where we have had a lot of discussion about this and then we still have a couple of specific action items we haven't discussed. So maybe we can discuss the specific action items and then get a rewording and reordering for this. Is that okay?

Yes. I'm sorry. Tom, Effie.

MR. CHAPPELL: I wanted to just ask the Chair if he could share with us your concerns about the Healthy People Consortium. I am feeling you don't have an adequate opportunity to participate in this discussion and I would like to give that to you for our benefit.

DR. ORNISH: Jim is so laid back and we need to give him assertiveness training.

MR. CHAPPELL: I didn't call on you, Dean.

[Laughter.]

DR. ORNISH: We don't need to give you assertiveness training.

DR. GORDON: Let me say, I appreciate the wisdom -- and I appreciate having the chance to talk -- I appreciate the wisdom of having this evaluated. My idea is, I don't want to be restricted in the way we are going to implement this.

This, for example, is an area where I would like to go directly to Secretary Paige and the Department of Education and talk with them about a mechanism to determine how to begin to improve the health and health education of school children. Obviously evaluation would be a component to decide what went into that, and that is not a decision that would be made just by one person.

What I am concerned about is that this is one of the strongest, I feel, one of the strongest recommendations, one of the ones that the public has the most interest in, certainly one of the ones I am most

interested in and what clearly Bill Fair was most interested in, and I don't want to be tied to the operation of a committee that may meet occasionally and may not come up with recommendations to which we may not have much input.

I feel just as we are making recommendations for more research in certain areas that are not necessarily tied to the meeting -- that are just trying to open up the domain of research, so similarly what I am suggesting is that this may be an area where we can go and talk with people in Congress, where we can go and talk with the Department of Education, where we can begin to facilitate the process, which may not fit so neatly or may take a long time to fit under the Healthy People process.

That is my major concern, and I am not saying it is the exclusive domain of CAM. I have never thought that and don't think that now. I think that this is part of good health education, and I think we as a Commission as well as individuals have something to contribute.

DR. ORNISH: But, Jim, how do you address the concern that Tieraona and others have expressed that

there is a presumption in what you are saying that these things are already proven, you know what works, you know how to implement it, and then it is just a question of getting the Secretary to do it?

DR. GORDON: No, I think that some things are proven and some things are not proven. I think there are a whole range of things. I think what we need to do is to encourage -- the idea is to encourage the Secretary of Education to look at these issues, not to just leave it for Healthy People 2010 or 2020.

DR. JONAS: Who would you like to target that to, then? Who would you like to target that to, then, if --

DR. GORDON: I would like to target it to the Department of Education.

DR. JONAS: To the Department of Education.

DR. GORDON: Yes, in this instance.

DR. JONAS: All right. So then Department of Education in collaboration with Health and Human Services should then evaluate, et cetera, et cetera?

DR. GORDON: Yes, something like that.

DR. JONAS: Okay.

DR. GORDON: But I am not sure if it has to be -- I mean, if it needs to be in collaboration with Health and Human Services. They are perfectly capable of setting up their own --

DR. ORNISH: I don't think you are really saying that, Jim. You are really saying you don't want anybody to evaluate it, that you already know what is proven.

DR. GORDON: No, I am not saying that. What I am saying is I want to encourage them to consider including these approaches.

Basically, as you know, health education now is a series of don'ts. Don't do this, don't do that, don't do the other thing. There is very little emphasis and even less time devoted to helping kids find what are healthy behaviors.

MR. CHAPPELL: Jim, could you help Wayne with the language, then, that you would like during lunch?

DR. GORDON: During a healthy lunch?

MR. CHAPPELL: Yes. Because I think we are appreciating your point of view, having heard you. So could you help craft that language for this piece during

lunch?

DR. GORDON: I could do it during lunch, but it is basically just encouraging the appropriate departments, including the Department of Education, to develop strategies for improving the health of our children, which may include CAM practices that have been proven to improve nutrition, promote exercise and teach stress management, something like that.

Yes, Dean.

DR. ORNISH: Again, please don't misunderstand me because there is nobody more committed to teaching people how to change their behaviors than I am, and certainly that includes kids. But I do think it is a perfect example of what I was trying to talk about in my memo, which is that there is this ethos of presuming that certain things work and then wanting to find the most direct way to implement them, and I think this is what, Tieraona, you are very eloquently having some concerns about, which is that just because I might think something works doesn't mean that it does, or just because some people think it works doesn't mean it does.

Tieraona, can you elaborate on that just a

little more, and then maybe we can just get closure on this and move on?

DR. LOW DOG: Well, I am just frightened by the notion that you can just sort of go lobby people to go implement things. I just think that is not a thoughtful way to do things.

You know, I believe in martial arts, I believe in Tai Chi, we eat a vegetarian diet. I mean, my own personal life is based around this, but I would not presume to say that the way I have chosen to live or raise my children is the way that is going to work for everybody.

I strongly support the recommendation that was made that an evaluation be undertaken. I fully endorse that that could include the Department of Education in collaboration with X, Y and Z, and that based upon that evaluation and determination, that those that have been shown to be effective, even demonstration projects I would say would be the next place to move, not just implementation, but demonstration projects to determine how to best implement it, and I think taking a step-wise approach is the way that 20 years from now our children

will be healthier. But to try to just bulldoze through it in a year to make it happen is not, I think, the most effective way to ultimately make the change that will protect us.

DR. GORDON: I think we are in complete agreement. I don't think there is any disagreement between us about how it is going to be implemented and how it is going to move ahead.

I think what I was saying is all the recommendations in this area should not be tied to Healthy People 2010, 2020, because that mechanism may not be the most appropriate.

What I am suggesting is that we may want to work with other and make recommendations to other departments that they can begin this process, which, of course, would begin with evaluating what is most appropriate, with demonstration projects and, if the demonstration programs are effective, with implementation.

DR. LOW DOG: I think we need to just say that.

DR. GORDON: That is fine.

Joe?

DR. FINS: You know, I really want to urge caution here, because I think where we started yesterday morning and where we were before we got to this section was a lot healthier for the well-being of our report.

I think we are really at a juncture here where we are at risk of CAM creep, we are at the risk of end-running the processes that exist, and it really does sound like proselytizing. I think you may win a rhetorical battle, but you are going to not promote the public health.

I think that there are mechanisms in the federal government, there are ways of conclusively proving things work or don't work. There are health indicators, there are responsibilities of certain agencies versus others that look at health indicators, and I think we have to be very careful to deal with this incrementally and prudentially.

DR. GORDON: Joe, that is fine. What I want to do is get the wording for the recommendation, okay?

DR. LOW DOG: Wayne had a recommendation earlier. Joe, would it be all right if we -- Wayne do you have something?

DR. JONAS: The only difference I can currently see from what we had done before is instead of targeting it toward Healthy People Consortium, the evaluation component, and implementation aspects and recommendations will come out of that, I think. So I don't think that evaluation means this is delayed, I think it is actually the most efficient way to do it, but it would be targeting something a little broader so that others could be involved in that.

I mean, you could say the federal government should, or you could say the federal government including the Department of Education, Health and Human Services, and the Healthy People Consortium, if you wanted to try to highlight those, should evaluate the role of CAM or CAM and CAM related, okay, CAM or lifestyle if you wanted to, for the 10 leading indicators and develop strategies for the use of appropriate practices in these areas.

So that is basically a rewording of 1.5 as I described before, but just broadening it so it is focused on federal agencies, highlight the ones that you think ought to be the leads in that, put it up at the top so it is Action Item 1.1 or in a separate recommendation, if

you want, and then just make sure through the rest of the recommendations you say that the CAM practices that have been found to be useful for this, and that means found by this particular evaluation process.

DR. GORDON: This is fine. I want to move ahead. We need to really move down the list of action items.

DR. ORNISH: Let's move ahead.

DR. GORDON: Effie, do you have a comment before we do that?

DR. CHOW: Yes. I think the problem we are running into is that when I look at that recommendation, it suddenly is all about children, and then the last few are about the general population.

I agree with Wayne that we should take 1.5, but along with 1.5, we should take 1.6 as well as a grouping to move it up, and if there is a problem, as Jim was saying, that you want some action, perhaps we need a separate recommendation to deal with the children, because I think that is very important, too, and then that doesn't tie it in with what is part of this recommendation.

DR. GORDON: Okay.

DR. FINS: The most vulnerable members of the constituency of people are the elderly and the children, and I think the standards -- I mean, from my point of view, since an adult could be willing to voluntarily participate in a study, that person, you know, he might or she might be willing to accept risks and benefits and make decisions. Children, because they are underage, are not able to provide consent to participate in things. So to start with children seems to me inverted, and I think it is, for all reasons that Tieraona said earlier, is really problematic.

It strikes me that there may be more receptivity in the Department of Education, so we are going there, versus HHS, where there may be the little more scientific rigor, and I think that we have to be very careful about that.

DR. GORDON: What I would like to do is to go with Wayne's recommendation, which is talking about a number of agencies that will become involved in different ways depending -- just the way the Department of Defense might become involved in other issues. There are a

number of agencies. My comment was really addressed to the fact that one specific process may not fit all these recommendations, including recommendations about children.

We need to move ahead, okay?

DR. ORNISH: Let's move on. Okay. Let's move on. If I can move now to the second --

MS. AXELROD: Jim, just for clarification, the Healthy People Consortium already includes all of the federal agencies you have mentioned, plus more, plus state, plus other organizations, so it is a little bit redundant to say it that way. The Consortium is actually one of the best examples of partnerships between federal agencies, the feds, the states, private organizations, and consumers.

DR. ORNISH: Okay, I agree with everything, and just to move on, I agree with everything, the last things said. Again, to address your point about the vulnerable populations, that is all the more reason to have a rigorous evaluation, because of that.

I also want to say that I spoke with Secretary Tommy Thompson yesterday, or the day before yesterday,

and also Mark McClellun, in the White House, who is President Bush's main health policy advisor in these areas, and they are totally committed to prevention. They want this to be the prevention administration.

Ken Cooper is probably going to be the new surgeon general. I don't think we have to worry about these things being implemented by simply making them evaluated properly. So I think we are okay there.

Can I move into the next section now?

DR. GORDON: Please.

DR. ORNISH: Which is Recommendation 2.

DR. GORDON: No, no, no. We need to finish with -- we have not gone through all the action steps in 1. I want to make sure that we are agreed on the action steps here.

DR. ORNISH: We have done 1.1. One-point-two is -- again, I think that --

DR. GORDON: We have not looked at 1.3.

DR. ORNISH: Have we done 1.2, then?

DR. GORDON: And we haven't done 1.4 or 1.6, and 1.2 we have not come to a conclusion about.

DR. ORNISH: All right. So we talked about 1.2

is about -- instead of saying they should incorporate these practices, that they should be evaluating -- to evaluate them to determine their role is kind of a corollary to what we have been talking about.

Tieraona, that was your idea. How do you all feel about that? Can we agree with that? The idea of the step-wise progression, that we do the evaluation, and then those that have been found to be useful, then we talk about how they should be incorporated.

DR. GORDON: Tieraona, do you agree with yourself?

DR. LOW DOG: I just want to know how that relates to our recommendation now that we have about these agencies and Healthy People Consortium and stuff like this. I want to know how that relates to this, Wayne, when we look at 1.2.

DR. ORNISH: As I understand it, Wayne, all of these recommendations would fall under that evaluation.

DR. JONAS: Yes.

DR. LOW DOG: Right. So it just seems redundant.

DR. JONAS: That I think would be the most

parsimonious way to do that, is that most of these are actually implement type recommendations, and instead of trying to rephrase them all to --

DR. LOW DOG: Right.

DR. JONAS: -- include evaluate, evaluate, evaluate, you make them contingent upon the evaluation aspect.

DR. GORDON: I just want to check with you and make sure that is the case.

MS. AXELROD: Well, just because of the way the bureaucracy is, that is just not going to happen. There is a group that works on the Healthy People initiative, the 10 health leading indicators and all that stuff. There is an entirely separate group that works on the guidelines in the schools. So, you know, whereas it makes sense the way you are saying it, in reality these paths do not cross.

DR. ORNISH: So what is your recommendation if the goal is to try to have some group that is considered an authority to evaluate what is considered -- where the level of evidence is sufficient to talk about implementation?

MS. AXELROD: The evaluation could be done by a group -- well, actually, again, we are looking at how these would apply to the goals and objectives, how they would apply to the existing curriculum, so you really need the people that are working on those to look at these things. I don't know, I think we have to work out --

DR. GORDON: I feel like Tieraona's original amendment to 1.2 works perfectly well: "should evaluate CAM practices and determine which safe and effective ones can be incorporated or can be included in national guidelines." I think that covers it. It relates to the specificity that Corrine is talking about about this being a group. It covers your concern for evaluation first before recommendation.

Tieraona, are you with me on this?

DR. LOW DOG: Well, if you are going to have this one, why is there not the American Academy of Pediatrics in here if we are talking about national guidelines on wellness and prevention in children?

DR. GORDON: This is federal agencies, No. 1.2.

DR. LOW DOG: Well, okay. I would ask for

their input at some point.

DR. ORNISH: Another approach is just to say "a body of authorities," without talking about which ones.

DR. LOW DOG: So "should evaluate CAM practices to determine their potential inclusion." I don't know.

DR. GORDON: That's fine.

Dean, let me respond to you. This is, as Corrine is explaining, about a specific project which has to do with these agencies. That is why they are included by name.

MR. CHAPPELL: Jim, I need to ask that our process return to order, where you are calling on people and people are waiting to talk. The conversation that is going on on one side of the room is leaving the rest of us just out of the picture all together. I need more order. We will do better if we have order.

DR. GORDON: Thank you. So let me try to keep the order here. The order is we are on No. 1.2.

DR. ORNISH: I need a point of clarification, because in the past when we had sections that we were in charge of, the person in charge of that section --

DR. GORDON: No.

DR. ORNISH: Is that not the case?

DR. GORDON: I am in charge of the whole meeting. That's what Tom is referring to, that you are obviously the major resources, but that this is a discussion that the chair moderates.

The issue with 1.2, as raised by Tieraona, is, I think, quite appropriate here, and Wayne may have another suggestion, that this is a particular initiative as Corrine has described it. The same principles of evaluation and possible incorporation are being articulated here.

Wayne, do you want to comment on that?

DR. JONAS: Well, I agree with Corrine that if it was just contingent on the first evaluation and everything followed, that these would not cross paths.

I want to just suggest a wording thing that I think you are trying to get at, Tieraona, which is essentially the same thing that is there, but then say, "should evaluate and incorporate appropriate CAM practices into national guidelines on wellness."

DR. GORDON: Okay. Are we okay with that, Tieraona? Because we really need to move along.

DR. JONAS: That links the two for that particular action item.

DR. GORDON: Are we okay with this?

Let's move to 1.3, please.

DR. FINS: We have excluded children.

DR. GORDON: What, Joe?

DR. FINS: It is a generic statement, it does not specifically focus on children as it is written now; is that correct?

DR. GORDON: No, 1.2 does focus on children as it is written.

DR. FINS: So could we read the whole thing with the whole -- I would leave out the children.

DR. GORDON: No, this is a specific initiative that has, as I understand it, Joe, that has to do with children that Corrine is talking about.

Corrine, do you want to explain again?

MS. AXELROD: This is specifically about guidelines that are either under development or in existence. CDC has had guidelines for several years and they are developing more guidelines that are utilized in all the schools. HRSA has been working with the American

Academy of Pediatrics to develop separate guidelines to address different aspects of children's health. So by taking children out, you might as well take the whole thing out because this is specific to guidelines for children in schools.

DR. JONAS: Okay. If you are going to do that, then you need to specify the particular program. Right here, all you have identified is the agency, and they are doing other things besides the ones you have just mentioned that aren't about children but are on these topics.

DR. GORDON: So, Corrine, is there a special program that you can put --

MS. AXELROD: I will add that language to make it specific to those programs.

DR. JONAS: I mean, if you made it generic, then it would allow them to focus on those particular programs around children, or if you put "including children" in it, then it would emphasize that we want to have children focused on and use these programs, but then it wouldn't limit it to only those.

DR. GORDON: Okay. Let's go to 1.3, please.

Do we have agreement on 1.3? Yes? Yes? Okay. One-point-four, please.

DR. JONAS: I want to also suggest we say "including children" instead of "among children," which limits it to children.

DR. GORDON: I'm sorry. That would read, "Healthy behaviors among all Americans" or "among Americans including"? How do you want to say it, Wayne?

DR. JONAS: "Including children."

DR. GORDON: But child is not a healthy behavior. I mean, I am just looking for wording.

DR. JONAS: "Including among children"?

DR. GORDON: "And encourage healthy behaviors."

DR. JONAS: "For All Americans including children Americans, little Americans."

[Laughter.]

DR. GORDON: "For all Americans including children," all right? As if they were not Americans.

[Laughter.]

DR. GORDON: Okay. Let's go on to 1.4.

MS. AXELROD: Do you want to say "particularly

children"?

DR. GORDON: Do you want to say "particularly children"?

DR. JONAS: I think that is fine.

DR. GORDON: Joe, you are shaking your head.

DR. FINS: I mean, I have said what I have had to say about the tone of this section. I have nothing else to say about it.

DR. ORNISH: Well, I have a question. I mean, we are going to talk about again this whole issue about who determines what behaviors we are going to be encouraging? Should we refer it back to 1.1 again?

DR. GORDON: Well, I think 1.1 is the framing statement for all the ones underneath here, as I understand it.

DR. ORNISH: I mean, do we want to just simply add "as indicated in 1.1" or something so it is clear that we have some mechanism that is maybe redundant, but it is clear?

DR. GORDON: That is an open question.

Listen, we need to get organized on this, so we need everybody to be focused on each of these

recommendations as they come up and to move through them as quickly as we can, okay? We are getting bogged down.

So the question on the floor that Dean has raised is -- say it again, Dean, please.

DR. ORNISH: I am not trying to bog things down; this is basically a yes or no. Do we want to make each action recommendation referred back to what will be 1.1, which is -- in other words, do we say -- we are talking about a public service campaign to encourage healthy behaviors. Implicit in that is we know what healthy behaviors are, and we have already said that we really need some authority or some body to try to sort through the data to say what it is.

DR. GORDON: I think that that has been framed by the new 1.1. Wayne, would you agree?

DR. JONAS: I think 1.3 and 1.4, which, in fact, do not have the word "CAM" anywhere in them and are simply statements of, gee, we want to see more healthy behavior activities, I think that is adequate.

DR. GORDON: And I think the reports have been deciding what -- you know, framing healthy behaviors quite well.

Yes, Joe.

DR. FINS: I think we really should be, again, cautious about this, and I think this crosses political lines and ideological bends. What constitutes the right kind of behavior? And this could become very prescriptive and this administration or any administration could use this to promulgate certain kinds of moral stands about what is right and what is wrong that Americans would not necessarily agree about.

Can I ask my colleagues to just tune into this for a second? I really think this is a land mine. It could be usurped in ways that we can't anticipate, and I think that whether you are a Democratic or Republican, Conservative or Libertarian or Liberal, this is potential problematic.

So, I mean, to get prescriptive in this way is a kind of proselytizing that I find objectionable and it is not only CAM creep, it gets into other areas where people could dictate abstinence as a way of dealing with sexually transmitted diseases, for example.

DR. GORDON: Joe, let me ask you a question which I hope will clarify it. We are framing this

according to the objectives of Healthy People 2010, 2020. Healthy behavior derives from that. Do you still object to it?

DR. FINS: Well, I mean, if we took it -- no, I endorse those reports as I understand them, but when I start looking at public service announcements and how the sound bites get constructed and what the message is that gets distributed and how it is interpreted and which public figures are chosen and what the implicit message about their representation means, I start getting concerned.

DR. GORDON: So even if this is all framed by Healthy People -- essentially what we are saying here, as I read it, is that there are objectives in Healthy People, some of which have to do with CAM, some of which don't, and that we are saying we want those objectives, those behaviors that are discussed in there to receive a higher profile and to have more public notice. I feel that is the intent of these recommendations.

DR. FINS: I think it is the line between -- and this is why I was concerned about moving to the Education Department away from HHS -- but it is the line

between ideology and what is scientifically, from a public health perspective --

DR. GORDON: Obviously, we need some more discussion about this. Dean, and then we have a number of other recommendations in this section. It's not going to be 6:00. We're going to be here until much later than 6:00 if we don't move ahead.

Okay. Please.

DR. ORNISH: This is one of the areas Joe and I don't agree on. I think it is actually a very good recommendation, but I just want to make sure that it refers back to 1.1 or whatever we have that somebody can help determine what is considered a healthy behavior and that we just don't assume it, that we all know what that means. That's all.

DR. GORDON: I think the intent is very clear as we have now reconstituted it that this comes under the Healthy People advice.

DR. ORNISH: I am happy with it.

DR. GORDON: Julia?

MS. SCOTT: I was just going to say, you know, again, this is another place where I don't think we can

prescribe what is going to happen with it. I think we can only set out what we think should be the goal and how it should be incorporated, and I don't think -- they might come out with an abstinence program for all we know, but I don't think we can do anything about that right now. But I think we have made clear our intent here.

DR. GORDON: Okay. Let's move ahead.

One-point-four. We have agreement on 1.3, then, with the understanding that this is framed by Healthy People?

One-point-four.

DR. ORNISH: It sounds great.

DR. GORDON: Okay. One-point-four? Joe, 1.4?

DR. FINS: Yes.

DR. GORDON: Okay. Five. We already made that 1.1.

One-point-six. Are we all right on that? Yes? Basically again referring back to national health surveys. Good. Thank you.

Let's look at Recommendation No. 2 on page 9. Let me read it and then you can read to yourself the

action items.

"Research on the role of CAM and wellness and health promotion, the application of CAM principles and practices, and the role of CAM practitioners in the management of chronic disease should be expanded."

Please, before you make comments, give everybody a moment to read the action items, then we will come back to the recommendation.

[Pause.]

DR. GORDON: Read the action items? Dean?

DR. ORNISH: This is something very close to my heart, no pun intended, and I happen to like this recommendation a lot, and you might even want to make reference to the work that we have done because it is a perfect example of that. We did randomized trials showing it was medically effective. We are in the middle of a Medicare demonstration project to see if it is cost effective. It is, to me, the very kind of thing that we are talking about and I like it.

DR. GORDON: Other comments on Recommendation 2? Veronica?

DR. GUTIERREZ: I would just like to know why

it is not in the Research chapter. Why isn't this in the Research chapter?

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

MS. AXELROD: Wayne?

DR. JONAS: Yes. Because we thought this was an important enough item that it should be highlighted in this section also. We do discuss the importance of research on wellness in the Research chapter, but we felt like that this was an important enough topic that we also should have it in here.

DR. GORDON: Okay. Anything else about the -- do we accept the recommendation? Yes. Let's go to Action Item 2.1, please.

Joe.

DR. FINS: We have here special mention of underserved and special populations. I think we don't want to single them out for special treatment because they are otherwise vulnerable and don't have health care services. I would not want this to be misconstrued as, you know, they would be more willing to agree because they don't have health insurance and they don't have

access to services, and I wouldn't want this to be perceived as being a substitute for those services.

DR. GORDON: Do you have a recommendation for dealing with that?

DR. FINS: I think if you -- I mean, I think we might want it to evaluate the clinical and economic impact of comprehensive health promotion programs that include CAM and leave out the populations.

DR. GORDON: Okay. Other comments on Action Item 1? Yes, Effie and then Julia.

DR. CHOW: I recall conversations on this, and I thought that it was very important that we do include the underserved and special population because they are so often neglected, and it isn't just, say, only to them, but it includes.

DR. GORDON: Julia.

MS. SCOTT: Yes. I think that you are misreading that, Joe, because it is saying that we should have demonstration projects to evaluate the clinical. Maybe it needs to be moved around, but to make sure that it includes, because so often, so many of these studies and projects just don't include us, so we don't know if

it is applicable to us.

DR. FINS: So can we put the emphasis on studying the clinical and economic impact of comprehensive health programs that include CAM and then the second sentence is, "These studies should also include underserved and special populations" separately as a second statement?

DR. GORDON: Does that suit everyone? Okay. And then listing the special populations?

DR. FINS: I think people know what that phrase -- demography is being referred to.

DR. GORDON: The only question I have about this is whether or not it should be stronger, because so many of these programs have gone to people who have money because there have been people with discretionary money. So there is a kind of imbalance.

DR. FINS: Well, by singling them out and saying that it should include -- you are acknowledging them without burdening them with being in research when they -- you know, similarly, people who have discretionary income have the choice to participate. People who don't have health insurance may have no choice

but to say, well, at least this is something.

DR. GORDON: Okay. Is everyone comfortable with this? I am fine if everyone else is comfortable. Yes, Effie, are you comfortable or not? I can't tell. Okay. You are sure? You don't want to add anything or say anything? I just want to -- you need to use the microphone, though.

DR. CHOW: It is not my preference to make the change, but I will go along with it if it is with the group.

DR. GORDON: Let's move on to 2.2. How does this seem to everyone? Dean?

DR. ORNISH: Again, I think it is great, but I would just expand it to explicitly say that the CMS, which is what used to be called HCFA, be encouraged to fund demonstration projects in this area.

DR. GORDON: Then you would add, for those that are safe and effective, you would want CMS -- that would be a second sentence? Again, it is following the principle of evaluation first and demonstration second.

DR. ORNISH: Yes. Well said.

DR. GORDON: Okay. Does that make sense to

everyone?

MS. AXELROD: Do you want to limit it to just CMS?

DR. ORNISH: No, but I think that I would mention CMS. You might say "federal organizations including CMS" or something like that. I think that is a good point.

DR. GORDON: And do want to say the second sentence that would include the evaluation, once evaluated safe?

DR. ORNISH: Yes. Just the way you said it.

DR. GORDON: Do you want to put it into words?

DR. ORNISH: Why don't you do it?

DR. GORDON: "Those programs that prove to be safe, effective and applicable should receive funding for demonstration projects."

DR. FINS: "By CMS and other federal organizations."

DR. GORDON: Does that make sense? Joe, are you okay with it? Okay. Good. Everybody okay with this? I just want to make sure fatigue is not setting in.

Recommendation 3 on page 12: "Safe and effective CAM practices used in the workplace to promote wellness and health should be expanded."

Page 12, let's just leave a moment so people can read the action items, and then we will come back to the recommendations.

SISTER KERR: Jim, excuse me. I think you made a mistake on the last one.

DR. GORDON: A mistake on 2.2?

SISTER KERR: Just a little inclusion.

DR. GORDON: Okay.

DR. JONAS: Well, I just think if you are going to highlight particular agencies that are kind of ripe and ready, and where this applies, CMS is certainly one. Social Security is clearly another, the VA is clearly another.

DR. GORDON: So, how would you like to word that?

DR. JONAS: I would simply add those on to the end. I would simply add them on to the end instead of just CMS.

DR. GORDON: Okay. Corrine, do you have that?

MS. AXELROD: Yes.

DR. GORDON: Great. Can we move ahead now?

Discussion about the recommendation. Tieraona, is that a beginning point for discussion?

DR. LOW DOG: Well, it's just my same old thing, that it's safe and effective, but how do you know which ones promote wellness and health, and how do you implement?

I guess it goes more to your action items. CAM wellness and prevention activities should be included. I guess I would have had some of the same languages that somebody should evaluate what these are, and those that truly do work really need to be implemented.

DR. GORDON: Okay. George?

MR. DeVRIES: Some of the work we did on the reimbursement side and, in fact, a conference call we had with the IRS and their tax attorneys related to the ability for an employer to even offer wellness programs and the tax deductibility of those programs.

I mean, we are making recommendations that the tax code doesn't even allow. So I am concerned that we are making recommendations that you need to -- we need to

change the tax code first.

DR. GORDON: This doesn't have to do with reimbursement here.

MR. DeVRIES: Well, but it is wellness programs that are being provided for employees, and therefore that is a covered benefit as would be interpreted.

DR. GORDON: I see. The intent of this recommendation may be, first of all, backed up to the previous recommendations where we are talking about evaluation for appropriateness and then demonstration projects. You are also bringing up another issue.

The question I have is how do we want to reframe, if we do, Recommendation 3? So I am looking for some wording and some guidance.

DR. ORNISH: What about just the parallel of what we did before? I mean, it is really the same issue, just in a different arena.

DR. GORDON: Do you want to read how that would sound, Dean?

DR. ORNISH: I don't have the language from what we had before, but the principle is that there would be some group that is evaluating -- why don't you do it,

Tieraona?

DR. LOW DOG: Can't we do something like, "CAM practices should be evaluated to determine what role they may have in promoting wellness and health in the workplace."

CAM in Wellness and Prevention

DR. GORDON: One thing I do want to mention is that there is a sizeable body of research literature on the use of many of these approaches in the workplace, and that material, some of it was presented to us, it was submitted in testimony. I am a little concerned with always evaluating when we already have done a tremendous amount of work in looking at the data.

MR. CHAPPELL: Jim?

DR. LOW DOG: Can I respond to that? I'm sorry, Tom. You had your hand up.

MR. CHAPPELL: Jim, I feel that this recommendation needs to be left alone. We are not talking about dictating to anybody here. This is really just sort of encouraging our workplaces to adopt these measures, and many of them already are, and, as you say, the information is well along in terms of the

cost-benefit relationship.

So I don't feel that we should be in the evaluation mode here.

DR. GORDON: Tieraona, yes.

DR. LOW DOG: When I look at evaluate, I guess because I don't know how a lot of these things work, I would imagine somebody like the Department of Labor or somebody evaluating the information in a thorough and concise fashion, which then begins to allow, once you have had an -- this is not going out and doing more research; this is evaluating the data that is already out there to determine what does it show.

My own feeling is that is the only way tax codes and other things are ever going to be impacted is if you have the relevant federal agencies do a formal evaluation, and that is the process to begin to move it in, because small companies, if they don't have tax incentives, they may not have the infrastructure or the money to be able to implement these. So it just seems like it is a step-wise progression, not doing more research, just evaluating what is out there.

DR. GORDON: Dean.

DR. ORNISH: Yes, just briefly, I think this is another example of the bigger issue, which is that there are certain of us that want to just get in there and say, it is time to do it, let's get it done and let's quit screwing around, and we know enough already.

I think that what Tieraona and I -- I am speaking for you, so correct me if I am wrong -- are saying is that, yes, listen, I understand those feelings. I have been dealing with Medicare for seven and a half years, it is incredibly slow and tedious and frustrating, but in terms of what is going to provide the most lasting change, it may be that if we take it a little slower, that we ultimately be more effective. That's all.

DR. GORDON: Let me offer another perspective, that there already have been hundreds of worksite wellness programs. What we are suggesting here is that perhaps some of these demonstration projects might take -- this might be a way to mediate -- take place at the federal level.

It just seems retrograde. If we know the information and there have been reviews of the literature again and again, aren't we ready to at least recommend

demonstration programs? That is my perspective.

Yes, Joe.

DR. FINS: We are not writing this for the true believers, and you are going to get a lot further along by setting up a step-wise process than by trying to push this forward. You believe it, this is your issue, okay? It is not my issue and it is not the issue of a lot of people who are going to be skeptical about this.

There is utility, there is value, and it should be studied, and the difference between doing workplace studies and implementing it in the context of a federal program, it is another level of complexity, and that I think is what Dean and Tieraona are trying to say.

DR. GORDON: Let me just respond very briefly and then call on George and Tieraona.

This is, actually, not particularly my issue, number one. What my issue here is, and this has concerned me at times and other recommendations, too, is that we have heard a tremendous amount of testimony, we have had a great deal of reviews of the literature on certain subjects presented, including this particular subject, and what I am wondering -- I am just raising it

as a possibility -- is whether or not we want to talk just about evaluation and then demonstration programs or are, at some point, we ready to have demonstration programs? That is my question, and I leave it in the air and leave it up to other people, to George and then Tieraona, to continue.

Also, I want to add that we need to come to a conclusion about this pretty soon.

DR. LOW DOG: Okay. What we are saying here is safe and effective CAM practices, and what I would like to point out is that much of the research that has been done on wellness programs have not been even primarily CAM practices. They have been weight reduction by Weight Watchers programs in large manufacturing companies -- just reviewed that -- safety belt use, tobacco cessation, and that has also been by policies that have been made about smoking on jobsites. A number of these proven or that have been involved in these wellness promotions have not been what we are calling CAM practices.

What we are saying here, though, in this recommendation is that we want CAM wellness and prevention activities to be included in these programs,

and what I am saying is that we need to evaluate which aspects have been shown to be effective and to reduce morbidity, mortality, promote health, promote wellness, and then demonstration projects should be done on those to see how they impact.

DR. GORDON: Tieraona, how would you like to reword this? I think it is time for us to come to some kind of conclusion. We have had plenty of discussion.

DR. ORNISH: Can we hear from George, though?

DR. GORDON: George?

DR. ORNISH: George knows more about this than anybody.

DR. GORDON: George, go ahead.

MR. DeVRIES: You know, my own experience, working with employers, Fortune 1000, is that most of them are convinced that there is value. Really, I think you need a 3.3 here. I mean, the tax code issues are so pervasive here that we minimize their impact, and the reality is, is if those were fixed, the market would drive this.

There is such interest in wellness programs, it would not -- I think the market would drive and would

move so much more quickly ahead of really some of the solutions we are talking about, and I think a 3.3 is about fixing the tax code.

DR. GORDON: Okay, George, but what would you do with 3.1 and 3.2? I am looking right now for a way, taking into account the discussion, a way that we can come together around a recommendation and action steps.

MR. DeVRIES: I support Dean and Tieraona with more of a stepped approach which says evaluation, demonstration projects, and implementation.

DR. GORDON: Can you give us the wording for that, one of the three of you, or anyone else, for that matter?

DR. LOW DOG: Some federal body somewhere, somehow, should, and then we go -- well, it is "CAM practices should be evaluated to determine what role they may have in promoting wellness and health in the workplace." Then I would suggest that those CAM practices found to do this, to promote wellness and health in the workplace, that a demonstration project should be done to show the cost effectiveness, et cetera, and then I think there does need to be an issue in here

about the tax code, that once these steps have been done, that the tax incentives, tax codes -- and you would know the language better than me, but it seems to have an organized approach.

DR. GORDON: Okay. Joe first, Joe Fins, and then Effie, and my question is whether 3.2 could not be expanded to included your point about the tax code. So Joe first.

DR. PIZZORNO: I was totally with you all the way, Tieraona, until the last part about the proven part. As you have noted, wellness and health promotion programs have already been documented to be efficacious. You covered wellness programs. We need to deal with that tax issue.

So I think we should have a 3.3 which says that for proven wellness programs, wellness and health promotion programs, we need to modify the tax code to deal with as George has said. We shouldn't say "CAM" in front of it; we should say any of them that have been proven to be effective should be included.

DR. LOW DOG: Yes, that sounds good. George would have to have the language for that.

DR. PIZZORNO: We need the language from you, George, what it should say.

DR. GORDON: Okay. I'm sorry, Effie.

MR. DeVRIES: I don't think the issue on the tax code is actually incentives as much as it is disincentives, removing the disincentives.

DR. PIZZORNO: Removing the disincentives.

MR. DeVRIES: Just to allow an even playing field.

DR. GORDON: While you are working on that, Effie and then Joe, please.

DR. CHOW: I think the qualification of "safe and effective CAM practices" as we have done in all the others, and it is not only implicated but stated in all the others that there has to be an assessment for its utilization in the workplace, and for the past 25, 30, 40 years, the whole aspect about wellness in the workplace has been developing and there is lots of data -- Ken Pelletier, you know, his book and all that.

I think we are really talking a turtle position and really going back when we then talk about these steps, because they will need to develop these steps of

evaluation. If they are not sure, they have to research into what is safe and effective. So I recommend that this remains the same as it is.

DR. GORDON: Joe.

DR. FINS: You know, we have heard no testimony on the tax issue at all. It was an issue that arose last time, I guess in December when you sent that e-mail, and I think we are basically two steps ahead of ourselves: (1) we have to have the demonstration project; (2) we have to approve impact; and then (3) we have to decide whether or not there should be a tax break, and we have to recognize there is a deficit, there is scarcity. A tax break means that less dollars will be coming into the federal government.

The question is, do you want to spend dollars on this, something yet to be proven by demonstration projects, or do you want to spend it on bioterrorism or on the military or benefits for soldiers? I mean, these are questions that we heard no testimony on, and I think it is incredibly premature.

DR. GORDON: Dean.

DR. ORNISH: I am a little bit different than

that. I think that, as Jim indicated, there is a tremendous body of evidence that worksite wellness programs do have cost benefit, that they affect everything from absenteeism to health claims to whatever, to even sabotage on the job.

So I think that when I am talking about doing an evaluation, it is more along the lines of what Tieraona said. It is not that we have to start doing a whole lot of new demonstration projects, but somebody simply needs to sift through the evidence and to make an analysis and say, okay, these things seem to work, let's move forward with them.

I do think that giving tax breaks makes perfect sense. If somebody evaluates this and they found that it is going to save more money than it is costing, then it doesn't take money away from other resources if there is enough data now to make those kinds of decisions, and I would defer to George on that, who probably knows more about this than anybody.

DR. GORDON: Corrine had a point of information, I think, here.

MS. AXELROD: Yes. Two things. One is on the

evaluation part, in the previous recommendations, it has been federal funding of these evaluations. So my question to you is, do you want this to also be federal funding when, just to point out, businesses are already doing quite a bit of this? So I just need clarification as to whether this is also federal funding of evaluations for worksite wellness programs.

Then also, if we do decide to put in language about tax stuff, I would ask your indulgence that I can work out the language with Maureen so it is consistent with what is in Coverage and Reimbursement.

DR. ORNISH: If you are asking me, I am saying federal funding of -- she was looking at me. I thought you asked that to me.

DR. GORDON: George is next and then Dean.

MR. DeVRIES: Just in terms of the tax issues, you know, and, Joe, I apologize, it did come up towards the end and we didn't have someone in here to testify, and it is really not an issue of saying -- we are not looking for tax credits or tax incentives; we are looking for an even playing field, so that when an employer includes wellness programs in their employee benefit

plan, they can deduct the cost of those programs just like they would deduct costs related to their hospital or physician benefit plan. So it is just an equal playing field.

I will just read very quickly in the Reimbursement section, and it may make sense to add this as a 3.3, but the recommendation under Reimbursement is, "Congress and the Executive Branch should amend the federal tax code to include CAM and wellness in the favorable tax treatment of health benefits granted to employers." Even playing field. That is all the recommendation is. Right now, it is excluded. It is excluded. An employer cannot deduct those expenses, it is not a deductible expense to them, and the employees, basically those additional benefits are treated as compensation, and so they would have to show on their 1099.

DR. GORDON: Do you have a question on that, Joe?

DR. FINS: I think we will come back to it in the Coverage and Reimbursement section.

DR. GORDON: Okay. Tieraona. And we need to

come to a conclusion here with No. 3 and with the action items.

DR. LOW DOG: Fine. I believe there should be an evaluation done. I think that if you don't do an evaluation, you have no body to take -- there is no body of the data. It is just scattered all over the place. It needs to be in a particular logical format so that the appropriate agencies then -- because you are asking here for federal. If all you want to say here is that --

DR. GORDON: Tieraona, can we have wording, please? Because I think we are ready for wording.

DR. LOW DOG: I already have given you the wording about three times that I have suggested.

DR. GORDON: Could you do it once more, please?

DR. LOW DOG: Oh, Jim. All right. Let me see.

DR. GORDON: I defy anyone here to repeat from memory what you said before. So please read it. Humor us.

DR. LOW DOG: "CAM practices" --

DR. ORNISH: "CAM wellness and --

DR. GORDON: Go ahead. Say it.

DR. LOW DOG: You just go right ahead, Dean.

DR. GORDON: Dean, do you want to do it?

DR. ORNISH: I am just repeating what she said. "CAM practices used in the workplace should be evaluated to determine their applicability and cost effectiveness. Those that are found to be beneficial should be included in federal worksite wellness and health promotion programs and should receive" the tax language that you talked about.

Corrine, to answer your question, which I thought was directed to me, that the federal government should pay for that evaluation, again, not in the form of doing new demonstration projects, but just sifting through the data that is there.

Finally, I was just curious. Tom, you have a lot of experience working with corporations. I was curious about your perspective on all this.

MR. CHAPPELL: Corporations are just going ahead and doing it, because the benefit, it helps improve health, increase motivation and just performance overall by the individuals. So any business is interested in improved performance and these things do it. We are not talking, however, about the private businesses here, as I

understand it.

DR. GORDON: Right.

MR. CHAPPELL: We are talking about incorporating these into federal workplace settings.

I just think that both concerns, whether we are taking a turtle-like position or whether we need to come to with a light and simple way of assessing beneficial methods, I am all in favor of the assessment process, but we just have to be simple about it and not put it into some bureaucratic process. That is what I want to try to do, is keep it out of a bureaucratic process.

DR. GORDON: Don.

DR. WARREN: Tieraona, did Dean's ad lib say exactly what you were going to read from your statement?

DR. ORNISH: I might take offense to that.

DR. WARREN: That is what you were asked to do and I would like to find out what the actual statement is.

DR. LOW DOG: "CAM practices should be evaluated to determine what role they may have in promoting wellness and health in the workplace." That was the first recommendation -- and when I mean evaluate,

just take the data that is there, don't do more research -- because I don't think that you can have 3.1 without that. CAM wellness and prevention activities, how would you know which ones to include?

DR. GORDON: Then read 3.1, please, after that, as you would amend it, then.

DR. ORNISH: Those that have been found to --

DR. LOW DOG: That's right, Dean. Take it away.

DR. GORDON: Please, Dean, go ahead.

DR. ORNISH: Okay. So she says, "CAM practices should be evaluated to determine what role they may have in promoting wellness and health in the workplace. Those that have been found to be beneficial" -- you don't even have to say safe and effective, just beneficial -- "should be included in," the rest of the sentence.

DR. GORDON: "In federal worksite wellness and health promotion."

DR. ORNISH: Yes.

DR. GORDON: Okay. So, are we clear? That is the recommendation, revised recommendation, and that is Recommendation No. 3.1. Are we okay with those? Yes?

Good.

Let's move on to 3.2. We have 3.2 as it is here. Are we okay with what we have here and do we want to add something about tax code and incentives?

Yes, Dean.

DR. ORNISH: Well, I like what it says. I would just again refer back to those that have been found to be beneficial.

DR. GORDON: Okay. Include "CAM wellness and prevention activities that have found to be beneficial." Are we okay with that? I want to take this step-wise. Yes? Okay. Charlotte, George and Joe.

SISTER KERR: George, I was just wondering if, in 3.2, when you put "should develop incentives," could you just include in there, right there or in parentheses, "to include reform of tax codes" and then not have to do a 3.3.

DR. GORDON: Okay. George?

MR. DeVRIES: The 3.2, you certainly could reference tax code changes to create that equal playing field. Looking at the wording in 2.98, "to decrease insurance premiums," the relationship between the

insurance carrier health plan and the employer is that of two corporations, and we really can't mandate a reduction in insurance premiums. So I don't see how we quite do that.

DR. GORDON: What are you suggesting, George?

MR. DeVRIES: You could put a period at the end of "coverage." If you really are seeking something around decreasing insurance premiums for employers as an incentive, then you are looking at not just leveling the playing field from a tax standpoint, you are looking at creating some kind of tax credit or rebate to the employer for covering it, and that is a whole different thing.

DR. GORDON: So would you recommend putting a period at the end of "coverage" and adding the "develop incentives including" -- what would you say about tax?

MR. DeVRIES: Yes. I mean, I would put a period after "coverage" and say --

DR. GORDON: You would include Dean's wording.

MR. DeVRIES: Right. Absolutely.

DR. GORDON: Dean, what was your wording again? "Beneficial"?

DR. ORNISH: "Those that have been found to be beneficial should be included," blah, blah, blah.

DR. GORDON: Okay. To include beneficial, CAM wellness and those that have been demonstrated to be beneficial. Okay.

George, what would you add there?

MR. DeVRIES: Well, I think the sentence we came up with in the Reimbursement section would fit in nicely here and I don't think it hurts to repeat it because I think it is such an important issue. Maybe we could drop, I think it is 2.3.

DR. GORDON: All right. Corrine and then Joe.

MS. AXELROD: Reforming the tax code would have to be done by Congress, so you really kind of need to be separate. There could be other incentives, non-Congressional incentives, but when you are dealing with the tax code, that has to be Congress.

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

DR. FINS: No.

DR. GORDON: Tom?

MR. CHAPPELL: I agree with George that a period after "coverage" is appropriate because I don't

think we want to try to get into the complexity of decreasing insurance premiums. So I would drop that right out of the picture and leave the subject there.

Now, with regard to the tax code, George, do you think we even have to approach that subject here?

MR. DeVRIES: Well, it is such an important thing and we have one very simple sentence under Reimbursement we could drop in here. The sentence simply is, "Congress and the Executive Branch should amend the federal tax code to include CAM and wellness in the favorable tax treatment of health benefits granted to employers." You drop that sentence in.

DR. GORDON: Joe is next and then Dean and Charlotte, and let's keep moving on this one.

DR. FINS: I just want to say for the record that the fact that people include CAM in benefit packages doesn't necessarily mean that they are effective and that there are economic rationales for doing that.

We heard from James Dillard from Oxford talking that for every CAM benefit that was included in the Oxford package in New York, there was an economic benefit to Oxford because they were able to recruit healthy

people who didn't use other health care resources.

One could also make the argument that corporations will provide these kinds of benefits in lieu of improved salaries or other kinds of conventional health benefits.

So I don't think the fact that corporations want to do this -- corporations may be doing it for their own less-than-altruistic reasons.

DR. GORDON: Corrine. Maureen?

MS. MILLER: I just want to bring up this. You know, I think it is a good idea, but the complexity is the way the tax law works with employer benefit programs affects all employees of an employer, and it just dawned on me that these wellness programs are probably only going to target subsets. So it is not going to be an easy thing to incorporate into the current tax laws that exist.

Maybe people have already begun working on this and have a way to amend the law, but it is a very different kind of benefit program than what employers currently have for their HMOs and PPO plans.

DR. GORDON: Dean?

DR. ORNISH: Real quick. I think number one is the fact that it may require an act of Congress to change the tax laws shouldn't keep us from recommending something. I mean, there are a lot of things we recommend that require people to do things differently, so I wouldn't worry about that so much.

The second is, how about changing the last part of that sentence. Instead of putting a period after -- well, let me just read it. It says, "Federal agencies in conjunction with the business community should develop incentives for employers to include CAM wellness and prevention activities that have been found to be beneficial in their workplace wellness programs and health coverage and to incentivize those that participate in them. For example," and you could talk about the tax issue.

DR. GORDON: I would like final wording and I would like a coming together on it. Dean, you sort of left that last part a little vague.

DR. ORNISH: No, no. Instead of putting a period after "health coverage," say "activities that have been found to be beneficial in their workplace wellness

programs and health programs, and to incentivize those that participate in them. For example," and then we can talk about the tax code language that George mentioned.

DR. PIZZORNO: "Incentivize" is already earlier in the sentence.

DR. ORNISH: Oh. You are right. I stand corrected.

DR. GORDON: It sounds like we have agreement up to "coverage" at this point. The issue that is still pending here is whether there should be a sentence about the tax code, and I would like to come to closure on that quickly because we have a major recommendation still to do before lunch.

David.

DR. BRESLER: Just quickly, I think George's point is really well taken that basically the way the tax code is now, it disincentives, and that is something that we have to be aware of. There is an abuse that the federal government has inadvertently put on employers that they cannot offer wellness programs to employees without it being taxable, and I think we need to fix that.

DR. GORDON: So I would like some wording here that we can make a decision. We have had a lot of discussion. George, let's hear it again.

Everybody, please, if you get impatient with me asking for the wording again, wording that has been discussed 10 or 15 minutes ago is not at the front of everyone's mind, so we need to hear it again. We all need to be clear what we are agreeing on or what are not agreeing to. So be cool.

George.

MR. DeVRIES: "Congress and the Executive Branch should amend the federal tax code to include CAM and wellness in the favorable tax treatment of health benefits granted to employers."

MR. CHAPPELL: I buy that.

DR. GORDON: Okay. Julia and Joe have comments on that.

MS. SCOTT: I think it should be a separate recommendation, and not tacked on.

DR. GORDON: I'm sorry, what, Julia?

MS. SCOTT: That this should be a separate action under Recommend No. 3.3.

DR. GORDON: So it should be a 3.3.

MS. SCOTT: Right.

DR. GORDON: Okay. Let's look at it as a 3.3.

Joe, you want to say something?

DR. FINS: Yes. I can't sign on to it the way that it is, and it might be worth looking at it and looking for the fiscal implications. I mean, we are recommending a change in the code. Even to neutrality means a change in revenue.

Whether or not it does improve revenue, tax receipts, because corporations would be more profitable, would be paying more taxes on the other end, those are all open questions. We don't know the scope of how much money this would mean for the federal government.

I think it is premature to say we should alter it at this stage when only some members of the subcommittee had any kind of conversation with Treasury. The whole Commission had no testimony on this issue, and there has been no data that has been presented to us in the aggregate. I think it is premature.

DR. GORDON: Other discussion on this?

MR. DeVRIES: You know, the issue is and I

would just suggest I think Congress and the Executive Branch will go through this process and GAO will go through a calculation of the cost, and it is ultimately going to be Congress' decision of whether they do it or they don't do it.

I think we need to be highlighting the issue in this report and saying it is an issue, it is a barrier to the promotion of these types of programs.

DR. GORDON: Joe, is there a way you might reword it so it would be more acceptable?

DR. FINS: I don't have it written down here, but, I mean, if it is laid out as an issue in the text and then you say something to the effect that an economic impact -- that should be analyzed. The question should be analyzed for its economic implications, because right now we are making a recommendation that we really don't have the kind of sound base to make that recommendation upon as we do for other things.

We were talking before about whether or not supplements should be registered, an issue that we know far more about. We suggested the FDA have a feasibility study.

MR. DeVRIES: Could I suggest a different language? Could I suggest different language? Just because I think there is value in maybe saying, "Congress and the Executive Branch should evaluate amending the federal tax code to include CAM and wellness that has been demonstrated to be beneficial in the favorable tax treatment of health benefits granted to employers."

DR. GORDON: Ken has some point of information.

DR. FISHER: This is a question. You have been using the term "recommendation." This is an action item. Does it stay an action item? Somebody said it should be converted into a recommendation.

DR. GORDON: No, it was another action item.

DR. FISHER: It stays as an action item.

DR. GORDON: Yes.

MR. CHAPPELL: I support this revised language very strongly because it accomplishes everything that we are all interested in.

DR. GORDON: Let's hear the revised language once more so everyone can get it down.

MR. DeVRIES: Okay. "Congress and the Executive Branch should evaluate amending the federal tax

code to include CAM and wellness that have been proven beneficial in the favorable tax treatment of health benefits granted to employers."

DR. GORDON: So it is essentially an evaluation rather than -- it is the same format we have been following.

MR. DeVRIES: Right.

DR. FINS: If the text could also say that, "We appreciate in times of scarcity that resources are limited, that this would --

DR. LOW DOG: Joe, I --

MR. DeVRIES: You know, we do have text on the tax code on page 17 in the Reimbursement, we have a paragraph. It just kind of talks about the issue more.

DR. GORDON: Joe is asking if we could have something in the text to address this.

DR. ORNISH: But, Joe, the Congressional Budget Office, any time that any change in the tax code is done, will always look at the implication and whether it costs money or not.

DR. FINS: I think I have achieved my goal with the evaluation.

DR. GORDON: Thank you.

Are we all comfortable with this now? Good.

Let's move on to No. 4. This is the last recommendation and action item in this section.

Recommendation 4: "Public, private and federal health care delivery systems and health-related programs should incorporate safe and effective CAM practices into their services to help promote wellness and health." Please read the action items before commenting so we can have a clear sense of this territory.

[Pause.]

DR. GORDON: Let's take a look at the recommendation and then look at the action items. Who would like to speak? Dean?

DR. ORNISH: It is just the same issue all over again.

DR. GORDON: Since it is the same issue all over again, do you have a wording that might fulfill some of the same goals that you and Tieraona articulated previously?

DR. ORNISH: I would just use parallel language to what we did before.

DR. GORDON: Parallel language about evaluation first and then programs that are beneficial then be incorporated.

DR. ORNISH: Right.

DR. GORDON: Proven to be beneficial.

DR. ORNISH: And again to make clear that the evaluation could include new demonstration projects, but is primarily to look at the existing data and then decide where we need to get more information, whether it is demonstration projects or more primary research, and then talk about how to implement it.

DR. GORDON: Okay. Is this a reasonable -- let me point out that 4.5 is somewhat different than 4.1 through 4.4. What I would like to do is, if we look at the recommendation, are we changing the recommendation or are we simply changing the action items? So if we can look at the recommendation first and then look at the action items, that would be helpful.

Joe.

DR. FINS: I think with that sort of preamble that we have incorporated along the way, 4.1 to 4.4 are fine. Four-five has actually already been addressed in

the Education section.

DR. LOW DOG: Uh-uh.

DR. FINS: Well, I believe we had a discussion about that yesterday.

DR. GORDON: I don't think it was addressed in -- it is not addressed in this. We had a discussion, but that was more in the text and it was addressed in passing in the Education section but not with this explicitness, and I think the feeling was that it needed to be addressed in the Wellness section just the way other recommendations needed to be addressed in the Wellness section and in the Education section.

But let's deal with 4.1 through 4.4 first and then come to the last one. Joe, repeat what you were saying about the recommendation in 4.1 through 4.4.

DR. FINS: I think it is the same thing we have just been through with their predecessors with the same kind of preamble.

DR. GORDON: Is everyone comfortable with that? Charlotte?

SISTER KERR: With that. I want to speak to 4.3. Is it appropriate now?

DR. GORDON: I want to get this general principle established and then we can look at some of the specifics in the action items.

Tieraona, are you comfortable with this?

DR. LOW DOG: Yes. Like in 4.1, you could just take out "incorporating" and you could put "for evaluating the potential role for CAM wellness and health promotion activities" into these things. So you just can take out "incorporating," which is an advocacy position, just say, "for evaluating the potential role for CAM wellness and health promotion activities."

DR. GORDON: As I remember, in the previous recommendations, the first part was evaluation and then the second part had to do with incorporation of those that were appropriate or of those that were beneficial. So there were the two steps in each of these. Are you okay with that? Is everyone okay with that? Okay. So we have the general principle, and, Corrine, you can work out the wording on that.

Let's go to any specifics in 4 from the recommendation through 4.4, and then we can move on to 4.5. Charlotte began with 4.3. Please.

SISTER KERR: No, 4.3 already included the evaluation concept, and I wrote this one and I had wanted to be sure that this was about wellness, health promotion, chronic illness.

I want to call your attention to the word "end-of-life programs," and this is just a word choice. I have been advised by a couple of people for consideration that sometimes this end of life, even though I think those are really the more common words used now, sometimes some people feel it is a code for kind of Kevorkian-type, you know, assisted dying, so "hospice" might be a better word, but I would like the group to just contemplate that.

DR. GORDON: Joe, do you have a thought about that?

DR. FINS: No. I mean, I don't think that is accurate. I mean, people talk about end-of-life care and the program which takes a stand against assisted suicide uses this phraseology all the time. But, I mean, I think we might say "end-of-life program such as hospice" to clarify.

SISTER KERR: That is good. I like that.

Thank you.

DR. GORDON: End of life, not ending life. All right. "End-of-life program such as hospice." Okay. Good.

Anything else on 4.1? Dean, you had something, 4.1 through 4.4?

DR. ORNISH: No, 4.5.

DR. GORDON: Okay. Are the okay with 4.1 through 4? Joe, go ahead.

DR. FINS: We talk about health promotion and wellness in the context of the dying. I mean, I think there is a lot of living to be had while one is in the process of dying, and that is really the hospice philosophy, but I think somebody could just pick up this recommendation and say it doesn't make sense. So I am wondering if we could incorporate some other kind of language.

DR. GORDON: Would you want to say "end-of-life care" here?

DR. WARREN: How about add "quality of life"? After "health promotion," "quality of life."

MS. SCOTT: Excuse me. Are we back on 4.3?

DR. GORDON: No, 4.4. Joe's concern is with the word "wellness" going together with "the dying."

DR. FINS: Wellness and health -- I mean, if you are dying, you are not, by definition, well. So "incorporating CAM quality of life promotion activities" instead of "wellness and health," because it just doesn't quite follow editorially in this context.

DR. GORDON: I think maybe we can distinguish, though, between the dying and the other groups, because it may be appropriate for the other groups.

DR. FINS: Right.

DR. GORDON: Why not just "serving the aging and those with chronic illness"? I mean "aging," that covers most of those.

DR. FINS: Well, I think we want to also cover those who are in the process of dying.

DR. GORDON: So let's separate that out as a separate group.

DR. FINS: It is also somewhat true for 4.3, but, I mean, I think you want to say, "The impact of CAM practices -- in fact, if you just took out "wellness, health promotion" in 4.3, so "The impact of CAM practices

on those with chronic illness and in end-of-life care programs," et cetera, et cetera, and then in 4.4, you say "incorporating CAM activities in the Nation's hospitals" without getting into the wellness and health, because it kind of confuses it in this context.

DR. GORDON: So how would 4.4 read?

DR. FINS: "For incorporating CAM activities in the Nation's hospitals and long-term care facilities and in programs serving the aging, the dying, and those with chronic illnesses."

DR. LOW DOG: Can I try?

DR. FINS: Yes.

DR. LOW DOG: "The Secretary of Health and Human Services should establish a task force to evaluate the impact of CAM practices on health promotion and quality-of-life issues in the Nation's hospitals and long-term care facilities and in programs." You have sort of taken care of health and then also quality of life.

DR. GORDON: Okay. Is that all right? So that way, you can apply quality of life to the dying and health promotion to the -- everybody okay with this?

Let's look at 4.5.

MS. AXELROD: Jim, before we go on to 4.5, I need some clarification on 4.3. Four-point-three currently calls for a demonstration project, and we have been talking this whole session about doing evaluations --

DR. GORDON: Right.

MS. AXELROD: -- and then, if appropriate, do a demonstration project. So I just want to be clear. Are we adding evaluation to this one?

DR. GORDON: I believe that is what people were saying. Is that correct?

DR. FINS: Yes.

DR. GORDON: Okay.

Let's go on to 4.5. Veronica?

DR. GUTIERREZ: One item. I think to be consistent we should add the term "quality of life" to 4.3. "Funding should be provided for demonstration projects to evaluate the impact of CAM practices on wellness, quality-of-life issues, health promotion," et cetera.

DR. GORDON: Is that okay with everyone? Okay.

Let's go to 4.5. Dean.

DR. ORNISH: I like 4.5. I think that it is important for people to experience these techniques themselves, both for their own development and also because it is -- you know, certainly medical training is such a burn-out experience anyway. I think the best way to really understand these is to experience them. So I think that is a good recommendation.

DR. GORDON: Okay. Other comments? Don?

DR. WARREN: I have got a 4.6.

DR. GORDON: Let's deal with 4.5 first. Four-point-five. Joe?

DR. FINS: I think one of the things that we were careful not to do in the Education section was have educational mandates. So we should have this "should consider," which I think we agreed to about education yesterday. And students should have the option, it shouldn't be required, but they should have the option of participating. So "should offer" not "include the teaching of self-care." "Should offer."

DR. GORDON: "Should offer" rather than -- Dean, I want you to hear it. Joe wants to substitute