"offer" rather than "include."

DR. ORNISH: "Offer" is fine.

DR. GORDON: I think we are way beyond -- Joe, I think this is one of those points where it is already being considered everywhere.

DR. FINS: I know that. Then the second point here is I think students should have the option of opting in or out.

DR. ORNISH: Yes, I agree with that, actually.

DR. GORDON: Well, why not "should offer the teaching."

DR. FINS: Right.

DR. GORDON: Okay. If we just have "offer" instead of "include"?

DR. FINS: Yes.

DR. GORDON: Okay.

Four-point-six. Don?

DR. WARREN: "Practitioners in federal health programs should have the latitude to incorporate CAM modalities, services and products --

DR. GORDON: Would everybody be quiet, please? We have a new action item and I want everybody to make

sure we hear it the first time around.

DR. WARREN: I just thought I would throw it out. "Practitioners in federal health programs should have the latitude to incorporate CAM modalities, service and products into their individual protocols as they deem clinically appropriate."

DR. LOW DOG: I am sorry, Don. What was the very beginning of the sentence?

DR. WARREN: Four-point-six.

DR. LOW DOG: The next beginning.

[Laughter.]

DR. WARREN: Oh, okay. "Practitioners in federal health programs should have the latitude to incorporate CAM modalities, services and products into their individual protocols as they deem clinically appropriate."

DR. FINS: That is the scope of practice. I mean, this is not this section. I mean, I think what we should do is, when we get to Access and Delivery, that kind of issue will definitely come up.

DR. GORDON: Because this is really, the focus here is wellness and I think we need to reserve that to

Access and Delivery, okay?

DR. WARREN: Okay.

DR. GORDON: Everyone with me on this? Okay.

Any major textual issues aside from the ones that we have dealt with? Tieraona?

DR. LOW DOG: There are lots of them, so I don't think we need to go through them, but --

DR. GORDON: Do you want to make a general statement, then?

DR. LOW DOG: I think that throughout this document, we are preaching CAM doctrine, and it needs to be far more balanced. Teaching safe and effective CAM practices from kindergarten through grade 12? What is that? St. John's Wort, you should take it for your depression? I mean, I don't like it. I think there are a lot of problems with it.

MS. AXELROD: Tieraona, I will change the text in accordance with the changes and the recommendations, so I don't think we need to go through each one of those because they all correspond.

DR. GORDON: Okay. Are you satisfied with that?

DR. LOW DOG: I will be satisfied when I see it.

DR. GORDON: When you see it, but you are satisfied with that, Tieraona, as a procedure?

DR. LOW DOG: Yes.

DR. GORDON: Okay. Anything else on the text, any specific issues? All right. We have made it through.

Wayne?

DR. JONAS: Again, this is just word consistency. Through most of the document or a lot of places in the document use terms like "CAM activities and approaches may have an important role," but then there are other places where you flip it over and say "do have" or "could have" or "do contribute." For example, page 6, line 148 where above it, it is "may," below it -- in the upper paragraph, it is "may" and below it, it is "could contribute," which assumes that we know it could contribute. I think those should be made consistent and probably changed to "may" because, again, I would emphasize the evaluation nature of this particular area.

DR. GORDON: Okay. Is everyone on board?

Tieraona, are you on board with this? Okay. Everyone okay with this, changing the "do" or "should" to "may"?

Thank you, Wayne. We are in agreement.

We will adjourn for lunch and we will come back at 1:15 promptly. Thank you very much. We will begin with Access and Delivery at 1:15.

[Lunch recess taken at 1:15 p.m.]

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A F T E R N O O N S E S S I O N

[Reconvened at 1:42 p.m.]

Access and Delivery of CAM

DR. GORDON: We are now up to the Access and Delivery Section. Linnea.

MS. LARSON: We, on the Access and Delivery team, have been working on what the recommendations would address. How we looked at it was from a definition of, how do we define "access" for the purposes of this report, and how do we define "delivery" for the purposes of this report.

Two criteria under access were, what CAM is available and what is affordable, and what are the models of delivery. Under "available and affordable," we recognized that we needed to address the issue of legal authority. Then we came up with a schema about readiness for licensure, emerging profession, and finally licensure issues.

I think that was the schema. Out of that, then came these recommendations. Is that the logic of it? What is available and what is affordable.

DR. GORDON: Tieraona, are you okay?

DR. LOW DOG: I just wasn't sure why we were going through all that. We hadn't really done that for the other ones.

DR. GORDON: The format for this section is going to be a little bit different. That is, that what is going to happen is Linnea presented, just in a few sentences, a brief schema. I don't know if there is anything more you want to say.

Then we are going to go through the recommendations as we have for the other sections. The difference in this section is that the text is not as ready for prime time as in the other sections. So rather than a line-by-line critique of the text after we have gone through the recommendations, what I am going to be asking is general considerations, what should be included to ground and back up the recommendations that we are making; what others issues should be raised in the text; what issues have you seen in the previous text you don't think should be there.

Everybody with me on this? So we are not at the same level of specificity with this section as we are with others, for a variety of reason.

So what we will focus on, as we do in the other sections, is the recommendations. The text that will bolster the recommendations will be then written out of a variety of previous drafts that have been composed before, as well as about some new work.

In the new work that is going to happen, both Maureen and Max Heirich, who is consulting with us, are going to work on developing that new text, and then they will get it to us as quickly as possible so we can all see it.

Everybody with me on this? So the format is slightly different, but not that different for this section.

So let's turn, first, to Recommendation No. 1 on page 5. It reads: "Access to qualified and competent practitioners, and to safe, effective, affordable CAM services and beneficial CAM products, should be improved for all Americans."

Do you think it would be helpful if I read both Nos. 1 and 2 here, Joe and Linnea, or should we just start with No. 1?

DR. PIZZORNO: I think, No. 1.

DR. GORDON: Just No. 1, okay. So let's begin with No. 1, then.

Under Nos. 1 and 2, the action items are really under No. 2 rather than under No. 1, Joe? Or, would you say they are under both Nos. 1 and 2?

DR. LOW DOG: So, what does that mean exactly, that first recommendation?

MS. LARSON: I am going to tell you a little history. This was written this way, I believe, to make room for an overall plan for legal authority. I think that is why it was written that way.

What I see this actually saying, Tieraona, is let's redo the whole Commission report. I mean, it could be a little bit tighter.

DR. GORDON: I would like to make a suggestion, that we read Recommendations 1 and 2, and the action items that follow, to give us a context, and then we can go back and reshape according to that, because then that gives much more latitude, rather than focusing just on this recommendation.

Joe.

DR. FINS: I think this is a leftover from the

discussion about setting up the need for access. People said, oh, there are all these people that need access. I don't think this says anything that we haven't said 100 times, much better, elsewhere.

I would just suggest that we go to Recommendation No. 2. I would just suggest, also, the framework that I think the text will have, once it gets done, of a micro-to-macro sort of perspective, that access is predicated on the ability to deliver services, and that there are three tiers: there is the practitioner level; there is the hospital, the community health center level; and then the health care system level, and that we are going to address regulatory issues that impact on the ability to provide access for those three tiers.

So, with that in mind, I think I agree with Jim. Maybe if we went to the second recommendation, which really focuses at the first step on that ladder of the practitioner. Let me read it, and then let me say what I think we really meant to say.

DR. GORDON: Let me read it, and then you can say what we really meant to say: No. 2, and this is page 9. I do think, Joe, I would like people to at least look

at the action statements that follow, so they have a context.

Julia?

MS. SCOTT: I'm trying to say this coherently, but I will just say it. When I read this section, it looks to me as if Recommendation No. 1, the Action Items 6, 7 and 8 fall under No. 1, and Actions 1 through 5 seem to fall under Recommendation No. 2, which deals with practitioners.

DR. GORDON: Yes, it does look that way.

MS. SCOTT: I think that separation might make it a little easier to look at both these recommendations. Just a thought.

DR. ORNISH: I have a somewhat radical proposal, which is that we just delete this chapter and be done with it.

[Laughter.]

DR. ORNISH: I'm serious about that. The reason is that, first of all, I think we are making so many recommendations anyway, that making fewer recommendations has value, but the major problem that I have with this chapter goes back to what we were talking

about this morning.

I mean, the first recommendation about having access available presumes that there is enough data that we should be advocating that. Issues of licensure and credentialing, and so on, are already covered in other chapters.

MS. LARSON: No, they aren't.

DR. ORNISH: Well, they are, actually, in the chapter on Education and Training, for example.

MS. LARSON: No, they aren't.

DR. FINS: That's just education.

MS. LARSON: That's education.

DR. ORNISH: Well, if we could maybe just take that part of it and put it into that chapter, and then just leave the rest of the chapter behind, it might be worth considering.

DR. GORDON: There is a suggestion on the floor. Are there responses, at this point.

MS. SCOTT: I guess I would just like to go on record saying I am on this task force, but this is so foreign to me, what is here, when I remember all of the things that we recommended, demonstration projects and

community health centers for low income people, and whatever.

So I am almost on a wavelength with you, Dean, but I don't, I really don't feel that access has been dealt with in the other sections.

DR. ORNISH: What about incorporating it into those sections?

DR. GORDON: Maybe if you could clarify a bit for people.

DR. GROFT: I think what was attempted here was to take this section and put it into the format of the rest of the report. Due to a series of circumstances, it did not come off well, obviously.

So I think the approach that we were trying to take today is, let's go and look at all the recommendations and actions, see if there are areas of agreement that we can reach, then build from there.

We feel that there is probably sufficient information on previous versions of the document that we can then bring them in, get it out to you, and then have a telephone conference where we can discuss this, probably over a two-hour session. I am asking a lot

here, because this is so convoluted from where we were at the December meeting.

Again, attempts were made -- it was so long and the recommendations were all at the end -- trying to bring the recommendations and the action items back up into the report, closer to where the subject material was actually discussed, again, to try to bring some consistency, and we obviously failed.

I think, now, trying to salvage it in a way that it will make sense and still get the points across that we would like to make, or you would like to make, I think we should make an attempt at it.

DR. GORDON: Tieraona.

DR. LOW DOG: I think that, again, this was one of our executive charges or whatever. We were supposed to deal with this, so we have to deal with it. I think a lot of us are sort of shell-shocked because the text is really problematic.

The point is what we have come back to again and again and again, before you can assure access, depending upon what you mean for access -- people accessing versus reimbursement and what you're paying for

-- you have to have some sort of evaluation of what people should have access to.

So we have sort of skipped through a lot of that. Like the first recommendation, if we are talking about that one, even with or without the second one, we are talking about improving that for everyone. I don't even know what that means.

I just think that we need to step back again, and we need to have recommendations that talk about evaluation and who is going to do the evaluation, get back to the demonstration projects that were originally in there, et cetera.

DR. GORDON: Dean.

DR. ORNISH: I completely agree with what Tieraona is saying.

Steve, while I think that if we had more time, your idea makes perfect sense, we don't. The idea that in a two-hour conference call, we are somehow be able to fix this, even talking about it today, I think is overly optimistic, particularly since we are going to be getting the entire report fairly soon that we are going to have to go through, and a lot of us are doing a lot of other

stuff, too.

So if we could just take one or two key issues here and somehow combine it into another chapter, I just think that is a much more practical goal.

DR. GORDON: Joe, go ahead.

DR. PIZZORNO: As Tieraona said, No. 4 in the directions we received from the President was quite clear that we are supposed to be determining how to improve access to safe and effective alternative and complementary health care.

Clearly, a majority of this health care is being provided by CAM practitioners. Our job is to make sure that health care that is being provided is as high quality as we can.

We have, right now, in the country, a situation where we have licensing and registration of CAM providers, and we have already received data that shows when they are licensed and registered as appropriate, we have a safer practice. We have a lot of people out there who are claiming to be CAM practitioners who do not have credentialing and for which we already have data that they are not safe and they do public harm.

We must provide guidance to Congress and to the states to differentiate between these two groups of practitioners; utterly critical.

DR. GROFT: And to mention, too, I think, as you can see from the table, Max Heirich is here, who we have brought on board as a consultant to the group to help us. Maureen and Gerri, Corinne and Joe, we have all agreed that whatever needs to be done, we will do to bring to you the best possible section of this document.

DR. GORDON: George.

MR. DeVRIES: Well, first of all, I think a lot of good work has been done here, and I really appreciate the work of the committee. It shows a lot of effort, and there is information here that I think is important to make sure that is in the Final Report.

I think maybe the comment that I would make that I think a couple of others have made -- and I really don't think it is going to take that much time, and we have an external consultant now to help us -- but we need to go back and we need to look at it, and perhaps put it into a format that more reflects the format that we have seen in the other chapters, so far, of the report, and

that seems to be working pretty well for us.

There is a lot of good material here. Some reformatting and some editing would probably help in getting it more like the other chapters, but it is important to have its own separate chapter.

Again, the Executive Order. I don't need to repeat it, but I think it is important that it be in its own chapter.

DR. GORDON: Joe, and then Tieraona, and Julia, and Joe.

DR. PIZZORNO: I wonder if it would improve things if we simply eliminated Recommendation No. 1 and just go to Recommendation No. 2, because I think Recommendation No. 1 is pretty vague, and it could be interpreted a lot of ways, some which we may not want. Whereas, Recommendation No. 2 gets to the whole issue of safety and access.

DR. LOW DOG: Well, I would be open to the dropping of Recommendation No. 1, sort of keeping that as an option thing there. I was just going to talk about a process issue so we can keep moving, that perhaps we should just dive in here and just start looking at this

recommendations and seeing what we think.

DR. GORDON: I would like to hear just a couple more opinions around the table, and make sure they get out, and then we will move in.

Julia.

MS. SCOTT: I am just very uncomfortable with this section because of what I see as an over-balance of recommendations having to do with the credentialing of practitioners. I am uncomfortable with that, and I think it probably should have been dealt more with Education and Training, but I want to see a balance in this section that not only deals with the practitioners being credentialed with access/delivery issues involving consumers, and the protection of consumers. There is not a lot to work with with what is here.

DR. GORDON: Conchita, you had your hand up. I'm sorry.

MR. PAZ: I was very much concerned about the access -- or, actually, the delivery part as well, because I didn't think that part was developed very much.

DR. GORDON: Joe, and then Effie.

DR. FINS: I think that the one thing here that

is most valuable, and would be valuable to the states -- and one of the reasons recommendations were not as readily makeable in this situation, was a lot of the regulatory questions related to practitioners devolved to the prerogative of the state.

So I think what we see on pages 7 and 8, sort of the taxonomy, is a guide, really, for states to take under consideration. One action item or recommendation that I think follows from that, and we heard this from Max and other folks, is to maybe look at his study, what the experiences have been, based on the different models that have been adopted in various states, and how it relates to consumer protection. I would add consumer protection is covered in the Information Section under DSHEA and labeling, and so it is elsewhere as well.

I also think it is important to state, and Joe Pizzorno and I were talking about this, that it is necessary, that one of the linchpins in our analysis -- and I must say that this document doesn't reflect where we were, I thought, after our December meeting -- was the issue that the ability to practice has a real impact on access.

So that, the focus on practitioners was because we had a lot of testimony and saw a lot of data saying that if you don't have the ability to practice in a jurisdiction, then all the people don't have access to your services. So that's why that relationship is there. Maybe it needs to be expressed more clearly, but that's why the focus was on the practitioner side.

The eventual idea was really to go up and deal with hospital and clinic/community health center issues and demonstration projects there, and then up to health care delivery systems and how managed care systems integrate, and all that.

I would recommend the staff go back and look at the December draft, because I think a lot of that was in there and it has gotten cut out as this gets reworked.

DR. GORDON: Effie.

DR. CHOW: I appreciate what Joe just explained, but I just wanted to say that I feel very strongly, too, that this is heavily overloaded with licensure and registration. That part is important, but the accessibility by locale, and by availability and dollars, and all that, accounts for people being able to

use the facilities.

DR. GORDON: Any other general comments? I want to try to summarize what we have heard so far.

Wayne, did you want to say something?

DR. JONAS: I just want to point out that, at least to the degree that licensing and credentialing is concerned, it is really only indirectly related to research. Most of it is about competencies, professional standards, and that type of thing. I am talking about conventional medicine.

So those things have to be addressed, but to put it in a framework of, access is dependent upon established safety and efficacy to practitioners is a confusion of categories.

DR. GORDON: Let me say a couple things that I am hearing, and let's see if we are all hearing the same thing. One is that the chapter is not in anywhere near the shape that we would hope it would be in, No. 1.

No. 2 is, there is a lot of information from previous drafts that could make it much stronger and much more coherent.

No. 3, that there is a sizeable concern of

people who feel that there is an overemphasis on regulation and licensure, and not nearly enough discussion about access from the consumer side.

So here are some issues. Max, as the consultant, and admittedly as one who hasn't had a lot of time, I'm wondering if you have any kind of general schema that you think might help to resolve some of these issues, both the concern about what has been left out, the improper development of the argumentation for regulation that just has not been in this draft, and the concerns about consumers.

Is there a way that we can put it together? I have a fundamental question, should we look at this now, or should we take another kind of leap and allow a group of people to work on this and then give it back to us in a slightly different form in a couple of days.

I am not crazy about that option, but I don't want us, also, to make ourselves miserable by going through something and just feeling incredibly frustrated with it.

Anyway, Max, please go ahead.

DR. HEIRICH: Well, I am going to be answering

off the top of my head because I just took on this assignment about 15 minutes ago.

It seems to me that the format for the chapter, it would be very important in the text to lay out clearly the range of issues that need addressing, the incomplete state of evidence for resolving them and the need for a strategy to move forward.

One could then, as was just suggested, say that there are several levels which are important to consider. We need to look at the level of access to individual services, the access at hospital/clinical/community center concerns, access for the system as a whole.

After we set that kind of framework of what needs to be done -- and I haven't seen the earlier draft, so I don't know what is useable within them -- we could then discuss the recommendations within that kind of framework.

DR. GORDON: The question I want to raise is -- and Joe, you in particular, and Linnea -- should we do our best to address the recommendations now?

DR. FINS: I think if we can salvage some of them, that the text then could be built around those

recommendations, but I think we should go through this and not be wedded to the recommendations, because they, too, have more. No one, I think, is really necessarily wedded to the way they are written right now.

DR. HEIRICH: I would like to suggest that there may be additional recommendations that will emerge from this discussion.

DR. GORDON: Let me make a suggestion based on the comments that have been made, that we read Recommendations 1 and 2, and Action Items 1 through 8, and then we go back and begin to address, because that way we will cover a fair amount of the territory.

Maureen?

MS. MILLER: I just wanted to comment, I think that would be a useful way to spend some time, as long as everybody understands that once we work on this and absorb this, that the recommendations might be slightly different. I'm hoping Max will agree with this, I think that it would be helpful to have a sense of the Commission before we leave and do this work.

DR. HEIRICH: Absolutely.

MR. PAZ: The only thing is, once some of the

text comes out from earlier stuff, that this may not be all the recommendations.

MS. MILLER: Exactly.

DR. LOW DOG: I just have a process issue, since this is going to be done by a conference call, because everybody has committed to be here during this time, and I know a lot of us have travel and stuff, that I would certainly hope that there is going to be real accommodation made, because this is one of the toughest sections that I personally had the most problems with.

I am not going to be very happy, after making the time to be here, if now, days later, I am not available for the conference call.

DR. ORNISH: Yes. I feel the same way. I agree. If we're going to do it, we might as well do it. I just cancelled my flight, too, and I would feel really dumb if we just postponed the whole thing.

So, why don't we get as far as we can with the current recommendations. If there are more recommendations later, we will deal with them at that time, but at least we can deal with what is in front of us.

DR. GORDON: Steve.

DR. GROFT: We will try to get a time in which all of you are available. I can't make a guarantee that 19 Commission members are going to be available at one time, but I think we have to get as close as what we can on the recommendations.

We have spent a half hour here. It is important to do this, so I think if we can get moving on them now, do the best we can, and even if it's a weekend where people seem to be a little bit more available, or an evening, that we can get people, that's what we will attempt to do.

Hopefully, by Thursday we will have something ready for you to look at, Wednesday or Thursday.

DR. GORDON: What I would also like to say is, to get a commitment that we will work on this now, and if need be, we will spend time on it after Public Comment as well. So we can do as much as possible while we are together, and then, I think, go to Reimbursement, which I think we would generally agree is a section in much better shape.

Can I have that commitment? Good.

I think that the best way to get a view of the territory in the beginning here is to read both recommendations and read all the action items. Everybody take a little time. Recommendation No. 1 is on page 5, and Recommendation No. 2 on page 9.

[Pause.]

DR. GORDON: Let's begin. Joe, did you want to begin?

DR. FINS: Just big picture structure. I think Julia's idea is something that we really should just adopt as a placeholder here, that the Action Item 6, No. 6 certainly, and No. 8, are ones that look like, what is the demography of the need and what is the need for the workforce out there as the first thing.

I think, on Recommendation No. 1 --

DR. GORDON: I'm sorry, you didn't finish your sentence, that those two go with Recommendation No. 1.

DR. FINS: I think, in the beginning. They don't necessarily go with Recommendation No. 1, but the issue to know what the workforce is. How does the workforce relate to access, is the first question. Then the question is, what is the workforce, and where are

they, and how are they distributed.

Those are questions that Action Item 6 would answer, and would be a predecessor to intelligent policymaking downstream. So that would be, I think, a good place to start, sort of diagnostics versus therapeutics; let's diagnose the state of the problem.

Recommendation No. 1, in my view, is overly broad, vague. We are talking about practitioners and services and products. I have said this before, this is about practitioners here. We deal with services. We deal with products elsewhere. Services are often related to the practitioner. It is really about, here, the licensing of individual practitioner types, at least in this section.

So I think products is something that shouldn't be here, because we deal with it in other places. Or, if we are going to deal with it, we should deal with it as a separate recommendation because there are enough specific issues about that.

DR. GORDON: Yes, Tom. Tom, Dean, George, Conchita, so far.

MR. CHAPPELL: I agree with Joe. We are

dealing with the product issues significantly elsewhere, and it does confuse things to have it here.

DR. ORNISH: I also agree with Joe, and I would take it even further and say, look, what question are we trying to answer. To me, the question is, how can I know that the CAM practitioner is qualified and competent. I mean, that is, to me, the most basic question.

Then the next question is, how can I get access to people who are competent and qualified. But the first question is, how do I know that someone I am going to has any kind of licensure, training, qualifications, credentials, and what are they.

Of course, then the question is, what should those credentials be for somebody. I think that's the first tier. The second tier, then, is, how can people get greater access to whomever those people are.

So I would like to focus just on narrowing this down to how can people in the general public know if somebody is qualified, what are the standards, and what should they be.

DR. GORDON: George.

MR. DeVRIES: I think, on Recommendation No. 1,

there has been a tendency to want to underplay the recommendation concerns of states rights, because that is ultimately what this comes down to.

I am going to suggest that we reword Recommendation No. 1, and that we go consistent with other recommendations we have in the report. It might be something to the effect of: The Commission recommends that states provide adequate licensure, registration, certification or nonregulation of providers, consistent with their scope of practice and education, something like that, which I think goes right to the heart of the matter of what is in Recommendation No. 1, which is really talking about making sure providers are appropriately licensed, certified, credentialed, consistent with scope of practice and education.

DR. FINS: Jim, may I answer?

DR. GORDON: No. Let's let everybody talk, and then we can come back to you, Joe.

Conchita.

MR. PAZ: I agree with that. I think we need to separate out the providers, or the practitioners, and we need to separate out the products. Even though we

have talked about products, we haven't talked about access to the products.

DR. GORDON: So you're saying products ought to be a separate section within this.

MR. PAZ: Yes.

DR. GORDON: Okay. Effie.

DR. CHOW: I think Recommendation No. 1 is a broad, general statement. Action Item 6, 7, 8 goes more with Recommendation No. 1, and I would move that to the beginning. I am a little bit confused that we have both recommendations and then the actions after the two recommendations. So that is what I would recommend.

I do agree that services and products should be separated and dealt with accordingly.

DR. GORDON: Any other comments? Don.

DR. WARREN: Didn't we hear about the House of Lords report that said that licensure did not guarantee competent treatment? Isn't that right?

I am wondering why we are worried about licensure at all. I think we ought to be licensed in our respective professional fields as dentists, chiropractors, NDs, DDSs, the whole gamut -- excuse me,

DOs, and then have registration as the alternative. Licensure of a CAM practitioner is not going to guarantee competent care. It is not going to guarantee access.

MS. SCOTT: Again, I hear the focus going on the practitioner, and if we are dealing with the practitioner first and then going to get to access to the consumer, and delivery to the consumer, I am fine with that, but just licensing or credentialing or registering the practitioner does not ensure that the consumer is going to have access and delivery. I want us to keep that in mind as we are looking at this chapter.

DR. LOW DOG: Don, what in Recommendation No. 2 doesn't address your comments? Because this says accountability to the public, and contains provisions for registration, licensure, and exemptions, so that there is room for all of it.

DR. WARREN: Well, when they put "licensure," in there, next to it I put "no," the entire recommendation. I just don't believe licensure should be part of it.

DR. LOW DOG: But there are CAM practitioners that are licensed, so shouldn't there be --

DR. WARREN: Are they licensed as CAM practitioners? "Naturopaths," they are licensed in how many states? But they are not licensed in Arkansas. So a CAM practitioner or a naturopath in Arkansas is practicing unlicensed. Patients still have access to them.

MR. DeVRIES: They don't.

DR. WARREN: Oh, yes, they do.

DR. LOW DOG: They still can go.

DR. WARREN: They can still go. That is access, isn't it? They just don't get it paid for, except out of pocket.

DR. GORDON: Let me just say that what we are doing here is very important, and what I want is to make sure that everybody's general concerns get heard, and that will enable us to focus more on the specifics.

So Don has expressed his concern. He has pointed out that at least in his state licensure is not what is happening for some of these CAM professions.

So we will keep going around. Joe, and Dean, and Tom.

DR. PIZZORNO: Don, I think it is true that

there is some access to some aspects of CAM services in states with no licensing, but it is a significant problem. One is, they can't practice their full scope of practice. Second is, they can't differentiate themselves from other health care professionals. Third, they can't diagnose and prescribe. I can go on. Of course, there is the whole issue of reimbursement.

So what happens is, in those states you might get one or two who show up who have proper credentials, but those with credentials will go to states with licensing because that is where they can actually do their scope of practice and have a defined practice right for their patients. It does not work.

DR. GORDON: Dean.

DR. WARREN: Would registration not accomplish this? I still don't like licensing.

DR. GORDON: This is important. It is important that we have a common understanding of some of the issues.

Dean.

DR. ORNISH: Well, I think it is important. I remember one of the people who testified before the

committee, saying that basically anybody should be free to practice any kind of CAM, no matter how they define it, no matter how unproven, no matter how safe, as long as they disclose what they are doing.

For myself, at least, I am really uncomfortable with that. It is not just a question of access. I would like to take a stronger statement, in the spirit of the other discussions that we have been having that I think will ultimately give our report a lot more credibility, is if we talk about the need to, not just limit licensure, but even the practice of certain types of modalities or approaches to those that have at least some evidence of safety and efficacy, recognizing that that is going to be a real problem for some people who say, gosh, I have been doing this for a long time; and, why should I have to submit to those kinds of standards.

I think if we are talking about protecting the public, we need to perhaps consider a stronger statement about, not just licensure, but even access.

DR. GORDON: I want to point out something that I think is an important part of the discussion that got left out of this draft, but that has been there

previously, that there are experiments underway, including one that we heard a great deal about in Minnesota, where exactly that principle is there. The belief on the part of the state is that registration, with the opportunity to register complaints about registrants, will be effective.

What I think is that it is important for us in this report to take account of these natural experiments that are underway, and to think through why we are making the recommendations that we are, and at the same time, to acknowledge and have a respectful attendance to what is happening with these natural experiments.

I am not saying where we should ultimately come down, I am saying that we need to look broadly at the terrain and understand that we have observed what is going on.

Tom, and then Tieraona, and Joe, and Don.

MR. CHAPPELL: I think one of the goals of this whole section is to understand how a consumer can translate competency or the standards of the professional. We found, in our work over the last two years, that the professional associations that set

standards for themselves, and ongoing training and so forth, was the best source of competency and standards.

I recall our feeling that we are powerless over the states' control on these issues, but that we really could draw from the experience that each professional association had gone through over time to raise up the standards of their membership.

DR. GORDON: Tieraona.

DR. LOW DOG: I think you raise a good point about the different models, if you will, that are currently underway. I don't think anybody has really evaluated them. I hate to come back to evaluation, but when you are looking very different models, such as Minnesota or what is going on in Washington State, they are very, very different. I think at this point, nobody really knows how it is going to turn out.

So perhaps, someplace, in a recommendation, an action item, someplace, maybe it should be, at an appropriate time for the evaluation of these different models, to see what works and what doesn't work, to try to determine what is the best path.

DR. GORDON: Joe.

DR. FINS: I agree. I think is in the spirit of the rest of the report that there are questions that we don't have answers to. We have identified a problem. I think that what we have offered here is a framework for states to consider.

One of the action items should be to protect the public health, funding should be made available, perhaps, to the states from the federal government through the health care or health professions, or HRSA, or the appropriate agency, AHRQ, to evaluate the various regulatory patterns that exist, from the libertarian Minnesota model to ones that might be more stringent.

I know that Minnesota's model would never work in New York. That is because it is different and we're different.

DR. GORDON: We do know that.

Effie.

DR. CHOW: Starting on page 11, "Delivery Issues Affecting Access to CAM," speaks to some of the concerns that I think we have spoken about and are central to my heart. Some of these are finances, proximity, professional practitioners, quality of the

location, the facility, the quality of care, and safety, of course, and the language, and then knowledge by the people, or having knowledge or having access to information that tells them about the program.

We don't have a recommendation here that speaks to those points. All of it has been on regulation and licensure.

DR. GORDON: I'm sorry, can you summarize the points, Effie, that we don't speak to?

DR. CHOW: Well, there is something here about "cannot afford to pay out of pocket," and so forth. What I am saying is a recommendation doesn't speak to these points that are missing, considering the finances of the individuals, the proximity of the available services, the professional practitioners, having available professional practitioners there, and the quality of care, and safety of care, of course, and then language considerations, and then the information and knowledge that is available for people.

DR. GORDON: So what you are referring to is a number of specific issues that may affect access of people to services.

DR. CHOW: These all affect access. Of the people, yes, and there is no recommendation that speaks to that.

DR. GORDON: And you would suggest that there should be such a recommendation.

DR. CHOW: Yes. There are some things that are stated here, from page 11 to 13, and so forth.

DR. GORDON: Any other general statements?

Charlotte, Wayne, and Conchita.

SISTER KERR: I just want to comment on what I think is an emphasis in some of the actions, or maybe the spirit of some of this. I wonder where we individually feel.

Before you look at the whole issue of access and delivery, and particularly under Action Item 2, there is this statement that the federal government, and it does say, "In collaboration with states, CAM practitioners will work on a definition of professions and practice."

The point I want to make is, it seems to me -- this may not be the best thing -- but self-regulatory and federal government working on defining CAM rules and

regulations is an issue. For me, I can't think of any medical school or school of nursing who would go to the federal government to say, help us work out our guidelines for directing our profession. This seems really puzzling to me in here. Thank you.

DR. GORDON: You are expressing a concern about federal intrusion into regulation of these professions.

Wayne.

DR. JONAS: I think that this is an area where the federal government does not have a lot of direct jurisdiction. They can have indirect jurisdiction by helping to facilitate producing guidelines and things like this that are then used by the states. I think this can be a very helpful win/win situation.

I have a question for those who worked on this. The relationship between this and the Access to Medical Treatment Act, which has been evolving and circulating for a number of years now, and has looked at and developed a variety of sets of guidelines in terms of assuring safety, competence of the practice, and freedom to choose.

Can someone speak to that? I didn't really see

that referenced. I didn't see the same language, and yet that seems to be dealing with a lot of these same issues and is directed towards the consumer, not the practitioner, per se. Can someone comment on that?

DR. GROFT: It may have come up at one point in time. Because it was proposed legislation, and not enacted legislation, I think the decision was made that we really weren't going to address that specific piece of legislation.

DR. JONAS: I am not asking that it be addressed specifically, but I mean, here is a whole body of effort that has gone in, several years, trying to do the very same thing. I am just wondering if that was used as a consultant.

DR. GORDON: Wayne, you are suggesting that we need to include that.

DR. JONAS: Well, I think that needs to be looked at, because a lot of people have worked on that for a long time in terms of trying to figure out, how do you address access and maintain safety, et cetera, et cetera. I am not saying that that is the way it ought to go, but I am saying that here is a whole thing dealing

with access that isn't a licensing issue, per se, that should be evaluated.

DR. GORDON: What we are doing now, and you are doing it very clearly, and others have done it, is we are raising some of the issues that need to be addressed in this chapter.

Conchita, and then Tom. Then I think we need to, pretty soon, as we come to a conclusion with general statements, start focusing on the recommendations and where we want to go with them.

MR. PAZ: What I wanted to emphasize was, in the spirit of trying to promote the CAM practices in states that have no licensing or registration, it possibly may be antagonistic if the state is having some snags in trying to develop their criteria, or giving some major resistance to it, I think that is where they can enlist the help of the federal government to try and facilitate that type of development. I think No. 2 is pretty succinct in saying that.

DR. GORDON: Tom.

MR. CHAPPELL: I don't see what value we will be able to add to the state licensure issue. So that, I

feel that our recommendations ought to be where we can add value, make a difference and so forth, as I mentioned earlier in my last comment.

I also just wanted to say goodbye. I have to leave now, and I wanted to thank you all.

DR. GORDON: Thank you, Tom.

[Applause.]

DR. GORDON: We will be in touch.

So, with all these things in mind, let's begin to see what we can do with the recommendations and the action items, see which ones are appropriate, how they may need to be altered, what might need to be added, and then having heard the shape that the Commission would like the chapter to have, we need to come back to it.

So let's, then, move ahead. George.

MR. DeVRIES: Can I go ahead and just start on Recommendation No. 1?

DR. GORDON: Yes.

MR. DeVRIES: First of all, just a couple of quick comments. Tom's comment, just as he left, what value do we add, we add tremendous value. It goes back to the fact that there are 50 state legislatures who are

trying to manage and regulate health care, and this is a federal body that can make tremendous recommendations.

The second part of this is that, many of you are medical physicians or dentists, and you have your license and you are able to practice, you are able to practice your professions, but there are other professions out there, and the naturopathic is one of them, where they only licensed in 11 states.

When they are licensed, their scope of practice or education says that they can diagnose a condition, that they can treat a condition. If they don't have a license, if they go to the State of Arkansas and do that on their own, they are basically practicing medicine without a license. So the license really gives them the ability to practice.

That is why it is our ability as a White House Commission to make a recommendation to the state. I think this committee has done just a superb job balancing all the issues, from the exemptions, those like the Minnesota law, allowing there to be flexibility in the system, up to saying to states, it is important for a profession like a naturopath or acupuncturist, these

people who, their education, their scope of practice is such that they diagnose medical conditions, they treat conditions, they need to be licensed. That protects the member, but it also allows the provider to practice their profession.

So I want to say that on the front end, that really I believe this is just a critical part of the report to keep in. I still go back to an earlier recommendation I made in terms of Recommendation No. 1, changing the wording, being more direct. I support leaving in what has been done here, and splitting out the products, perhaps, into a second recommendation, and really letting this focus solely on the ability of the provider to be legally empowered to practice their profession.

Now, I say that with the caveat, Julia, I support 100 percent that this section needs to be balanced with facilitating patient access to services, too. So this is just a part of this Access Section.

DR. GORDON: George, do you want to repeat the wording you had for Recommendation No. 1.

MR. DeVRIES: Sure. Sure.

DR. PIZZORNO: Could I ask a question first, George? The wording you came up with sounded more like a recommendation for No. 2, rather than for No. 1.

MR. DeVRIES: Okay.

DR. PIZZORNO: Because No. 2, I think, is more about the credentialing. I think No. 1 is about the access issues that are independent of credentialing.

DR. GORDON: Do we want to begin with No. 2, or do we want to begin with No. 1?

Wayne?

DR. JONAS: I'm not going to answer that question. I had a suggestion that is different.

DR. GORDON: Please, give us your suggestion.

DR. JONAS: I would like to suggest a modification of these recommendations along these lines, my suggestion is that we start first with, not licensing and credentialing, but we start as our first recommendation with a recommendation that looks at access directly to the consumer.

I would suggest that the action items that are at the end, actually, are the ones that address those, more than the ones at the beginning. So those should be

moved up front.

I don't have a lot of problem with those action items as they are written, but I think they should be framed with an actual recommendation that goes over them that might go something like that, and addresses specifically looking at the barriers to consumer access, again, to safe and effective, and to qualified practitioners.

DR. GORDON: Is one of the staff taking down this? Yes? Okay, good.

DR. JONAS: And here is some suggested wording for a recommendation that I would say would be No. 1, and these would follow as action items, and perhaps they could be modified: The federal government should evaluate current barriers to consumer access to safe and effective CAM practices and qualified practitioners, and develop guidelines for removing those barriers and increasing access.

So this is a general recommendation. It is directed at the federal government. They are looking at the barriers, focusing on safe and effective practices, and qualified practitioners as the initial focus.

DR. GORDON: That, then, would be a replacement for the current Recommendation No. 1.

DR. JONAS: Correct.

DR. GORDON: Repeat it again, Wayne, so everyone can hear.

DR. JONAS: The federal government should evaluate the current barriers to consumer access of safe and effective CAM practice, and to qualified practitioners, and develop guidelines to remove those barriers and increase access.

Then the action items, Nos. 6 through 8 actually largely address that.

DR. GORDON: I would like to have discussion on this substitute recommendation that Wayne is making. People's responses to it?

Charlotte.

SISTER KERR: I just want to complement that. I think in the case of the wording of this recommendation, I agree with the role of the federal government to do that.

DR. GORDON: Julia.

MS. SCOTT: I like Wayne's. I was trying to

get some language together, and I like what he has done with that recommendation. What I would add is that, while Nos. 6, 7, and 8 seem to go under that, perhaps with a little rewording, there are additional action items that need to go there.

DR. GORDON: Thank you, Julia. Effie.

DR. CHOW: I just want to thank you, Wayne. That was the recommendation I was saying was needed. Thank you.

DR. GORDON: Dean.

DR. ORNISH: Well, I don't want to sound like Eyore, but it just sounds like there is a greater body of evidence that these various practitioners are effective than, I think, exists for most of them, and that we should therefore try to really knock down those barriers and open the floodgates to people, when I am not sure that for many modalities that we are even close to that point.

DR. JONAS: That's right. I mean, it may turn out that there is only three, but I can tell you that I know I have made many attempts -- and I am licensed -- to get acupuncture available for chemotherapy-associated

nausea and vomiting, proven safe and effective, et cetera. Cannot do it. There are barriers to that. We need to examine those.

I can tell you there about a half dozen, at least, herbs that have good evidence that they are safe and effective for a particular clinical condition. So I think the issue is that we ought to examine those. That is what this is for. I would suggest that there may not be a whole lot, but there is probably enough to actually address this issue.

DR. ORNISH: Is there a way to somehow put language in there that is a little more modest in terms of recognizing what you're saying? Tieraona, do you have any thoughts about that? I'm just curious.

DR. LOW DOG: Well, I think, again, if you're talking about evaluation -- I guess my main concern is evaluation of barriers -- and that is the only thing you're talking about.

DR. JONAS: So you would add opportunities with barriers and challenges?

DR. GORDON: Wayne, and then Effie and Joe also have something to say.

Do you want to say something at this point?

DR. JONAS: Well, I was going to suggest that we pair access with accountability in each of those statements that I mentioned, so that they look at barriers, not only to access but barriers to accountability, to assuring accountability.

DR. GORDON: How would that sound, Wayne?

DR. JONAS: It would sound cumbersome, but I think it would address the issue that this is not just about, give me more, give me more, but what we are doing is making sure that the practitioners that are delivering this, and the practices, are accountable, that they are addressing safety issues.

DR. GORDON: I'm sorry, I want to hear from Effie, and from Joe and Buford.

DR. CHOW: In our discussion it seems like the interpretation of these recommendation are for immediate action, and we are talking about short-term and long-term, because these are recommendation for change into the future, way into the future, and not just these next years.

So therefore, it might be just three now, but

it lays the groundwork for others as the research is proven and so forth.

DR. FINS: I think the issue about removing the barrier presupposes that there is efficacy, and all that stuff, but if we look at Action Item No. 6, and we took part of that, I think it gets the spirit of what Wayne has just said, and what Effie just said about current and future, and says, "HHS and other appropriate federal agencies should seek to identify current and future health care needs or access that qualified CAM practitioners may address."

Then they should seek to remove barriers that preclude their provision of things that have been deemed to be safe and effective and beneficial, and then we should get data, workforce data, national surveys, et cetera. Then the other action items sort of follow.

The point is that you want to try to identify current and future health care needs that this workforce might address.

DR. GORDON: Buford.

MR. ROLIN: Thank you. My concern is with Action Item No. 8 here, this whole issue of traditional

healing, and the recommendation that the Secretary should identify common uses and practices of indigenous healing in the United States, and on down where we are talking about dealing with the issues of how to protect cultural heritages, and things of this nature.

We had some real discussion on that many times, and I don't think that captures the original statement that we had come up with.

DR. GORDON: Can you redraft it the way you think it should be?

MR. ROLIN: Well, we had some language there before, and I thought it was acceptable, and this has been tweaked.

DR. GORDON: And the difference between that language and this language is what?

MR. ROLIN: Well, the difference is the approach here, I guess, in the matter of saying the Secretary should. I don't know, in the case of American Indians, if we are going to ever get to the point of where we are going to share our cultural heritage and what is happening in that process. That is what I am concerned about.

DR. GORDON: Maybe if you could take a minute while we are talking about some of the others, or at some point say how you think it should be written, because nobody is wedded to the exact form of any of these recommendations or action items. So if you make a proposal, that would be very helpful.

DR. LOW DOG: Buford, I think part of the problem here as well is this sort of invasiveness of coming in and expecting people to share rituals, song, practices. Also, the feeling amongst many peoples that they have just about been researched to death, and they are sick of it. I don't think this is what it is getting at at all.

DR. GORDON: Tieraona, I would like it rewritten in a way that feels appropriate. I think we're ready for that, we're up for that.

DR. LOW DOG: Where is the language from the last one? Do you have that in your pocket, Julia?

MS. SCOTT: I do, but it's at home.

DR. GORDON: I think Wayne's substitute recommendation for No. 1 is very appropriate. If there are three or 30 that are safe and effective, the point of

it is it provides an avenue, it provides a rationale that is well within the approach to scientific medicine. So it seems to me a very way to express the issues.

The basic issue -- and I just want to repeat what he said -- for patients is, how can I get this thing that is effective, that is safe for me, whether it is through a licensed doctor, through an acupuncturist, whoever it is. Their concern is getting the services, and I think we really need to recognize that. It is fine to say safe and effective, but we need to recognize what everybody on this side of the room has said, which is that there is a real consumer issue here.

DR. JONAS: Well, just to address the accountability issue, I have a paired recommendation that would then address that together. So we can talk about that when we are finished discussing this.

DR. GORDON: Tieraona.

DR. LOW DOG: I am getting ready to leave you all. So I had just a couple of things that I just want to say, for whatever they are worth. When you are talking about access, the ability for somebody to go could be limited by income, but that is true of many

things.

We have published studies that actually show watching comedic movies are very beneficial to health, but do we pay for people to go to the movies? We have evidence that Resveratrol and red wine is very beneficial for the cardiovascular system. I would love for the government to pay for my chianti, I really would, and would argue for its health benefits.

However, I think it is more to me, when you are talking about access, of something just being safe and effective. There are a whole lot of other consideration that has to go into what we are paying for, and what we are not paying for.

I would like to encourage again that we just keep in mind about evaluation and going back to demonstration projects to begin to explore team approaches, exploring ways to begin to determine who needs what and how it will benefit us, but to be thoughtful in that process. Just because something is safe and effective, it doesn't mean we pay for it. We deal with this with OTCs all the time. Many of these are safe and effective, but you pay for them out of your

pocket.

The last thing, is to keep in mind that I have some personal issues. I want to be very careful about what we are going to recommend is covered when many people don't have access to basic medicine, a prescription.

As a Navajo gentleman told me recently, "Have you thought that maybe some of us may perceive that you are trying to give us second-class medicine, medicine that has not been proven, medicine that has not been shown to be effective, because you think it's cheaper, and that maybe that is the way you are going to deal with our health problems?"

I think that we have to be sensitive to that perception. Thanks a lot.

DR. GORDON: Before you go, and before we thank you, Tieraona, I would like to ask you if you have any thoughts about how to address that last issue that you just raised.

DR. LOW DOG: I think part of it is through demonstration projects, evaluation and demonstration projects, which I do believe were in earlier iterations

of this draft, which I think, then, address these issues in a way that doesn't let us believe that is what we are actually doing to underserved populations.

DR. GORDON: Including the issue of people perhaps feeling they are getting second-class health care.

DR. LOW DOG: Yes. Yes.

DR. GORDON: So through demonstration projects.

DR. LOW DOG: And evaluation.

DR. GORDON: And evaluation.

DR. LOW DOG: You have got to have the evaluation to determine what you are going to do a demonstration project on.

DR. GORDON: Good. I just wanted to make sure we had your thoughts on it.

DR. LOW DOG: Thank you and thank everybody for this process.

DR. GORDON: Thank you.

[Applause.]

MS. SCOTT: I want to support what Ti just said, because the formation of recommendations of action items under this section, I would encourage us to look at

what is already being explored for these populations of people in existing work, such as the Medical Practice Act, looking at the Surgeon General's Report.

All of these deal with access, so I don't think we have to reinvent the wheel, but I think we need to have a couple of them that are applicable to access to safe and effective CAM services.

DR. GORDON: Julia, does it make sense to you to come back to the recommendation that Wayne put forward, and for us to discuss that at this point? Or, are you looking for another recommendation on the section?

MS. SCOTT: No, no, I'm not looking for another recommendation. I am supporting what he put forward. All I am suggesting is there are places we can go to look for action items, other than the ones that are listed here.

DR. GORDON: I've got that. I hope we all have that understanding, that even if this recommendation comes forward, there are other concerns that you have.

Joe.

DR. FINS: We have sort of come full circle,

because we are having conversations that we had on the very first day when we were going around the table and somebody was asking for each of our own world views.

I was struck by what Tieraona just said, what that Navajo gentleman was concerned about, and what the gentleman who did the Spanish radio shows -- I think it was in Washington -- Dr. Huerta, I believe his name was.

I think it is really important that our purview is really not to address access in general. That is not within our mandate. We appreciate that any recommendation that we are making is in the context of access for complementary and alternative medical services, practitioners, or whatever.

We would say as a guiding principle, and I think we all can agree, that access to CAM is meant to complement, it is meant to augment, it is never meant to substitute for, conventional access to health care. I think that should be stated clearly, so that that Navajo gentleman, who was instructing us from 2,500 miles away, would be reassured, because I think separate is not equal.

DR. GORDON: Joe, it is important that that be

made clear and adumbrated in the text. Yes?

DR. FINS: Yes.

DR. GORDON: Are we in agreement about that point, that we are not talking about getting acupuncture instead of antibiotics if what you need is antibiotics?

DR. WARREN: Separate is not equal, but separate doesn't imply superiority by one or the other.

DR. FINS: I'm saying, look, people are free to choose what they want. If somebody is sick and they want to go for acupuncture instead of bypass, or they want to do the Ornish diet instead of acupuncture, one of our principles is they have the right to choose.

What I am saying is, that as policy we should say that separate is not equal, this is not as a substitute for. The presumption is that all the people who are calling Dr. Huerta's radio show wanted conventional health care and they were obliged, because of their poverty and their disenfranchisement, to seek this alternative sort of care because they could pay for it, it was accessible.

DR. GORDON: I think, Joe, without quoting Huerta, your point is well taken. I think the point is

basically we are not saying that people should not have access to conventional medicine and instead they should have access to CAM. We are saying that whatever access they may have to CAM, they also should have access to conventional medicine. This is not an either/or.

DR. FINS: I just want, for the record, to say I don't mean to misquote Dr. Huerta.

DR. GORDON: I think we understand the principle here. I want to get head nods to make sure we have this general principle, that we are not saying throw out conventional medicine and give them CAM instead. We are saying that there are many systems. Yes. We've said it.

DR. WARREN: We are saying free choice by the consumer as to which, as long as they have got equal access to both. They can take free choice, and it is their informed consent that implies that, correct?

DR. FINS: Choice implies voluntariness, and if one is uninsured, they may not have as much free choice. The goal here is to never have them feel, based on any government policy, that we are giving them a second-tier intervention, because there may be situations where it is

as good as or better than.

I think I said what I meant to say, and I hope somebody was recording it or whatever. Just as a principle, the Navajo gentleman's concerns are ones we have to resonate with, but also, at the same time say that people are free to make their own choices. Some people are coerced into certain choices because of their poverty.

DR. GORDON: I think there is general agreement on this principle. Do we have general agreement on this principle? Okay.

Yes, Dean.

DR. ORNISH: I agree with that principle, but a corollary of that principle is that, with access there needs to be information. One of the things that you said earlier which didn't account for that, was that this is only about access. I think a direct function of access is information about efficacy, the kind of things that Tieraona was talking about in terms of demonstration projects, and the kind of things that Wayne is talking about in terms of accountability.

It is not only accountability in terms of

accountability to standards of your own profession, but information that the consumer can use to make those kinds of decisions.

DR. GORDON: I think that's a very good point.

Now, I would like to get, if we can, a Recommendation No. 1, and then take a break and have public testimony, which we are scheduled to have, and then come back and move through the rest of the recommendations.

DR. ORNISH: Since some people have to leave, like me, is it possible that the public testimony could be delayed for half an hour so we can continue this, and then continue it? I mean, there are several people that have to leave, but if not, then fine. I just want to put that out there.

DR. GORDON: Let me ask, how many of the people are here who are going to be giving public testimony?

[Show of hands.]

DR. WARREN: I would like for all the commissioners to have a chance to listen to public testimony. We have walked out on them before, and I don't think we ought to do it again.

DR. GORDON: In fairness to the people who have come here and set aside their time, I think we should have public testimony at the appointed time. We will pick up a half hour later.

I would like to come back to Recommendation No. 1, if we could. Wayne, do you want to state it how you have fashioned it?

DR. JONAS: I think if the first one is accepted to deal directly with the access issue and not the licensing issue, then I think, as we discussed, barriers in access are the appropriate focus, again, focus on safe and effective, identifying those things that are safe and effective.

The second recommendation, then, I think, can address the licensing issue, and the primary focus there is accountability. Now, the problem we have discussed with that is, that is not in the federal purview, unlike what could be done initially on the first recommendation.

So here, I think the federal government's role could be in facilitating the states in developing their own guidelines. So I would like to propose some wording to help that so that it does give a role for the federal

government, but it is not a role in which it is dictating any kind of guidelines to them.

Again, this can be reworded. What I have done, actually, is, I have taken Action Item No. 2 and reworded this as a potential thing to address this, because I think this got at least as close as possible. To say something like, "The federal government should assist states," and one could say "by" or "in" "developing guidelines for" -- and I scribbled around in this.

I've got to make sure I get this right -- "for establishing accountability and competence in CAM delivery, including," and then list: standards of practice; scope of practice; education and training; registration, licensure or exemption; and professional oversight. So in other words, list some of the items that are involved in what those accountability items are, which are already in that paragraph, but we just pushed them down towards the bottom.

DR. GORDON: So, would that be Recommendation No. 2?

DR. JONAS: I think that would be Recommendation No. 2.

DR. GORDON: Then come back to Recommendation No. 1, if you would, and then read Recommendation No. 2 again, so we have them both together.

DR. JONAS: All right. I should have written out in more detail. Recommendation No. 1 is actually on the board in the back. It is, "The federal government should evaluate current barriers to consumer access to safe and effective CAM practices and qualified practitioners, and develop guidelines to remove those barriers and increase access." So that addresses the direct access issue.

Recommendation No. 2 is, "The federal government should assist states by developing," or "in developing guidelines for assuring accountability and competence in CAM delivery, including standards of practice; scope of practice; education and training; registration, licensure or exemption; and professional oversight."

DR. GORDON: Can we discuss these two recommendations? Thank you, Wayne, very much for the reworking.

Joe, do you want to comment on these?

Wayne, do you want to read them again?

Let's read them once more, and if we can discuss them in the next little period of time, great. If not, we will put off the discussion. I would like everybody, though, if people are leaving, to have a chance to address both of them before they go.

So read them again, Wayne, please.

DR. JONAS: No. 1 is about access, and it is that, "The federal government should evaluate current barriers to consumer access for safe and effective CAM practices and qualified practitioners, and develop guidelines to remove those barriers and increase access." That is No. 1.

The second one is that, "The federal government should assist states in" or "by" -- I'm not sure -- "developing guidelines of accountability and competence in CAM delivery, including standards of practice; scope of practice; education and training; registration, licensure or exemption; and professional oversight."

DR. GORDON: Thank you very much.

Comments on either No. 1 or 2? Dean and Charlotte first, and then Joe.

DR. ORNISH: I liked Wayne's recommendations. I just wonder, is there any way within Recommendation No. 1 to put anything about accountability or safety, efficacy, anything beyond just -- pardon me?

DR. GORDON: Safety and efficacy, I believe, is in there.

DR. FINS: But I think accountability is a practitioner.

DR. ORNISH: I missed the safety and efficacy part. Is that part of No. 1?

DR. JONAS: That is No. 1, actually. That's why I suggested we look at the barriers.

DR. ORNISH: Fine. I like them. I think they are really good.

DR. GORDON: Joe just pointed out that accountability is more a practitioners issue than a practice issue.

DR. ORNISH: I like it.

DR. GORDON: Other comments about these two? Charlotte.

SISTER KERR: Wayne, you've done No. 2 and you remembered my concern. I'm not sure if I have copied

right: "The federal government should assist states in developing guidelines" -- I need your feedback -- "for establishing accountability and competence in CAM."

I mean, it doesn't even say in this case that you are going to collaborate with anybody. Again, I don't have it exactly in front of me. "The federal government is going to assist the states to develop guidelines in these areas."

DR. JONAS: Well, this is why I said "in" or "by." One could say, assist the states in developing accountability and competence "by" developing guidelines, in which case then the federal government would simply do it. They would say, here are guidelines that we think are appropriate for accountability. These are some things that states can now take and individualize to their particular requirements.

DR. FINS: Developing and assessing guidelines. In other words -- I'm looking to Don -- because it is the issue of assessing, because there is a heterogeneity, a possibility, developing and assessing.

I liked Max's idea, the states are the laboratory of democracy; let's assess it a little bit.

That is not exactly what he said, but it's the spirit of what he said.

DR. HEIRICH: That's a nice sentence.

DR. FINS: It wasn't mine, it was Jefferson. But assessing.

SISTER KERR: I think this is real important. I am still not clear -- and I want to see it in front of me -- is the federal government going to offer guidelines to different disciplines as to how they should regulate themselves? If we are saying that, I am not for it.

DR. GORDON: I am going to suggest that this is going to require more discussion. What I would like to do is take a five-minute break, and then come back for public testimony, and then we will pick up and go into these issues after public testimony. A five-minute break.

Could we call the first panel to come forward? We will have public testimony, and then we will come back to this discussion.

[Break.]

Public Comment Session

Joyce Frye, DO, MBA, National Center for Homeopathy

DR. FRYE: My name is Joyce Frye of the National Center for Homeopathy. A year or so ago, Joe Fins made the astute observation that CAM is a symptom of the diseased health care system. The homeopathic treatment of that disease, according to the law of similars, would be to stimulate CAM until the organism brings itself back into balance.

Clearly, that is what the Commission is attempting to do in its recommendations, and with the establishment of CAM Central for implementation. So we congratulate you on your homeopathic perspective in creating this remedy.

There is considerable overlap between your recommendations and those from the NCH, which you have at place. So, to the extent that they can be carried forward into specific CAM Central activities relative to homeopathy, we will be very happy.

Speaking for myself, I have one very deep concern. That is, while your remedy is correct, the potency may not be. Specifically, the word "should" is universal in your recommendations. There are no carrots and no sticks, and "shoulds" only go so far in changing

behavior. We should exercise and eat right. One hundred years after the Civil War, Rosa Parks should have been able to sit anywhere on the bus, but it took years of mandated integration and affirmative action to gain something approaching equal opportunity.

In the last several months, we have provided testimony to the House Committee on Governmental Reform, and to NIAD, and to NCCAM, and to Secretary Thompson about the potential benefits of investigative homeopathic history in treating bioterrorism, and we were politely dismissed. CDC and NIAD should have been beating down our door, trying to figure out how they could use this and investigate it.

For CAM to move forward, conventional medicine is going to have to share its seat on the bus, and sometimes even sit in the back. It will not do that without a fight. So at the very minimum, your Recommendation No. 1.1 for CAM Central has to include the word "authority" along with "budget" and "staff" in order to carry out these recommendations.

I would like to suggest that you take an even bigger step and recommend to Congress that they enact

legislation mandating affirmative action in the study and implementation of CAM procedures and protocols for a defined period of time until this health care system can come back into balance.

DR. GORDON: Thank you.

Let's wait until all the speakers have spoken, then we can ask questions.

Madan Khare. Is that the proper pronunciation?

DR. KHARE: Good enough.

DR. GORDON: Okay, thank you.

Madan Khare, DVM, MS, PhD, American Complementary and Alternative Veterinary Medicine Association

DR. KHARE: On behalf of the Complementary and Alternative Veterinary Medical community, I thank you for giving me the opportunity to speak with you today. My name is Dr. Khare, and I am a microbiologist and a practicing veterinarian.

I do not need to emphasize the bond between humans and their family pets. Even the President of the United States, when stepping off the helicopter on the White House lawn, he picks up his dogs, Barney and Spot, instead of his wife and kids.

The family pet has proven to be therapeutic and valuable to cancer, psychiatric, and nursing home patient management. More and more, pet owners are demanding CAM health care for their other family members, their pets.

Academia and associations are making concentrated efforts to ensure continuous training and education of CAVM practitioners. We need validation and acceptance of their efforts. Recognition of this vital process by this commission will tremendously ensure that the consumer receives high quality CAVM care for their pets.

The CAVM academic and individual research communities are engaged in shared research. Through research and quality control, the CAVM industry is engaged in production of quality products. However, we need more support and cooperation from local, state, and federal providers. Recognition of this need by this commission will help increase our resources.

CAVM practitioners are active in promoting consumer awareness. However, again, we do need your help in our quest to educate pet owners about CAVM.

CAVM practitioners are providing efficient and

effective modalities to their patients. However -- I am repeating like a broken record -- we do need resources to standardize the implementation of standards.

On behalf of the CAVM community, I request that this commission recognize the role and place of CAVM in pet health care. I urge this commission to mention and include in your report the need of a certain level of policy and procedures regarding CAM for the family pet.

Finally, I thank every member of this commission for giving me the opportunity to express my views.

DR. GORDON: Thank you very much, and thank you for presenting a viewpoint we have not heard before. So I really appreciate it.

DR. KHARE: Thank you, sir.

DR. GORDON: Boyd Landry.

MR. LANDRY: I follow Mr. Kriegel.

DR. GORDON: I don't think Mr. Kriegel is here.

Boyd J. Landry, MPA, The Coalition for Natural Health

MR. LANDRY: Well, Mr. Chairman and members of the Commission, my name is Boyd Landry, as you all know, and I am executive director of the Coalition for Natural

Health.

At the close of today, this part of your journey will be over, and what remains is how your work will be received, reviewed, and acted upon. Further, as commissioners, you should be wary of being labeled as a self-serving body. I say that because at the last two meetings, this issue was brought forth at the beginning of the meeting for you to look at and realize and be cognizant of.

Since I do not have a copy of the text of the report, I can only speak to recommendations and action items. Initially, I want to address the usage of the terms "safe and effective." This phrase is used over and over throughout the report, and it creates an interesting dichotomy because consumers have a right and expect all products to be safe. Effectiveness is a relative term, defined by science to some extent, and by consumers of the products themselves.

You may not realize it, but you only recommend that CAM products be safe. There is no mention of effectiveness. Practices have to be safe and effective, but products need only be safe. Where is the

consistency? Where is the difference? Let consumers decide effectiveness, and the let the government attempt to guarantee safety.

On the issue of elevating CAM providers to primary care physician status, we agree with Dr. Fins, there are vast differences in the education and training of conventional medical providers and CAM providers. If CAM providers want to be viewed as primary care, they must receive the same level of education and training that conventional medical providers receive, which includes comprehensive residencies and internships.

By continuing the proverbial carrot of loan forgiveness and tuition reductions by way of scholarships, to recruit providers to underserved areas, is a faulty premise. In a recent AM News article, in the American Medical News, it stated that statistics show that providers are born and raised in underserved areas more so than they are recruited to them. All you have to do is look back to the CBS series "Northern Exposure" for a comical example of that.

Access and delivery is a major issue for the Coalition. I want to use the majority of time of my last

public opportunity to address this issue. I cannot hammer enough the fact that this commission, in its recommendations and action items, has ignored and disrespected the most comprehensive piece of state legislation in this area in the last five years, and that is the Minnesota Health Freedom law.

The Minnesota law has now formed the basis of legislation that has been introduced in Rhode Island, New York, and California. Rhode Island and California have an excellent chance of passing their versions of the legislation in their respective legislatures this year. The Minnesota law created access to CAM providers for the entire public, and provided public accountability and public redress.

The Rhode Island State legislature recognized that CAM is a growing industry, and it also recognized that the state cannot afford to license, certify, or register every modality, therapy, or their derivatives. By grouping these practices, modalities, and therapies into one group that is accountable to the public, without overburdening the state and the practitioners with unnecessary regulation, guarantees the widest net of

access.

MS. AXELROD: Mr. Landry, your time is up.

MR. LANDRY: I'm sorry. I have two short paragraphs.

With respect to coverage and reimbursement, I caution you against falling into the trap that coverage and reimbursement is the key to greater access. It is our fundamental opinion that issues involving access and delivery must be worked out long before discussions should take place regarding coverage and reimbursement. There is a plethora of issues surrounding coverage and reimbursement.

Finally, I want to thank you for the multiple opportunities to address the Commission. It is my hope that the many points that I have made, and the points made by the constituency I serve, make their way into the report and the recommendations.

At this time, the recommendations do not reflect the needs of a large percentage of the CAM community. I cannot comment about the text of the report because I was not given a copy, which you have but we don't. Thank you for your time and attention, and good

luck in these final weeks in preparing your Final Report.

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

Hiroshi Nakazawa, MD, American Board of Medical Acupuncture

DR. NAKAZAWA: Mr. Chairman and the Commissioners, good afternoon. My name is Hiroshi Nakazawa. I am chairman of the American Board of Medical Acupuncture, ABMA. I was educated in Japan and the United States, and completed my residency in surgery at the St. Agnes Hospital in Baltimore, where I am senior attending physician in the Department of Surgery and Anesthesiology.

I have practiced medicine since 1962, and medical acupuncture since 1995. I am a past president of the Baltimore City Medical Society, past executive committee member of the Maryland State Medical Society, and have spoken around the world on the topic of medical acupuncture, which is a combination of ancient Chinese medicine and Western medicine, as practiced by the Western-trained physician.

I have presented my credentials to underscore

the respect I have for education and competence in health care training. Today, I would like to focus on one credential in particular, my certification by the American Board of Acupuncture, the ABMA, because it represents a milestone in the level of expertise which medical acupuncture has achieved in areas of training, education, certification, and accountability.

The ABMA was created in April 2000 as a separate entity within the American Academy of Medical Acupuncture, AAMA. It has an independent board of trustees responsible for the direction and operation. The mission of the ABMA is to promote safe, ethical, and effective medical acupuncture to the public by maintaining high standards for the examination and the certification of physicians as medical specialists.

As in other medical specialties such as radiology or pediatrics, the ABMA establishes requirements for qualified applicants, conducts the exam, and issues certification to those who successfully complete these criteria. The certification process is intended to provide the public with physicians who have completed an ABMA-approved education program and passed

the board examination in medical acupuncture covering a multiplicity of acupuncture paradigms.

To date, nearly 200 of the Academy's members are certified, up from 83 just six months ago. Enthusiasm for the program is clear.

Candidates for board certification must have graduated from an accredited allopathic or osteopathic medical school in the U.S. or Canada, or possess a certificate of ECFMG, namely the Educational Council for the Medical Graduate. They also must have a valid medical license and good ethical standing in the community.

Applicants must complete a minimum of 300 hours of acupuncture training acceptable to the ABMA, at least 200 of them in a formal course program which meets WFAS standards and includes instruction in auricular, energetics, TCM, neuro-anatomic, and other acupuncture disciplines. Further, at least 100 of these hours must be in an approved clinical setting. Eight schools have been, so far, approved. Those candidates who meet the above eligibility and educational requirements may sit for the certification exam.