Responses on Education and Certification from the American Herbalists Guild (AHG) for the White House Commission on Complementary and Alternative Medicine Policy

The following responses were prepared by Aviva Romm, Executive Director and Director of Education and Certification for the American Herbalists Guild, Co-chair of the American Herbalists Guild-Botanical Medicine Academy Examination Commiitee, with the assistance of Roy Upton, Director of the American Herbal Pharmacopoeia, Vice President of the American Herbalists Guild, Board of Director, Botanical Medicine Academy, at the request of Commission members Joseph Kaczmarczyk,DO, MPH and Steven Groft, Pharm D.

1. **Are there national educational standards for herbal and botanical undergraduate, postgraduate, and continuing education?**

While there are naturopathic universities and acupuncture schools that include courses in botanical medicine as part of their medical training, at present there is no nationally recognized standard for western botanical medicine training other than other than that established by the American Herbalists Guild (see Appendix A). Our educational standard was developed on the basis of a consensus committee and national surveys of clinical practitioners in botanical medicine and naturopathy (restricted to graduates of four-year on-site programs). These standards were developed in response to the requests of those seeking information on how to study botanical medicine, and in keeping with our organizational goal of foster excellence in botanical medicine practice and education.

Lack of established educational standards at the national level presents a problem for those seeking herbal training, as they are uncertain as to which programs will offer them a comprehensive education. We get numerous requests for educational guidance from those seeking training in herbal medicine. In response to this, the AHG Education Committee, with the approval of our Administrative Council and Directors, has agreed to proceed with the development of a school assessment program. This program, to be directed by Dr Tracy Romm, EdD, and Aviva Romm, AHG Director of Education, will evaluate individual programs to see which portions of the AHG Education Guidelines are met. It is possible that this assessment program could evolve to a national accreditation standard.

The American Herbalists Guild requires its professional members to obtain continuing education (20 CEUs every two years), and to my knowledge, is the only national herbal organization to do so (see Appendix B).

Should those national educational standards include exposure to conventional or western medicine as well as CAM other than herbs and botanicals?

In this era of an evolving medical paradigm, it seems essential that health care practitioners be conversant in a common language, thus achieving the optimal opportunity for serving individual patients. It therefore seems imperative that herbalists seeking to practice within the framework of CAM practices must have some knowledge

of conventional medicine as well as other CAM modalities. Functional referral systems, understanding patient lab work, and educating patients about the pros and cons of various CAM practices, are just a few of the areas that depend on such knowledge.

However, in the effort to preserve the integrity of herbal medicine as an art and science in its own right, it is important that we do not require herbalists to essentially become naturopathic or medical doctors in order to obtain herbal medicine training. Herbalists must retain the essential language of their own paradigm, which is not always biomedically oriented, and which is based on multiple options for training. Toward this end, the Guild has adopted additional education guidelines, which allow herbalists to train in varying modalities (Cherokee medicine, for example), and in various models (ie, clinical apprenticehip), but encourages its professional members to have training in several core medical sciences such as biochemistry and anatomy and physiology. We do not, however, automatically reject those who lack this training, nor do we automatically accept those who possess such knowledge but are not sufficiently conversant in botanical medicine to practice it efficaciously.

What is the current status of your certification? Who is eligible to participate in your certification?

The AHG is currently in the process of developing a national certification process to increase the credibility of our present admissions process. Currently we have a three-tiered membership system: student members, general members, and professional members. The last category can be entered by successfully demonstrating competence in herbal medicine to the Admissions Committee (comprised of David Winston, Herbalist, Tieraona Low Dog, MD, Christopher Hobbs L Ac, Michael Tierra OMD, and Brigitte Mars, Herbalist) through submission of a comprehensive application. Though we turn down two of three applicants in this rigorous assessment system, this long-standing system does not provide the objectivity we require, nor does it confer a recognizable title.

We are actively revising our criteria and process toward a national certification. Those who achieve the professional member status will be referred to as Registered Herbalists (RH). These members will then be eligible to sit for the national certification examination, successful completion of which will confer national certification in clinical herbalism, recognizable by the designation (CCH)—Certified Clinical Herbalist.

Why, how, and by whom was the certification process and examination developed and administered?

The AHG National Certification Program was suggested by Roy Upton and proposed to the AHG Council by Roy, Steven Horne (AHG President) and Aviva Romm, who is currently guiding the process. The AHG has moved in the direction of certification for several reasons:

1- In order to bring the role of herbalists and the AHG into the dominant American health care system, both must respond to the expectations of the conventional medical system and the general public in terms of training, standards, and accountability;
2- In order to promote excellence and consistence in herbal care, a more rigorous assessment method was needed;

3- Numerous herbal students request information on certification through the AHG office—this new generation of herbal students is clearly demanding an acceptable and recognizable credential with which to publicly practice herbal medicine;
4- In order to preserve the integrity of the practice and modes of entry into botanical medicine practice, it was clear that we needed a standard to be developed internally;
5- Developing an internal standard possibly reduces the likelihood of other professions creating standards for herbal medicine that would possible exclude herbalists from practice.

The American Herbalists Guild and the Botanical Medicine Academy (BMA) Examination Development Committee, directed by Eric Yarnell, ND, Aviva Romm, AHG, CPM, and Kathi Abascal, JD, are currently developing the examination. Successful completion of the exam was also intended to confer board Certification in Botanical Medicine through the BMA, but there is now discussion between the directors of merging the BMA into the AHG and forming one national association (American Association of Herbal Practitioners) in order to focus our resources. The exam development will continue throughout the discussion of this merger, and will happen regardless of the final decision

The exam has been developed on the basis of AHG and BMA professional standards and is geared toward a postgraduate level (an entry level, core competency exam is also being planned for the RH level, and for health care professionals who use herbs but don't feel prepared for this level of testing). Both exams will be available to all licensed health professionals and herbalists who demonstrate that they have met the core requirements for eligibility, as determined by the AHG and BMA. The exam will be multiple choice and essay format, 8 hours long, and is designed to test competence in clinical botanical medicine.

To design the exam, Dr Yarnell and Ms Romm conducted two extensive surveys of the experienced clinical practitioners from our organizations, representing primarily a pool of herbalists and naturopathic doctors. This information was evaluated and statistically weighted by Dr Yarnell and Ms Romm to provide information on material medica, course content, and textbooks from which exam questions will be derived. A study guide is complete and available through the AHG.

Currently, items (questions) are being written by a select group of botanical medicine professionals who are following standard item writing guidelines used by other national certifying organizations. A cut score exam is expected to be offered in November at the annual AHG Symposium. When the exam is established (Spring-Autumn 2002) it will be offered at the AHG Symposium or can be taken locally with an approved preceptor.

How much does it cost?

It currently costs $10 to obtain the AHG Professional Membership Packet, $50 (non-refundable) for the Professional Application Process, and once accepted, $95 annually to maintain Professional Membership in the AHG.

We have currently estimated that to cover expenses, it will cost approximately $450 to take the national exam. Maintaining certification thereafter will cost the cumulative membership fees for both the AHG and BMA (approximately $200/year), and the practitioner will have memberships and designations within both groups. If the organizations merge, the certification fee will be reduced slightly.

The AHG has been primarily financing the exam. We assume that moneys brought in from the examination will eventually allow the process to pay for itself.

Is the certification life-long or time-limited?

The certification will need to be renewed, though the exam will only need to be taken once by those who remain certified in good standing. Continuing education requirements will need to be met, and the members must abide by the Code of Ethics of the AHG for AHG certification to remain valid.

What does your certification mean for patients and for practitioners/providers? How does your certification relate to the assuring the public access to safe, effective CAM practices and products? What lessons did you learn as a result of embarking on the certification process?

No certification process can guarantee the integrity or quality of individual practitioners, but it does provide a baseline assurance of quality and accountability. Thus patients or other professionals who hire Certified Clinical Herbalists will have the guarantee that those individuals went through a rigorous assessment process and met stringent standards before bearing our credential. This is also the case with our current Professional Members. As CCHs will be required to provide evidence of CEUs and will be held to our Code of Ethics, we will provide internal mechanisms to foster continued quality in our practitioners. A national certification program will hopefully encourage hospitals, clinics, and doctors to place greater confidence in herbal practitioners, and thus bring them into their practices, ensuring greater public access to these competent providers of botanical medicine.

While herbal product safety is a separate issue from practitioner quality, qualified practitioners can serve an important function in educating the public about herbal product safety, efficacy, and reliability.

Embarking on this certification process has revealed that there is tremendous potential for cooperation amongst varying health professionals, and has created the foundation for a strong bridge between individuals and groups of herbalists, naturopathic doctors, pharmacists, and physicians who would like to see such standards established. However, there are those in the herbal community who would prefer to remain entirely unregulated. This latter issue has had to be addressed by continual reassurance from the AHG that we are not seeking in anyway to dominate or control who can practice herbal medicine, but that we are creating a standard for those who want this.

2.Should there be national standards or certification to

provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?

Again, CAM products and CAM practices are to some extent, separate regulatory issues. While there are certain products (toxic botanicals, acupuncture needles) that should primarily be under the discretion of the practitioner, access to products should remain a right of the American public, and should not be relegated to any one profession.

Individual professional associations best regulate national standards and certification internally, in order to most accurately reflect the needs of those professionals and those they serve. Representatives of the general public and related fields (naturopathy, medicine, pharmacy) should be included in standards development to broadly inform the professional association.

In the case of botanical medicine, which has a rich folk history and varied practitioner body in this country, national certification would best be applied to those who desire the certification, without criminalizing those who would not be eligible for (traditional curanderas, Appalachian herbalists, etc.) or desire to obtain the certification. Those who would prefer to hire certified professionals would have that option, while others would not be penalized for a lack of certification.

Ideally, the national certification will be implemented by an arm of the national professional organization (AHG) or a sister organization developed by the AHG that focuses solely on this task. Currently, the joint work committee of the AHG-BMA serves this purpose. We have discussed the possibility of the BMA merging with the AHG but retaining its integrity as the certifying body of the AHG, which would be an optimal solution. Funding currently prohibits us from obtaining the services of an independent psychometrics organization for administering of the examination, but this is our goal.

3.**Should the numerous herbal and botanical organizations come together to form "a community?" If so, how and by whom should that "community" be formed?**

The cooperation between the AHG and BMA has been a landmark achievement, demonstrating what is possible in the herbal community. Dr. Yarnell and Ms Romm have discussed the value of creating an annual national caucus to bring together leadership from various other organizations (American Botanical Council, American Herbal Products Association, American Association of Naturopathic Physicians, National Association for Acupuncture and Oriental Medicine) to focus on possible inter-group project possibilities, as well as discussing standards of practice, product safety and quality, and education. However, the development of national standards for the study and practice of botanical medicine should remain in the hands of professional herbalists, who should not be marginalized by other associations that have already achieved professional licensure for their members (NDs, MDs, pharmacists).

4.Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

The American Herbalists Guild, on suggestion of Dr Tieraonoa Low Dog to Ms Romm, has established a committee to define scope of practice for AHG professional members.. Though this committee is not currently active, due to other pressing projects, it consists of Chanchal Cabrera, AHG, MNIMH, Dr Low Dog, Roy Upton, and Aviva Romm.

Again, skilled professionals can best develop guidelines internally, with the input of others in more established clinical professions, that the emerging profession has feedback on the successes and failures of other similar efforts. Specific guidelines can be extremely helpful but cannot substitute for the judgment of skilled practitioners who will tailor treatment protocol to the patient's needs.

5.Are your members concerned about malpractice liability associated with providing CAM practices and products?

Yes, many of our members and potential members are concerned about malpractice liability, and phone the AHG office with questions. This is especially the case for those already possessing licenses in other health specialties such as nursing or pharmacy. The American Herbalists Guild provides professional members with access to an optional malpractice insurance program designed for herbalists through Hylant MacLean of Ohio. The willingness of this company to provide malpractice insurance to non-licensed practitioners is a testimony to the fact that they recognize that they are unlikely to be sued.

6.Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?

The answer to this question depends upon to which types of risks you are referring. I will mention those that I think are of concern to herbalists.

1- CAM has become very popular in the past five years, whereas modern herbalists have been actively practicing herbal medicine in this country for decades. Many professional and even student members have expressed concern that this popularity will lead to MDs and pharmacists controlling the prescribing of botanical medicines, leading to the marginalization or even criminalization of herbalists. Such concerns are not unfounded as recent initiatives in North Carolina, Florida, and other states have revealed. Not only do herbalists have concern for their own ability to earn a livelihood, but also they are concerned for the public. Herbalists recognize that medical doctors and pharmacists can become excellent in herbal prescribing, but most have only the most rudimentary knowledge of not only the botanicals themselves, but the philosophies and principles of herbal medicine that differentiate it fro those other fields. To minimize this risk, it is essential that professional herbalists have the central voice in the development of standards for this profession, and that the voices. of herbalists, both within and outside of the AHG be respected, and that legislative initiatives such as the Minnesota be supported.

2- Herbalists are concerned that the popularity of CAM practices using botanical medicine will lead to the loss of fragile botanical ecosystems and individual species due to over harvesting and poor environmental practices. This can be avoided by including herbal-ecology groups in the discussion of standard development. United Plant Savers, with which AHG has a liaison and many mutual members, is a prime example of such an organization.
3- Herbalists are concerned about herb product safety and quality. As the market had grown to include literally millions of CAM products, the input of herbalists should called upon to help determine industry standards. This will actually lead to a likely improved product efficacy and a renewed increase in the herbal market.

7.Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?

There should absolutely be a consumer grievance mechanism for CAM practices. Each CAM profession should have a conflict resolution program to which a client or patient can appeal. The AHG does have a conflict resolution policy and process, as well as a method for our membership to address concerns about applicants for professional membership before admission is granted.

Individual states can also establish conflict resolution committees, as has been done in Minnesota under the new legislation. In such cases, investigation and mediation are the primary courses of action.

Consequences for legitimate grievances can be established by a national organization or by individual state committees.

Product liability is a separate issue from professional grievances.

8.What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?

Health care providers should practice within the boundaries of respect for patient confidentiality, all parties providing whatever is requested with written consent of the client. Establishing professional referral networks between conventional and CAM providers is essential if we are to meet the health care needs of patients. CAM providers, whenever possible, should maintain records that are understandable to conventional providers, and should be willing to provide interpretation when necessary.

9. What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

The American Herbalists Guild recommends the recognition of the developing American Herbalists Guild CAM designations Registered Herbalist (RH), Certified Clinical Herbalist (CCH), as well as our educational standards, along with other CAM designations such as licensed NDs (versus non-licensed NDs).

On behalf of the American Herbalists Guild Council and Executive Committee, thank you for giving the American Herbalists Guild the opportunity to address the White House Commission on Complementary and Alternative Medicine.

In health,
Aviva Romm
Certified Professional Midwife and Clinical Herbalist
Executive Director and Director of Education and Certification,
American Herbalists Guild
Co-chair, American Herbalists Guild-Botanical Medicine Academy Examination Committee
Executive Editor, *Journal of the American Herbalists Guild*

Tab 8

White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 31, 2001

Ms. Marlys Sperger
Executive Director
American Massage Therapy Association
820 Davis Street-Suite 100
Evanston, IL 60201-4444

Dear Ms. Sperger:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. Are there national educational standards for massage therapy undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than masage therapy?
2. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
3. Should the numerous bodywork organizations come together to form "a community?" If so, how and by whom should that "community" be formed?
4. Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

5. Are your members concerned about malpractice liability associated with providing CAM practices and products?
6. Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?
7. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?
8. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?
9. What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Thank you for your invaluable assistance. Please send your written comments to Dr. Joseph M. Kaczmarczyk (e-mail: KaczmaJo@mail.nih.gov, fax: 301.480.1691, phone: 301.435.6197 or 7592), and contact him with any questions you may have.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Responses to Questions from White House Commission on Complementary and Alternative Medicine Policy

In responding to these questions, the American Massage Therapy Association (AMTA) has focused its attention on massage therapy and massage professionals, which are its areas of expertise. AMTA cannot answer for other CAM therapies.

1. *Are there national educational standards for massage therapy undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than massage therapy?*

There are educational standards for massage therapy programs, which may be taught at massage schools or through undergraduate institutions.

The American Massage Therapy Association has worked for many years to Develop and promote educational standards for massage schools. In the 1960s, AMTA began administering a school approval process, giving schools a way of affiliating with the association as it serves the profession. In 1982, the AMTA Council of Schools was established, in recognition of a shared concern among educators and school directors for the quality of massage therapy education. Early council work focused on the need to develop and maintain educational standards. In 1989, with the support of the AMTA Council of Schools, AMTA took steps to initiate an independent accreditation commission, which would accredit massage schools based on established standards. Now called the Commission on Massage Therapy Accreditation (COMTA), it submitted its petition for recognition as an accrediting agency to the U.S. Department of Education in November 2000. COMTA schools and AMTA school members (members of the AMTA Council of Schools) must offer a massage program of at least 500 in-class hours and operate legally within their jurisdictions.

AMTA's Council of Schools continues to be a forum for massage school owners and directors to enhance the quality and standards of massage education.

COMTA provides both institutional and programmatic accreditation, which is unique because:

- Standards of Accreditation are set by practitioners and educators in the profession, with input from employers and regulators;
- Standards are designed to encompass diversity in curriculum content and organization and in methods of instruction reflecting the diversity in professional practice, while emphasizing the standards of ethical behavior;
- There is an elected Board of Commissioners who have experience in the profession as practitioners, educators and administrators, as well as employers and members of the general public.

- Institutional and programmatic review by peers ensures that evaluations are by people who know the profession and value the importance of maintaining high standards.

COMTA schools and AMTA school members all include required course work in physiology and anatomy. COMTA also is adding a programmatic area to accredit Asian bodywork. Training programs in COMTA and AMTA member-schools typically include information on the theories upon which allied CAM approaches are based. Currently, there are 53 schools accredited by COMTA and more than 235 members of the AMTA Council of Schools.

To maintain their Professional Active Member status in AMTA, massage therapists must provide proof of recognized CEUs.

2. *Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?*

For many years, AMTA has recognized the importance of offering a national certification exam and program for massage therapists. Through our efforts in this regard, AMTA identified a core body of knowledge for massage therapists. In 1990, AMTA initiated the creation of the National Certification Board for Therapeutic Massage and Bodywork (NCBTMB), as an independent body to test and certify massage therapists for basic competence and qualifications to practice. NCBTMB is recognized by the National Commission of Certifying Agencies. The National Certification Exam has become a standard for licensure used by most of the 29 states that regulate massage, to measure a competent and qualified practitioner. More than 40,000 massage therapists now have National Certification.

Certification by the National Certification Board for Therapeutic Massage & Bodywork (NCBTMB) is an indication that a massage therapist has attained professional credentials and is qualified to enter the field. The certification process incorporates testing in competency, ethics and practice standards; also, it requires periodic evidence that the massage therapist participates in continuing education to keep current and remain competent in the field. To take the exam, a massage therapist must have graduated from a minimum 500 in-class hours massage program.

National Certification is an assurance for consumers that a massage therapist has the knowledge and ability to perform competently and safely. And, it strengthens the credibility of the profession. National Certification qualifies a massage therapist to be a Professional Member of AMTA.

3. *Should the numerous bodywork organizations come together to form "a community?" If so, how and by whom should that "community" be formed?*

Should the various massage and bodywork organizations determine the need to form a "community" of their various professions and groups, they should do so as they feel best suits the needs and requirements of the professions and the public. The Federation of Therapeutic Massage, Bodywork and Somatic Practice Organizations, begun in 1991, is one forum through which many massage and bodywork organizations discuss issues of importance to their various practitioners. Member groups include the American Organization for Bodywork Therapies of Asia, American Polarity Therapy Association, Feldenkrais Guild of North America, International Somatic Movement Education and Therapy Association, the Rolf Institute, the Trager Institute, and the American Massage Therapy Association.

4. *Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?*

Condition-specific and modality-specific practice guidelines have not been fully-developed by the various practitioners (or by all associations/organizations) within the various fields that might fall under the category of massage and/or bodywork. Some areas of specialty have guidelines for standards of care and scope of practice that are in various stages of development.

Practitioners and educators tend to promote specific guidelines within their fields of emphasis. For example, neuromuscular educators teach guidelines within their modality. However, a massage therapist may use a variety of approaches and modalities for a specific condition. Universal guidelines across modalities can not be designed, while condition-specific guidelines cannot take into account the variety of approaches a practitioner may use.

AMTA continues its development of a standards-of-care document and accompanying algorhythms. The association has approved a standards-of-practice document for its members. AMTA also has a definition of scope of practice for its members who are not practicing under a scope of practice prescribed by the municipality or state regulations where they practice.

5. *Are your members concerned about malpractice liability associated with providing CAM practices and products?*

AMTA members are concerned about malpractice liability associated with their practices. Professional liability insurance is readily available on the open market

and through professional associations and other organizations. AMTA members ensure that such liability insurance is in effect by maintaining their membership.

According to our data, the number of malpractice liability claims against massage therapists is far below that for medical professionals or chiropractors. Increasing public acceptance of massage and growth of the profession does not indicate that expansion of or evaluation of liability insurance is an issue.

6. *Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?*

AMTA hasn't formally evaluated the risks of CAM for its members. However, some of the main risks associated with CAM, and specifically massage therapy, are as follows:

- The risk to the independent practice of massage therapy, if it is merged into other healthcare or medical care;
- The possibility of reduced income for massage therapists (who already have low levels of income from their profession), due to efforts to promote discounted fees as part of health insurance affinity programs;

7. *Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?*

Some mechanisms to address consumer concerns or grievances about massage therapists are in place. AMTA has a well-established Code of Ethics to which its members agree to adhere upon requesting membership in the association. Consumers have access to a grievance process against individuals who they feel have violated this Code of Ethics and the association has a Grievance Commission, which investigates grievances made against AMTA members. There are mechanisms imbedded and implied in municipal and state regulations, where they exist, for consumer grievances.

8. *What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?*

Within the scope of practice of massage therapy, a massage therapist can only communicate with medical and other healthcare providers about massage work and observances related to a client with the client's permission. When medical providers interact with massage therapists, they must do so within their proscribed legal scopes of practice. For example, they could not share medical files with massage therapists, unless massage therapists are legally permitted to operate as medical providers. Likewise, because massage therapists do not

uniformly operate within the medical context and do not make diagnoses, they would require diagnoses codes from medical professionals who make referrals. (This would be necessary when operating within the realm of covered insurance benefits and the use of standard reporting forms, such as HICFA Form 1500.)

According to AMTA studies of its members (June 2000), one third of massage therapists view themselves as working within a wellness environment, while 12% feel they work within the medical world. In the states of Florida and Washington, where massage therapy is more fully-integrated into health insurance reimbursement, a larger percentage of AMTA members view themselves as working within the medical world. Therefore, though AMTA members are in a period of transition with regard to work in the medical arena, generally, massage therapists do not have a medical focus and are not familiar with standard medical communications and transfer of medical files (and information) that exist in the medical community. Communications between providers must recognize this and collaborate for a better quality of care for the patient/client.

9. *What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?*

- Valid accreditation of educational programs that lead to skilled and knowledgeable practitioners who serve the public in a competent, safe, ethical, and caring manner.

- The federal government should recognize and accept massage therapy for federal employees, resulting in healthcare coverage that includes such therapies.

- Recognizing National Certification in Therapeutic Massage and Bodywork as the established standard and entry-level credential into the massage profession.

Tab 9

White House Commission on Complementary and Alternative Medicine Policy

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January 30, 2001

Barbra Esher
President
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Dear Ms. Esher:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

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3. Should the numerous bodyworker organizations come together to form "a community?" If so, how and by whom should that "community" be formed?
4. Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

5. Are your members concerned about malpractice liability associated with providing CAM practices and products?
6. Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?
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Thank you for your invaluable assistance. Please send your written comments to Dr. Joseph M. Kaczmarczyk (e-mail: KaczmaJo@mail.nih.gov, fax: 301.480.1691, phone: 301.435.6197 or 7592), and contact him with any questions you may have.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,

Stephen C. Groft

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

American Organization for Bodywork Therapies of Asia
1010 Haddonfield-Berlin Rd., Suite 408
Voorhees, NJ 08043
856-782-1616 ☯ fax 856-782-1653
AOBTA@prodigy.net ☯ www.aobta.org

February 13, 2001

Dr. Joseph M. Kaczmarczyk
e-mail: KaczmaJo@mail.nih.gov
fax: 301.480.1691, phone: 301.435.6197 or 7592

Dear Dr. Kaczmarczyk:

Thank you for including the American Organization for Bodywork Therapies of Asia (AOBTA) in your deliberations.

Our Director of Education, Rylen Lee-Feeney and I have answered below the specific questions you set forth.

1. **Are there national educational standards for bodywork undergraduate, postgraduate and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than Asian bodywork?**

National standards have been established by the AOBTA and the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). The AOBTA professional level membership requirements and the formal education route to sit for the NCCAOM Asian Bodywork Therapy (ABT) exam are based on completion of an entry-level curriculum. The minimum eligibility is 500 hours training.

Please see Exhibit A for AOBTA's curriculum breakdown. You will note that the 500 hours include 100 hours of Western Anatomy and Physiology. As far as whether or not exposure to other CAM is something that should be required, perhaps it might be at some time in the future if the minimum hours of study are increased. We feel that the current 500 hours are a bare minimum. However, most Asian Bodywork programs do expose their students to other Asian practices – in particular nutrition, acupuncture, herbalism and *qigong*. At times chiropractors or physical therapists teach Western A & P classes. Although most who study Asian Bodywork Therapy tend to be naturally drawn to many forms of CAM, it is not necessary to require ABT's to study non-Asian courses, other than Western Anatomy and Physiology.

With regard to undergraduate programs, there are several schools in the United States that are creating Associates' degrees in Asian Bodywork Therapy. We are not aware of any postgraduate programs. The New York College for Wholistic Health, Education, and Research, a member of our Council of Schools and Programs (COSP) offers a Bachelors Degree in Asian Bodywork, which does include western medical sciences and pharmacology in its curriculum.

Professional Development Activities (PDA's) such as Continuing Education, in addition to meeting minimum practice requirements, are required in order to maintain national certification with the NCCAOM. One needs 60 PDA's every 4 years. PDA's include continuing education courses, research, teaching, published work, etc.

2. **Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?**

As mentioned previously, national certification is currently available to Asian Bodywork Therapists. In 1996 the NCCAOM offered certification through Credentials Documentation Review (grandfathering) and on October 28, 2000, the NCCAOM administered its first National Exam for certification in ABT (Asian Bodywork Therapy, formerly referred to as Oriental Bodywork Therapy, or OBT).

The NCCAOM is a nonprofit, independent certification organization that has been in existence since 1982. Their exams are administered with the assistance of an independent testing service. They are a member of the National Organization for Competency Assurance (NOCA) and are accredited by the National Commission for Certifying Agencies (NCCA), which represents the highest voluntary certification standard in the US. The NCCAOM has an excellent reputation and a tremendous amount of experience certifying acupuncturists and Chinese herbalists. Asian Bodywork Therapists use the same assessment system based upon the parameters of Traditional Chinese Medicine (TCM). Therefore, it's logical that the same commission that certifies acupuncturists and Chinese herbalists certifies ABT's.

Currently, each state has its own requirements for regulating the profession of Asian Bodywork Therapy. Some states do not regulate ABT. It is our hope that all the states that do will adopt the NCCAOM ABT exam as part of their eligibility requirements, so that there will be consistency from state to state. It has been an ongoing mission of the AOBTA to educate the public about Asian Bodywork Therapy and to have it recognized as a separate practice from that of European or Swedish massage. Many states view them as similar and require that Asian Bodywork Therapists learn Swedish massage in order to be licensed or certified in their state. We disagree with that view. ABT is not an offshoot of Swedish massage. As you can see by our educational requirements, the only overlap in training between European and Asian somatic practices is with Western Anatomy and Physiology. The theory, practice and techniques are different. We are hoping the NCCAOM ABT exam will begin to offer an alternative in states that regulate our profession.

3. **Should the numerous bodyworker organizations come together to form "a community?" If so, how and by whom should that "community" be formed?**

There have been various attempts for the different bodywork organizations to come together. One such successful "community" is the Federation of Therapeutic Massage, Bodywork and Somatic Practice Organizations, referred to as "The Federation." AOBTA meets twice yearly with the American Massage Therapy Association (AMTA), the American Polarity Therapy

Association (APTA) the FELDENKRAIS GUILD® of North America (FGNA), the Rolf Institute, The US Trager® Association and the International Somatic Movement, Education & Therapy Association (ISMETA). Qualifications for membership include being a non-profit somatic practice membership organization and having a 500-hour minimum education requirement and a code of ethics. We feel the Federation is an important communication forum for the different massage, bodywork, somatic and movement therapy modalities. Together we work to maintain high standards and integrity in all our professions.

The AOBTA is also a member of the Oriental Medicine community. For example, we meet with the Oriental Medicine Task Force and discuss mutual issues with acupuncture and other Oriental Medicine professional organizations. Having a lot in common, we attend each other's conventions and communicate well together.

4. **Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?**

Rather than condition or modality-specific practice guidelines we recommend that all schools and programs that teach ABT should teach a solid contraindications segment. The AOBTA has been working hard on producing such a document. It is currently in its final stages. Once complete, it will be circulated to all AOBTA member Schools and Programs. Meanwhile, we have enclosed our "Guidelines for the Safe Practice of Asian Bodywork Therapy" as Exhibit B.

5. **Are your members concerned about malpractice liability associated with providing CAM practices and products?**

Asian Bodywork Therapists are not, by and large, concerned about malpractice liability. Our members do apply for liability insurance but few if any claims have ever been made. ABT has little, if any iatrogenic effects. It is recommended that all CAM practitioners have their patients/clients sign an informative consent form. This consent form should include in detail what the patient/client can expect from the treatment and clearly state that the services provided are not meant to replace standard western biomedicine.

6. **Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?**

Certainly there are risks associated with some forms of CAM, such as pneumothorax with acupuncture, or fracture with chiropractic. However, the risks associated with Asian Bodywork Therapy are minimal. Again, safe practices and contraindications should be taught and followed. The NCCAOM ABT Exam contains a "Professional Issues" section, which includes questions on limitations of ABT scope of practice and knowing when to make referrals. (e.g., If a patient/client has chest pains radiating down the left side, then he should be sent to the emergency room!) The AOBTA and NCCAOM each have codes of ethics, which require that ABT's perform only those services for which they are qualified and refer clients to other professionals when appropriate. National Certification attempts to take care of unqualified practitioners practicing ABT, or claiming to practice ABT.

7. **Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?**

AOBTA has a Grievance Committee in place, as do the other organization members of the Federation. If you wish to receive our grievance procedures, please let us know.

The NCCAOM has a review and disciplinary committee to respond to consumer (or any) concerns regarding Certified Practitioners in ABT.

Or another option would be to make available to the consumer a grievance board. A board could be formed from representatives from various CAM organizations. This board could be a "watchdog" committee designed to educate the public and conventional health practitioners about valid CAM modalities, could handle grievances, review public statements and encourage a cooperative relationship between conventional health practitioners and CAM practitioners.

8. **What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?**

A conventional healthcare provider should communicate all relevant health concerns to CAM practitioners in order for that CAM practitioner to be able to best treat the patient/client, and vice versa. Ideally, we should encourage cooperation between all forms of healthcare, each respecting the different practices that people may choose in order to facilitate their healing process.

9. **What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?**

Investing in CAM research for efficacy studies would highly benefit the public. Many people are unaware of the gentle, non-invasive therapeutic techniques available to them. Research can support promoting public awareness of preventive health care for their patients. By taking care of patients before they get sick – doing what is necessary to keep them healthy and taking care of problems before they get out of hand – everyone would save a lot of money and patients would have a better quality of life.

Professor Wang Jin-Huai (who was featured on Bill Moyers' "Healing & the Mind" documentary series) was the keynote speaker at AOBTA's 1995 convention in Boston. There, he spoke of a 25,000 year-old Chinese concept, *Treat small things before they become big.* Lecturing on *The Yellow Emperor's Classic*, Prof. Wang shared, "The enlightened ones treat the nonexistent diseases. They treat the potential causes, before any disease would appear, thus preventing the symptoms of disease. Hence, the best time to treat yourself is when you're healthy. Don't wait to become sick. Don't wait until you're thirsty before you start digging your well for water."

As far as policies are concerned, all CAM providers and products should be able to provide the consumer with truthful disclosure of the therapy or product and their qualifications to provide their services. This would require a board to review such statements. It could be the same board mentioned above, or an already established national certifying body.

To further assure the quality of Asian Bodywork Therapy, we need to make sure that ABT is and continues to be distinct and separate from that of other bodywork professions. A qualified practitioner of Asian Bodywork Therapy needs at least the minimum required hours in Asian Bodywork. A 500-hour massage program, which includes a 40-hour class in Asian Bodywork, does not make a qualified ABT. It is our deepest desire to see all CAM practitioners respect each other's profession and provide appropriate referrals. We need to work cooperatively with each other. We do not, however, promote a lot of cross training or professions "bleeding" into each other, as this only provides the public with practitioners that know a little about a lot of things but not ones that know one thing well.

Another important way to assure the continued quality of ABT in the future is to issue a policy recommending the adoption national standards and certification.

Self-care techniques such as a form of self-massage called Do-in, or self-acupressure, and *qigong* can be safely taught in community classes or outlined in self-help books.

We hope the above sufficiently answers your questions. Please feel free to contact us if you have any further questions. We are sorry that we are unable to attend the February meeting as we have a National Board Meeting on those same dates. Please keep us in mind for the future.

For your reference, we have included our educational requirements, safe practice guidelines, and professional scope of practice and code of ethics.

Sincerely,

Barbra Esher, Dipl. Ac. & ABT (NCCAOM)
AOBTA President

Rylen Lee-Feeney, BA, LMT,
Dipl. ABT (NCCAOM)
AOBTA Director of Education

AOBTA

American Organization for Bodywork Therapies of Asia
500 Hour Curriculum
Certified Practitioner Level

The AOBTA requires its professional members to have a minimum of 500 hours training. Those 500 hours must include 100 hours of Western Anatomy and Physiology, 160 hours of an Asian form of bodywork technique (these hours must be progressive, i.e., not several intro classes in different styles), 100 hours in Traditional or Classic Chinese Medicine Theory, 70 hours of supervised clinical practice, and 70 hours of electives which must include business, legal & ethical considerations, contraindications, first aid and CPR.

ANATOMY AND PHYSIOLOGY (100 hours)

I. Osteology (Nomenclature, structure and function of the skeletal system **(15 hrs. minimum)**

II. Myology (Structure and function of the muscular system, including origins and insertions) **(30 hrs. minimum)**

III. Structure and function of the other major systems

A. Integumentary
B. Digestive
C. Neurological
D. Respiratory
E. Cardiovascular
F. Lymphatic
G. Urinary and Reproductive
H. Endocrine

CHINESE MEDICAL THEORY (100 hours minimum)

I. General Theory

A. Overview of Traditional Chinese Medicine
B. Basic Cosmology
   1. Chi: Definitions, functions
   2. Concepts of Tao, Chi, Yin/Yang, 10,000 things...
   3. Six energies
   4. Five elements
C. Comparison of Eastern & Western medicine: including the basic concepts of disease and treatment in each.

II. Yin/Yang

A. Concepts of Yin/Yang-properties and principles
B. Yin/Yang relationships
C. Yin/Yang imbalances in the body

III. Five Elements (Five Transformations)

A. Description, historical basis and context within Chinese Philosophy
B. Laws of the five elements (cycles)
C. Five elements related to the body
D. Correspondences

IV. Fundamental Substances of the body (descriptions, functions and relationships among them)

A. Qi (Ki)
B. Blood (Xue)
C. Jing (Essence)
D. Shen (Spirit)
E. Fluids

V. The Organs – Visceral Manifestation Theory (functions, description and typical signs of imbalance of disturbed functions)

A. The five Zang (Yin) organs (viscera) plus the pericardium
B. The six Fu (Yang) organs (bowels) including Triple Warmer theory
C. The Curious organs (Brain, Uterus, Gall Bladder)

VI. Channels and Effective Points **(30 hrs. minimum)**

A. Twelve regular channels (external/superficial and internal/deep)
    1. Description
    2. Function and relationship with organs
    3. Paired relationships
    4. Order and direction of circulation (24 hour cycle)
    5. Anatomical location
    6. Main pathological signs
B. Eight Extraordinary Vessels
    1. Description
    2. Function
    3. Anatomical location
    4. Main pathological signs
C. Tendino-Muscular Pathways or Channels
D. Cutaneous Regions
E. Effective Points
    1. General description
    2. Anatomical location and main indications
        a. Twelve general points (LI 4, ST 36, SP 6, SI 10, BL40/54, GB20, GB 21, GB 30, LV 3, CV 4, CV 17, GV 20)
        b. Tonification and sedation points
        c. Source points (Yuan points)
        d. Lou connecting points
        e. Front Mu (Bo or Alarm points)
        f. Back Shu (Yu or Associated points)
        g. Beginning and Ending points

VII. Evaluation – the four examinations

A. Looking (observation)
   1. Spirit
   2. Complexion
   3. Body appearance
   4. Tongue

B. Listening/smell

C. Asking

D. Palpating (touching)
   1. Pulse
   2. Hara
   3. Channels and points
   4. Mu and Shu Points

VIII. Pathology – causes and patterns of disease or imbalance

A. Etiology – cause of the imbalance
   1. Exogenous causes – the six exogenic pathogens
   2. Endogenous causes – the seven emotions
   3. Other causes – infections, injury and lifestyle

B. Patterns of imbalances and assessment
   1. The Eight Principles
   2. Zang-Fu Organ patterns
   3. The Six Channels (divisions)
   4. The General Theory of Channels
   5. The Five Elements
   6. The Four Levels (Defense, Qi, Nutritive, Blood)
   7. The Three Heaters

DISCIPLINE TECHNIQUE & PRACTICE **(160 hrs. minimum)**

I. Technique – Lecture and Demonstration

A. Definition and history of modality

B. Theory relative to modality including effects on major body systems

C. Contraindications and potentially harmful techniques (cautions)

D. Principles of manipulations

E. Full body treatment

F. Passive and active exercises

II. Treatment oriented application – Lecture and Demonstration

A. Assessment and evaluation

B. Integration of techniques focused upon pathologies likely to be treated by practitioners

III. Classroom practice **(80 hrs. minimum)**

This is supervised practice performed on other students and instructors

IV. Sessions received from a Certified Instructor in the discipline being studied (10 hrs. optional)

CLINICAL APPLICATION (70 Hours)

I. Supervised Clinical Practice

A. Students will have the opportunity to integrate all of their training and practice In providing sessions for the general public in a supervised atmosphere.

1. A professional environment will be maintained at all times
2. There will be constant, qualified supervision at all times
3. During a client's first visit, a complete case history will be taken
4. Session summaries will be written after each patient's visit
5. "Rounds" will be regularly held so that students can share their sessions, interesting aspects, problems and successes with their peers

II. During the program each student will be required to give at least 50 logged sessions

OTHER (70 Hours)

I Other topics relative to the practice of Asian Bodywork Therapy at the discretion of the teacher. A survey of other Asian Bodywork Therapies is recommended.

II. Somewhere in the program, business, legal considerations and ethics must be covered.

III. All students must have completed a First Aid and CPR course.

Guidelines for the Safe Practice of Asian Bodywork Therapy (ABT)

Guiding principles for the Asian Bodywork Therapist are:

1. Use common sense.
2. Do only what you are trained to do.
3. Do no harm. Safety of giver and receiver are paramount.

It is the responsibility of the bodywork practitioner/therapist to ascertain that the client/patient is healthy enough to receive a treatment. It is the client/patient's responsibility to honestly inform the practitioner/therapist (p/th) of any medical condition or symptoms s/he is experiencing or has experienced. The use of an intake form with permission for treatment signed by the receiver (or guardian) and the maintenance of treatment records are the responsibility of the p/th. Medical records must be kept up to date. The use of the Four Examinations of Oriental Medicine is standard in an ABT session.

Bodywork is inappropriate and may be dangerous if the giver or receiver is in a highly altered state of awareness due to alcohol, drugs, or other substances. Certain medical conditions warrant referral to or consultation with a medical practitioner. Referrals to medical doctors, chiropractors, dentists, acupuncturists, herbalists, psychotherapists, or other ABTs may be appropriate. Practitioner notes referrals in client's records. If the p/th lacks necessary information to safely proceed with a treatment, the treatment must be cancelled or postponed until a treatment can safely be given.

Emergencies that warrant immediate action (e.g., Dial 911.) include the following:

- Bleeding, hemorrhage - external, sudden onset
- Headache - "the worst headache of my life," a sudden, painful h/a that begins in one place and spreads, may become dull and throbbing. May/may not be accompanied by other symptoms. (May be life-threatening sub-arachnoid hemorrhage.)
- Chest pain - crushing chest pain/fist to the chest
- Sudden loss of consciousness, sudden vision impairment, stroke, or suspected stroke
- Shock - BP drops, heart rate slow/fast, patient appears pale or red, may complain of lightheadedness or dizziness. Place supine with feet and legs elevated.
- Diabetic coma/insulin shock
- Inability to breathe, as in asthma attack or sudden, severe allergic reaction, or breathing stops.

Use caution and appropriate techniques to avoid injury in treating someone with any of the following. If someone has not been medically evaluated, refer.

- Fever or overheating due to hot tub, exercise, or sauna
- Fever due to yin deficiency or EPF
- Backache/neck ache and fever
- Inflammatory condition - avoid local pressure
- Contagious disease. If protection to the practitioner cannot be assured by the use of gloves, postpone treatment. If spread (e.g. of scabies) in the client is possible, avoid treating the area.
- Pitting edema
- Internal bleeding - vomiting blood (hematemesis), coughing blood (hemoptysis), blood in stool/rectal bleeding (hematochezia), blood in urine (hematuria), bleeding from ears, penis, or vagina (excluding menstruation), etc.
- Decreased sensation, e.g. in diabetes
- Acute phlebitis
- Deep venous thrombosis or pulmonary embolism
- Acute trauma, accident. Open wounds, acute pain, possible fractures warrant medical referral.
- Recent surgery, childbirth, hospitalization - medical practitioner should be consulted before treatment.

Moxibustion: Practitioners trained in and able to legally practice indirect moxibustion observe precautions and forbidden points.

Asian Bodywork Therapy Scope of Practice

Methods of assessment and evaluation may include the Chinese Four Pillars of examination as follows: observation, listening, asking and touching. Assessments are based primarily on Traditional Chinese Medicine (TCM) parameters relating to the balance and circulation of the five essential substances. Qi, Jing, Shen, Xue, and Jin-ye.

ABT is one of the three branches of TCM in which the NCCAOM (National Certification Commission for Acupuncture and Oriental Medicine) certifies people for entry level into the profession. Treatment may include, but is not limited to the following: touching, pressing or holding of the body along meridians and/or on acupoints primarily with the hands, stretching, external application of medicinal plant foods, heat or cold, dietary and exercise suggestion. Cupping, guasha, moxibustion and other methods/modalities may also be used by properly trained practitioners.

ABT Definition

The treatment of the human body/mind/spirit, including the electromagnetic or energetic field, which surrounds, infuses and brings that body to life, by pressure and/or manipulation. Asian Bodywork is based upon traditional Asian medical principles for assessing and evaluating the energetic system and use of traditional Asian techniques and treatment strategies to primarily affect and balance the energetic system for the purpose of treating the human body, emotions, mind, energy field and spirit for the promotion, maintenance and restoration of health.

AOBTA Mission Statement

AOBTA is a professional membership association, which advocates public policy that protects and promotes Asian Bodywork Therapy and its practitioners, while honoring the diversity of the disciplines we embrace. AOBTA serves its community of members by initiating appropriate credentialing criteria; defining practice and educational standards; and providing resources for training, networking, and professional development. AOBTA promotes public education about the benefits of our work and our principles and standards.

AOBTA Code of Ethics

1. Social/Ecological Concern

AOBTA members recognize their intrinsic involvement in the total community of life on the planet Earth.

2. Professional Conduct

AOBTA members conduct themselves in a professional and ethical manner, performing only those services for which they are qualified, and represent their education, certification, professional affiliations and other qualifications honestly. They do not in any way profess to practice medicine or psychotherapy, unless licensed by their State or Country to do so.

3. Health History and Referrals

AOBTA members keep accurate client records, including profiles of the body/mind health history. They discuss any problem areas that may contraindicate use of Asian Bodywork techniques, and refer clients to appropriate medical professionals when indicated.

4. Professional Appearance

AOBTA members pay close attention to cleanliness and professional appearance of self and clothing, of linens and equipment, and of the office environment in general. They endeavor to provide a relaxing atmosphere, giving attention to reasonable scheduling and clarity about fees.

5. Communication and Confidentiality

AOBTA members maintain clear and honest communications with their clients, and keep all information, whether medical or personal, strictly confidential. They clearly disclose techniques used, appropriately identifying each in the scope of their professional practice.

6. Intention and Trust

AOBTA members are encouraged to establish and maintain trust in the client relationship and to establish clear boundaries and an atmosphere of safety.

7. Respect of Clients

AOBTA members respect the client's physical/emotional state and do not abuse clients through actions, words or silence, nor take advantage of the therapeutic relationship. They, in no way, participate in sexual activity with a client. They consider the client's comfort zone for touch and for degree of pressure, and honor the client's requests as much as possible within personal, professional and ethical limits. They acknowledge the inherent worth and individuality of each person and therefore do not unjustly discriminate against clients or colleagues.

8. Professional Integrity

AOBTA members present Asian Bodywork in a professional and compassionate manner representing themselves and their practice accurately and ethically. They do not give fraudulent information, nor misrepresent AOBTA or themselves to students or clients, nor act in a manner derogatory to the nature and positive intention of AOBTA. They conduct their business honestly.

9. Professional Courtesy

AOBTA members respect the standards set by the various AOBTA modalities, and they respect service marks, trademarks and copyright laws. Professional courtesy includes respecting all ethical professionals in speech, writing, or otherwise, and communicating clearly with others.

10. Professional Excellence

AOBTA members strive for professional excellence through regular assessment of personal and professional strengths and weaknesses, and by continued education and training.

Tab 10

White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 30, 2001

Ellie Simmons, RPP
Executive Director
American Polarity Therapy Association
P.O. Box 19858
Boulder, CO 80308

Dear Ms. Simmons:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. Are there national educational standards for polarity therapy undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than polarity therapy?
2. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
3. Should the numerous CAM organizations similar to APTA come together to form "a community?" If so, how and by whom should that "community" be formed?
4. Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

5. Are your members concerned about malpractice liability associated with providing CAM practices and products?
6. Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?
7. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?
8. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?
9. What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Thank you for your invaluable assistance. Please send your written comments to Dr. Joseph M. Kaczmarczyk (e-mail: KaczmaJo@mail.nih.gov, fax: 301.480.1691, phone: 301.435.6197 or 7592), and contact him with any questions you may have.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

From: LaRose S. Daniels [mailto:larose@earthlink.net]
Sent: Monday, February 12, 2001 4:30 PM
To: Kaczmarczyk, Joseph (NCCAM)
Subject: White House Commission

Dear Dr. Kaczmarczyk,

I am LaRose S. Daniels, MS, RPP, President of the American Polarity Therapy Association (APTA). I am responding on behalf of the APTA to the nine questions asked our organization by the White House Commission.

We received these questions approximately two weeks ago, which has not allowed us ample time to do these insightful questions justice. We are, however, very appreciative that we have been asked to respond, and hope to have the opportunity to remain a part of the White House Commission process in the future. If we can be of any further assistance, please feel free to contact me (919-778-0172). Thank you.

1. Are there national educational standards for polarity therapy undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than polarity therapy?

Two levels of study are recognized by the American Polarity Therapy Association (APTA) in the education of Polarity Therapy practitioners. The first requires at least 155 hours of training for recognition as an Associate Polarity Practitioner (APP). The second level requires at least 675 hours of training for recognition as a Registered Polarity Practitioner (RPP). Curriculum requirements are referenced to the APTA Standards for Practice. In order to maintain these recognitions, at least 12 hours of continuing education, documented with APTA once every two years, is required.

Polarity Therapy blends well with both CAM and conventional or western medicine. However, it is not necessary that education in either area be included in training for Polarity Therapy practitioners.

2. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?

Having national standards would be one means of creating consistency from state to state for the various CAM practices and products. Care should be taken not to categorize too broadly when developing or applying specific standards. Aside from the most general of standards, APTA feels strongly that each practice should be allowed to develop standards for their particular profession.

One possibility would be a national registry for which practitioners qualify by meeting the

standards for practice and education as developed and administered by each practice.

3. Should the numerous CAM organizations similar to APTA come together to form "a community?" If so, how and by whom should that "community" be formed?

While it is not deemed necessary for the numerous CAM organizations to come together to form a community, it is felt that this will most likely emerge naturally as needs emerge. It would be a great opportunity to have such a group nationally organized.

4. Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

If guidelines are to exist, it is felt that those guidelines would need to be relevant to and specific to each practice. If found to be necessary, as with standards, the APTA recommends that guidelines be developed and administered by each practice. One problem which Polarity Therapy and other practices which involve some form of touch has faced has been the desire of the massage therapy world to bring all such practices into the massage therapy scope of practice. In states where this has happened, education for and the practice of Polarity Therapy has become restricted. The foremost challenge is with the definition of appropriate education requirements for each individual practice employing touch in service delivery. This is one example of what can happen if categories or fields of practice become to broadly defined.

5. Are your members concerned about malpractice liability associated with providing CAM practices and products?

The APTA offers malpractice insurance to its members. Interest has been shown. To date, no malpractice claims have been filed against any of our members.

6. Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?

Primarily, false advertising and false claims. Education of the public regarding expectations from the delivery of services by each practice will serve to support the consumer. It may be necessary that each practitioner be held legally responsible for all claims related to therapeutic outcome. It is felt that the MN Medical Freedom Legislation provides a good model for addressing consumer protection without stifling or restricting the development and growth of innovative health and wellness options.

7. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?

APTA supports there being a mechanism to address consumer concerns or grievances. It is felt that this mechanism needs to be in addition to the ethical processes of the

organizations representing each practice. This mechanism could be through state or federal agencies, or both.

8. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?

A conventional health care provider needs to communicate the health history of the individual, along with the primary reason for which the referral is being made. Any contraindications should be noted. A CAM practitioner needs to contact the primary conventional health care provider informing them of the individual's request for services, evaluation results, recommendations, and a prognosis for care. Regular progress reports need to be provided.

9. What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Standards, guidelines, truth in advertising, ethical behavior, and consumer education.

Tab 11

White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-1691
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 5, 2001

Kay V. Lahdenpera, RN, MPH
Executive Director
American Qigong Association
905 Kavik Street
Anchorage, AK 99515-1068

Dear Ms. Lahdenpera:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. Are there national educational standards for Qigong undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than Qigong?

2. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?

3. Should the numerous Qigong and other energy healer organizations come together to form "a community?" If so, how and by whom should that "community" be formed?

4. Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

5. Are your members concerned about malpractice liability associated with providing CAM practices and products?
6. Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?
7. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?
8. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?
9. What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Thank you for your invaluable assistance. Please send your written comments to Dr. Joseph M. Kaczmarczyk (e-mail: KaczmaJo@mail.nih.gov, fax: 301.480.1691, phone: 301.435.6197 or 7592), and contact him with any questions you may have.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,

Stephen C. Groft

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

First, I would like to thank you for your efforts on this most important project of gathering the "pulse" on CAM in America. I have worked hard with my television productions for PBS, my books, videos and website, to help educate people on what healthcare options and alternatives exist for them.

I was recently asked to answer the following questions relating to my expertise in the area of Qigong. Although I have sent them off to Effie Chow by the due date, I have received another request and notice that your name is on this one. I am sending you my responses (below), to be added to what I am sure is a very large pile you are collecting..... I wish you all the best on the upcoming Commission meeting. I must be traveling to Japan and China. but will be at the meeting in spirit.

Peace..... Francesco Garri Garripoli

1. There are so many varieties of Qigong... sure, it would be helpful if practitioners had integrity and sought to learn about anatomy and physiology, contraindications and body mechanics... but what about practitioners who teach a meditative form of Qigong, don't know a thing about the body, yet are helping every student/patient that comes to them? Do you penalize them for not knowing the "national educational standards"?

2. I think certification is important... but I feel that each organization should be responsible for their own certification rather than follow any national standard. I'd rather see national "guidelines." Our organization is embarking on certification courses and we are making sure that our Medical Board of Advisors includes a wide range of experts from both traditional Western and traditional Eastern disciplines. In this way, we keep our standards high and maintain a high level of integrity. How can a "national standard" be applied to the multiplicity of CAM offerings?

3. I think there already is a "community." The unique, individual natures of these groups maintains a healthy diversity and promotes growth. I believe in a Taoist approach to harmonious integration... in other words, allow things in this area to proceed in a natural way. The key is to promote communication between organizations... that is best.

4. There are many practitioners, each with their own techniques, many radically different from each other. I believe it would be counterproductive to try and create a homogenous approach to condition-specificity. The beauty of "complementariness" is diversity. I've seen a variety of techniques have successful results on patients. If you looked at them scientifically, there would be virtually NO way to correlate their approach or operational paradigm. How do you create guidelines for the way clouds form in the sky?

5. I think malpractice liability is part of the downfall of Western medicine. When I was a kid, we'd never think of suing a doctor... at the same time, if we didn't get results or didn't like our

physician, we'd find another. Sure, there are extreme cases of malpractice, but what has happened in my opinion is that physicians are so fearful and constricted in their practice that they resort to the most conservative of medical solutions - usually pharmaceutical-company promoted prescriptions. This is why people are migrating to CAM. If CAM modalities fall prey to what has happened in the Western model, where will people turn?

6. There are risks with every modality. If there is a practice that is intrusive in any way (breaking the skin or ingesting substances) then there must be guidelines, of which many are already in place. Beyond that, I think the best thing we can do is work to get potential patients informed enough to ask the right questions and interview practitioners before they hire them for service. Education should be our primary concern, not regulation.

7. If would be great if there were a clearinghouse for this. That's part of the education process that is so important. It would also give practitioners something to consider, knowing that information will be made public and that the public is being informed.

8. I think this should be between the two referring parties. A standard referral form would be a challenge to create because of the wide range of specialties.

9. Education is key... information empowers the public. The best policy is to create easily accessible information that is free to anyone who wishes to learn more.

Discussion Group IV
Tab 11: American QiGong Association

I'm Linda C Hole, MD, with nearly 20 years experience in wholistic medicine, Past President of CA State Homeopathic Medical Society, & about to be published as contributing author to AM AC Neurology text on Alt Medicine.

Some brief thoughts specifically re qigong

1. Are there national educational standards for Qi Gong undergraduate, postgraduate, and continuing education?

YES

Should those national educational standards include exposure to conventional or western medicine as well as CAM other than Qi Gong?

YES QUALIFIED - MEDICAL QIGONG PRACTITIONERS SHOULD HAVE SOME TRAINING IN HEALTH & DISEASE & SOME ENOUGH KNOWLEDGE EXPERIENCE TO KNOW WHEN TO REFER FOR MEDICAL WORKUP, HELP, ETC

2. Should there be national standards or certification to provide CAM practices and products?

YES FOR MEDICAL PRACTITIONERS, & FOR TEACHERS

If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?

NEED A MEDICAL QIGONG ASSOCIATION, EG LIKE AM AC MED ACUPUNCTURE - WHICH I'D BE DELIGHTED/HONORED TO SPEARHEAD,TO WORK ON THIS

3. Should the numerous Qi Gong and other energy healer organizations come together to form "a community?"

INFORMALLY YES, GREAT . FORMALLY FOR ACCREDITATION, ETC NOT NECESSARY & WOULD MAKE MATTERS MORE COMPLICATED QIGONG IN & OF ITSELF DESERVES IT'S OWN ACCREDITATION PROCESS

If so, how and by whom should that "community" be formed?

SEE ABOVE

LET'S FOCUS ON CREATING QIGONG COMMUNITY, QIGONG ACCREDITATION -

OBVIOUSLY WITH American Qigong Association and the World Qigong Federation AS LEADERS

4. Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

NO - SHOULD BE AT UPXX OF PRACTITIONER AS AN MD OF OVER 20 YEARS EXPERIENCE IN MEDICINE, & 5 YEARS IN QIGONG - I FIND THAT THE "MIRACLES" POSSIBLE WITH QIGONG ARE LIMITLESS TRYING TO LIMIT QIGONG WOULD BE LIKE TRYING TO LIMIT PRAYER - TO SPECIFIC CONDITIONS, ETC.

GUIDELINES SHOULD BE FOCUSSED ON WHEN TO REFER FOR MEDICAL BACKUP

5. Are your members concerned about malpractice liability associated with providing CAM practices and products?

NO. QI WORKS FAR BETTER THAN TRADITIONAL MODALITIES AGAIN - BEGINNING PRACTITIONERS MUST BE TAUGHT WHEN TO REFER, ETC

6. Are there any risks associated with CAM that may be of concern to your members?

YES - PRACTITIONERS WITH NO BACKGROUND IN MEDICINE & CHIP ON SHOULDER RE WESTERN MEDICINE MISSING LIFE THREATENING DIAGNOSIS - OF WHICH I MYSELF HAVE SEEN SEVERAL CASES - EG RUPTURE ECTOPIC PREGNANCY SENT HOME BY LOCAL ND AS "HEALING CRISIS" ETC.

If so, can you suggest ways to minimize those risks?

GUIDELINES RE WHEN TO REFER ENCOURAGE PATIENTS TO SEE CAM PEOPLE AS COMPLEMENTS TO THEIR FAMILY MD- FOR DIAGNOSIS, & FOR MEDICAL BACKUP WHEN NECESSARY

7. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?

YES, AS IN ANY FIELD OF MEDICINE, THERE ARE A WHOLE RANGE OF PRACTITIONERS, & NOT ALL ARE COMPETENT OR ETHICAL WHAT ABOUT A BETTER BUSINESS BUREAU LIKE DATABANK, GRIEVANCE ORGANIZATION?

8. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?

DEPENDS ON HOW CLOSELY THE CONVENTIONAL & CAM PRACTITIONER WANT

TO WORK TOGETHER.

AS BOTH AN MD, AND A CAM, - I COMMUNICATE WITH MY COLLEAGUES JUST AS WOULD IN ANY ORDINARY REFERRAL TO A SPECIALIST FOR THE MOST PART VERY SUCCINCT & TO THE POINT - EG "45 Y.O. WHITE MALE WITH SCIATIC PAIN - PLEASE EVAL"

THE MAIN GOAL IS FOR PATIENT TO GET BETTER - LET'S KEEP PAPERWORK TO A MINIMUM, & LEAVE TO DIGRESSION OF PRACTITIONERS.

9. What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

WOULD BE GREAT TO HAVE A BETTER BUSINESS BUREAU CONSUMER GUIDE TYPE ORGANIZATION, TO HELP GUIDE CONSUMERS.

American Qigong Association

530 Bush Street, Suite 202, San Francisco, California 94108
Telephone (415) 788-2227; Fax (415) 788-2242

February 11, 2001

Steve Groft, Executive Director
White House Commission on Complementary
And Alternative Medicine Policy
6701 Rockledge Drive
Suite 1010, MS 7707
Bethesda, Maryland 20817-7707

Dear Dr. Groth,

American Qigong Association and the World Qigong Federation is happy to make input to the White Commission on Complementary and Alternative Medicine Policy. The answers to the questions of the White House Commission on Complementary and Alternative Medicine Policies cannot be simply answered because it is a complex factor. Therefore, I submit brief answers to each question and include the policy recommendations that has evolved since 1990 to now through three World Congresses, one Qigong Summit and myriads of meetings with various qigong organizations, the organizations of present modern medical health care system, business, politicians, qigong masters, students, input from other countries, etc.

This involves more than twenty five hundred individuals and organizations that has their own constituents. The major conference events has received support from the President of the United States, the Assistant Surgeon General, Director of Bureau of Primary Health Care, the President of the National and World Home Care Association, the U.S. Public Health Services, Region 10, Senator Tom Harkins, Mayors of Washington D.C. and San Francisco proclaimed Qigong Week and Qigong Day.

These policy recommendations were developed with the intent of submitting them to administration of policy-making organizations or departments of major organizations and to foster the proper development of qigong in the United States and Wester World in exactly the areas of concern that has been put forth by the White Commission on Complementary and Alternative Medicine Policy. Research, education of professionals and practitioners, accessibility of services and eligibility of financial reimbursements. It certainly seems that we have worked and anticipated this day where our recommendations can be seen and used with the greatest impact. It seems that we have anticipated the development of the White House Commission on Complementary and Alternative Medicine Policy's direction as mandated by the President and Congress. Therefore I submit this total package in answer to the questions that you have posed to us. Please read the specific answers to your questions with reference to the entire enclosure. The enclosure consists of:

1. the questions and answers with
2. the policy recommendations and rationale
3. American Qigong Association
4. the East West Academy of Healing Arts bylaws and articles of incorporation
5. Kay Lahdenpera's resume
6. the programs of the First International World Conference and the Second World Congress and the 3rd World Congress, the Qigong Summit and the 4th World Congress

The parent organization of the American Qigong Association and the World Qigong Federation is the East West Academy of Healing Arts (EWAHA) founded in 1973 to integrate eastern and western medicine and complementary and alternative medicines. EWAHA, besides having its own programs, has been a consultant to many other organizations and has established organizations within its own structure assisting it to become independent, such as the well reputed Qigong Institute with its focus on promoting research was established within EWAHA in 1988 and became independent in the mid 90's. Our 110 international faculty reflects the "who's who" in qigong masters in the world and America. We combine this prestigious platform with aspiring qigong practitioners for motivation and inspiration to them

EWAHA has worked in cooperation with the NCCAOM, National Certification Commission for Acupuncture and Oriental Medicine, the American Association for Oriental Medicine (AAOM), the (NQA) National Qigong Association, and many other organizations to promote and foster and support their interests in qigong.

CAM, (Complementary and Alternative Medicine) is valuable in its entirety and its broad scope and each individual practice or systems within CAM is important as well. We would like to put forth that qigong has a special place in that it is one of the most powerful self help tools to help people gain independence and self discipline or control over their own health and it is an ultimate health promotion wellness fostering vehicle or system and takes into consideration the total body, mind and spirit, giving the power back to the people to take control of their own lives and health.

Qigong has had minimal presentation to the commission it is one of the lesser known systems of CAM to both the scientist, the health professions, the general public, the businesses and the politicians. Therefore I urge you to take a look at this system of qigong with a special eye and heart. Qigong has successfully helped people where western medicine and even other complementary alternative medicine practices have not been successful.

I would like to request a time to present at your Commission meetings, preferably the February 22-23 meeting.

Thank you for your kind attention.

With warmest regard and respect,

Kay

Kay Lahdenpera, R.N., M.P.H.
Executive Director

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White House Commission on Complementary and Alternative Medicine Policy – Questions & Answers

1a. Are there national educational standards for Qigong undergraduate, postgraduate and continuing education?

No, there are none existing. However, many traditional colleges and universities, as well as, Traditional Chinese Medicine (TCM) Colleges grant CEU's for Qigong for nurses and acupuncturists The TCM Colleges CEU's are reviewed by the Board of Acupuncturist (this is true in CA). Also state nursing associations offer continuing education under the American Nurses Association guidelines for CEU's. State governing boards are not involved in Qigong continuing education at the present time. Since Qigong is preventive oriented it should begin long before college level. It has been shown that Qigong has helped elementary and high school students to improve in focus, self-confidence and concentration, resulting in higher grades. Curriculum in all schools, colleges and universities should include Qigong as a required course to enhance student's potential (K -12gd and upwards).

1b. Should those national educational standards include exposure to conventional or western medicine as well as CAM other than Qigong?

Yes, both western medicine (which has natl. educational standards) & CAM (which includes Qigong) should also have natl. educational standards.

2a. Should there be national standards or certification to provide CAM (Qigong) practices and products?

Yes, eventually, at this time because Qigong is a baby to the west, more education is needed about what is Qigong and it's many styles. Then common parameters and it's uniquenesses can be considered in the exploration for standards and certification.

2b. If so, how and by whom should natl. standards or certification be established, to whom should they apply, and how should they be implemented?

Each identified component of CAM (Qigong included) should have national standards; licensure, when appropriate; and certification. Those practitioners/professors dealing with a specific component of CAM (Qigong) in their curriculum be it in universities, colleges (both western and TCM) i.e. School of Medicines, School of Nursing, School of Pharmacy, School of Physical Therapy, Occupational, etc. should form natl. committees of their peers to formulate these natl. standards which will evolve into licensure/certification by each states occupational boards. These standards need to apply to the appropriate practitioner who uses the specific component. Implemented by governing state boards. Because Qigong is 5000 years old and has several thousand styles it is unreasonable to believe that all forms of Qigong should be requiring licensure. It would be important to distinguish between hard and soft Qigong. Soft Qigong is known as Medical Qigong. Those practitioners offering Qigong as medical therapy should be licensed/certified. These are practitioners with high skill levels and working

will people who are ill. Many teachers work with Qigong with people who are well and that is a different category. There is a definite role of the World Qigong Federation (WQF) and the American Qigong Association (AQA) in cooperation with other organizations to oversee the setting of standards for Qigong practitioners for all of the many different styles and schools of Qigong. Both the WQF and the AQA should act with other Qigong associations (which they are already doing) to form governing and regulatory bodies to increase public knowledge and trust by setting guidelines for Qigong practitioners, ensuring standards and requirements are met. A code of ethics, criteria for credentialing and standards of practice and peer review could be addressed by WQF and AQA. The WHCCAMP is timely in assisting and promoting the need for Qigong and CAM to move forward to answer and work toward the solution of these essential questions that WHCCAMP are posing to the health care community, professionals and the general public. It does take time to note the progress of the acupuncturist was 27 years (1973); California Board of Acupuncturists licensed their members 1977 and other states at different times. However, still not all states offer licenses to acupuncturists and there is not a compulsory national licensing.

3a. Should the numerous Qigong and other energy healer organizations come together to form a "Community"?

Yes. AQA has been a leader in the United States and the western world in bringing the Qigong community. There already is a "community." The unique, individual natures of these groups maintains a healthy diversity and promotes growth. Many believe in a Taoist approach to harmonious integration... in other words, allow things in this area to proceed in a natural way. The key is to promote communication between organizations... that is best. There are innumerable organizations and this is the reason AQA is trying to bring them together through offering Congresses/Conferences along with cooperative cosponsorship and meetings between times with national organizations, such as the American Association of Oriental Medicine (AAOM), Accreditation Commission for Acupuncture & Oriental Medicine (ACAOM), Council of Colleges of Acupuncture & Oriental Medicine (CCAOM), National Acupuncture & Oriental Medicine Alliance (NAOMA), the National Certification Commission of Acupuncture & Oriental Medicine (NCCAOM), Qigong Institute, National Qigong Association and others.

3b. If so, how and by whom should that "community" be formed?

This would be a task of the WQF & AQA to initiate this. They have already begun to do so with policy recommendation set forth from their World Congresses and AQA Conferences. The Policy Recommendations are attached as part of this document.

4a. Should there be condition-specific or modality-specific practice guidelines and why or why not?

Yes, both should exist. Condition-specific practice guidelines would be more user-friendly as it would list the condition and/or disease, i.e., lower back pain and then you would have all the different types of treatment listed in one place. The Western and CAM (Qigong) approaches in one place. Truly an easier way to find solutions for the

provider of care. The modality-specific practice guidelines is more how a system is practiced and would require more research by the provider to find the various methods/treatments of care and probably CAM (Qigong) would not be integrated as frequently; and the client would not be offered choices. Many people do not know many of the CAM practices and would therefore not know to look it up.

4b. If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

The guidelines should be developed by the practitioners, university curricula, professionals involved with the various aspects of CAM (Qigong). These guidelines need to address criteria for education, accessibility, practice and research on Qigong.

5. Are your members concerned about malpractice liability associated with providing CAM (Qigong) practices and products?

Yes. There are 2 areas of consideration. Those practicing Qigong for their own pleasure and health there's no concern about malpractice. But those who are practicing medical Qigong for therapy for other people, then there needs to be consideration about potential liability. WQF and AQA have discussed the need to explore legal consultations on design of informed consent so practitioners can limit liabilities.

6. Are there any risks associated with CAM (Qigong) that may be of concern to your members?

The main concern with Qigong would be the use of Qi negatively by someone with ill intent. In Qigong, the vital life force helps the body maintain harmony, stay free of disease and helps to maintain a healthy body, mind and spirit. Therefore, Qigong should be integrated into health promoting centers and into the therapeutic practices and clinical work of healthcare practitioners to provide better holistic care for people of all ages and nationality, regardless of sex or creed. If so, can you suggest ways to minimize those risks?
By having the WQF and AQA and other organizations and individuals promote the positive and the healing aspects of Qigong, address the ethical implications of practicing Qigong and the importance to developing a code of ethics, criteria for certification, standards of practice and instituting peer review.

7. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM (Qigong) practices and products?

Yes. Often licensing/certification boards have seats for consumers on the board. This belief is carried through with AQA and WQF. This is good because they are involved with discussion of health care issues with professionals. Consumers often present practical and logical information that is helpful to the professionals. Also health care professional associations receive calls from the consumer and could have an

ombudsman answer these questions.

8. What information should a conventional health care provider communicate to a CAM (Qigong) practitioner and visa versa?

Both should be aware of each other's role/expertise through inservice, informational hand out sheets (for the professionals as well as the public), orientation manuals that cover both subjects.
Qigong is preventative and the healthcare practitioners should emphasize the use of Qigong to promote better health, wellness and empowerment. Qigong is an effective form of health promoting therapy for physical diseases, such as cancer, chronic pain syndrome, RSI, tumors, asthma, paralysis and other disabilities. It is an effective therapy for mental conditions, such as depression, anxiety, trauma, excessive stress, etc. It is an effective form of therapy for addictive behaviors such as substance abuse, alcoholism, smoking, and weight gain. Qigong can be used in many different settings such as, hospitals, clinics, nursing homes, rehabilitation centers, public parks, community centers, schools, businesses, jails, etc. Mainstream healthcare organizations should promote the use of Qigong for its preventive factor, providing for early diagnosis and detection of illness. This strategy leads to lower healthcare costs and is in accordance with the concept of managed care. The public needs more information also often they know more quickly about Qigong and CAM services and self refer.

9. What policy recommendations would you like to make to assure the quality of CAM (Qigong) practices and products whether they are provided by a practitioner or used as self-care?

Products, i.e. vitamins, herbs, over the counter medications, nutritional supplements, etc. need to be appropriately labeled with a seal of recognition, especially over the counter products for practitioner and the public's safety.

Please see the attached set of Policy Recommendations.

Policy Recommendations from

The Second and Third World Congresses on Qigong, The Qigong Summit, & The First to Fourth American Qigong Association (AQA) Conferences

INTRODUCTION

"Qigong Week" was proclaimed by San Francisco Mayor Willie Brown when the Second World Congress on Qigong and The First American Qigong Association Conference convened in San Francisco, California November 20 – 26, 1997. This was the largest international and national conference on Qigong ever held in North America. Letters came from the President of the United States and the Assistant Surgeon-General-the Director of the Bureau of Primary Health Care. Senator Tom Harkins and other dignitaries interest in Qigong has escalated in large part due to the many reports from China of diseases healed by Qigong and the increase in research on Qigong undertaken by the Chinese academic and medical community in China. Additionally, the growth in use and research into various complementary and alternative medicine practices in the United States has necessitated the need for a formal conference on Qigong, where experts and scientists from around the world could meet to discuss future directions.

The Second World Congress on Qigong (WCQ) and The First American Qigong Association (AQA) Conference were planned with three expressed purposes in mind: 1) to broaden the influence of Qigong as a viable practice for enhancing health in everyday life and as an effective system for use in mainstream healthcare; 2), to bring together people to determine policies, to pursue research on Qigong and to act as a springboard for raising funds for much-needed scientific research; 3), to inaugurate an international and national organizations to promote the benefits of Qigong, and its Masters of Excellence, worldwide and in the United States.

The Third World Congress on Qigong (WCQ) and the Second American Qigong Association (AQA) Conference was convened in San Francisco, California, November 19-23, 1999 to continue to expand on the three purposes from the 1997 WQC and the AQA, additionally incorporating two other purposes. 1) to involve government as co-sponsors; and 2) to declare a World Qigong Week and a World Qigong Day.

The Second and Third World Congresses on Qigong, and the Qigong Summit 2000; and the First , Second and Third American Qigong Association Conferences were sponsored by the East West Academy of Healing Arts (EWAHA), a non-profit organization with the goal of integrating Complementary and Alternative Medical (CAM) practices, especially Traditional Chinese Medicine, into the mainstream of western medical care. EWAHA, also organized the first conference on Qigong to take place in America, The First International Congress on Qigong in 1990, that was held concurrently with The Fifth International Congress of Chinese Medicine, which focused on acupuncture. EWAHA was invited by The People's Republic of China's organizing committees to organize a second conference on Qigong in America in both 1993 and 1995, but the decision to sponsor the conference was delayed until 1997 when increased public demand in the form of overwhelming telephone calls and letters seeking information on Qigong suggested it was the appropriate time to commit resources for such a conference.

The Qigong Summit 2000 and the Third American Qigong Association Conference was convened in Washington, DC, April 21-24, 2000 at the historic Omni Shoreham Hotel to continue with refining the purposes and recommendations from the previous two Congresses and Conferences.

WHAT IS QIGONG?

Qigong has been the foundation practice of Traditional Chinese Medicine for over 5,000 years, predating acupuncture. It is an ancient, self-help subtle energy healing art and science involving the practice of energy exercises and postures done in specific sequences along with diaphragmatic breathing, which promotes an increase of "Qi" or life force in the body. Qigong brings the body into a state of maximum repose and self-regulation, thereby improving health and inducing a healing of disease conditions. Though in existence for centuries, the practice of Qigong was jealously guarded and reserved only for the elite spheres of classical Chinese society and later banned altogether during the Cultural Revolution. Popular interest in Qigong exploded after the Cultural Revolution to the point where now tens of millions of Chinese practice Qigong on a daily basis. It is practiced primarily for health promotion with a special focus on slowing down the aging factor. The government heavily sponsored more than fifteen years of intensive research into Qigong to prove its scientific merit. Now, Qigong has been incorporated into the health system in China, where people especially those with severe disabilities, including cancer, are advised to practice Qigong exercises by their doctors, in addition to their routine medical care. News spread throughout the world and drew attention to this ancient practice as severely disabled and cancer patients in China were improving, many to remission, by daily practising Qigong. As the west is now looking towards complementary and alternative healing methods to improve the quality of life and health care, ancient Qigong has moved to the forefront as one of the most promising of these "new" alternative self-help practices.

THE SECOND & THIRD WORLD CONGRESSES & SUMMIT 2000 ON QIGONG

Attendance at the Second World Congress was over six hundred and fifty, people from sixteen countries around the world met to teach and share and discuss the topic of Qigong. The conference was designed to cover both hard Qigong and soft Qigong styles, with an emphasis on medical Qigong since this is the style that is used for maintaining health and healing disease. In an inclusive approach, Qigong styles that are deemed to be safe and yield positive, healing results were demonstrated. The conference featured sixty-five speakers who ranged from Qigong masters and teachers to medical doctors, acupuncturists, and scientific researchers. Over seventy-five workshops were held covering topics varying from the teaching of Qigong to exercises offered by representatives from the many, different existing schools of Qigong, lectures on integrating Qigong into a variety of health professions, and the presentation of scientific papers on Qigong. The main result of the conference was highlighting the importance of developing strategies for incorporating Qigong into mainstream healthcare. The research from China on Qigong has proven that Qigong works beyond that which may be attributed to a placebo effect and the subjective results have been considerable. This scientific research, however, needs the validation of its Western counterparts, a step that is necessary in bringing credibility to Qigong in the west.

Attendance at the Third World Congress was over seven hundred; people from sixteen countries around the world met to teach and share and discuss the topic of Qigong. The conference was designed to cover both hard and soft Qigong styles, again with an emphasis on medical Qigong. The conference featured sixty-two speakers from various parts of China and the USA, as well as fourteen countries around the world. Over sixty-six workshops were held covering a variety of topics, which were similar to the Second World Congress. Some main results of the conference were the continuing of the positive purposes developed in 1997 with an emphasis on scientific research and client involvement to demonstrate the power of Qigong.

The Qigong Summit 2000 was presented on the east coast to further expand the concepts and information on Qigong across the USA. The focus of the Summit was to further invite government participation and increase the focus on Qigong research. The Summit was held on Easter weekend with over four hundred and fifty attendees from various parts of China and the USA, Romania, Germany, The Netherlands and Canada. There were thirty-eight speakers offering fifty-three workshops.

One of the primary speakers on cancer from China was involved with research projects with the University of California at San Francisco, the Complementary Medicine Research Institute at the California Pacific Medical Center and UMDNJ—New Jersey Medical School during the Congress, as well as, participating in research studies following the Congress. One of the research studies was presented at the Qigong Summit 2000 and Third American Qigong Association Conference.

The client involvement in a panel at the plenary opening has culminated in another panel plus a workshop of clients discussing "Qigong Saved Us! Our Experiences Might Help You" which portrays Qigong in mainstream healthcare. This was presented at Qigong Summit 2000 and the Third American Qigong Association Conference.

THE OUTCOME OF THE CONGRESSES & SUMMIT 2000

During the closing plenary session of the conference, participants voted to inaugurate a new organization, The World Qigong Federation (WQF) to act as a networking body for information exchange on Qigong, to set policies, and to promote the introduction of the benefits of Qigong into mainstream healthcare. The organization's structure contains supporting groups at the national level, two of which were also inaugurated at the conference, the American Qigong Association (AQA) and the German Qigong Association (GQA). To oversee and encourage sound, modern scientific research, a prestigious Scientific Committee was also established. In addition, a Policy and Recommendations Committee was developed to continue to influence administrative bodies and communities in the public and private sectors to integrate Qigong into mainstream life and healthcare. The work of this committee and the conference culminated in the formulation of a list of policy recommendations (included below) to educate politicians and leaders in the business, education, and health care fields about Qigong and how to introduce it into mainstream healthcare and society.
Since 1997 membership in both WQF and AQA has grown considerably. More research is occurring involving Qigong in universities within the USA. Romania has formed a Qigong Association (RQA) and many other countries are following suit. The Scientific Committee has

met over the past three years and its members encourage more research on Qigong. After the Summit, one of the primary speakers on cancer from China participated in research at the University of Arizona – Tucson - and continued his work with UMDNJ—New Jersey Medical School. The Policy and Recommendations Committee members discuss and meet periodically and share their information at Congresses and AQA Conferences. There was a workshop as well as a panel at the closing plenary session at the Summit to review and share policy and recommendations with participants and membership at the Summit.

RECOMMENDATIONS

The following is the series of policy guidelines developed and voted on by the participants of the Second World Congress on Qigong and the First American Qigong Association Conference. November 21 – 23, 1997, in San Francisco, California, USA.

The additions are those recommendations brought forth from the Third World Congress on Qigong and the Second American Qigong Association Conference, November 19-21, 1999, in San Francisco, California, USA; and the Qigong Summit 2000 and the Third American Qigong Association Conference, April 21-24, 2000 in Washington, DC. These additions include adaptation and updating the policy recommendations from the Second WCQ and the First AQA, as well as new recommendations.

QIGONG INTO THE FUTURE: Policies and Recommendations

I. Policy Recommendations:

At the Government Level:

1. Making Qigong accessible to all sectors of society in America is crucial in helping to create a healthier society. Qigong programs should be supported by the federal, state and local levels of government in the United States in addition to being supported by the World Health Organization (WHO) and National Health Administrations.
2. Government Agencies should fully accept complementary and alternative medicine (CAM) to be an integral part of the national health care system. Funding should be available to support Qigong research, training, and clinical services. To achieve this end, a formal public educational effort should be made by the Qigong community to educate and advocate the clinical efficiency and economic benefits of Qigong.

Additions:

1. Document the actual amount of involvement of the federal, state and local governments, WHO and National Health Administrations involvement with Qigong.
2. Develop surveys to determine where the funding for Qigong research, training, and clinical services is coming from to assure that Qigong is in the medical, nursing, and other accredited health care professionals curricula.
3. Review and implement CAM objectives in *Healthy People 2010* and testify for Qigong to be a part of the *Healthy People 2020 Objectives.*
4. Develop a PR and public education package and develop a speaker's bureau across the country to better educate the public and policy makers.

Health Insurance/HMOs

1. Complementary and Alternative Medicine (CAM) practices, such as Qigong, should be included as a part of coverage and benefit packages in all health insurance plans.
2. Qigong insurance benefits should be available to all members covered by insurance, regardless of age, ethnicity, economic status, or sexual orientation.

Additions:

1. Develop surveys to determine the number of insurance companies that cover Qigong.
2. Offer presentations to HMOs and insurance companies at their local, state, and national meetings.

Hospitals/Medical Schools:

1. Encourage and support the establishment of complementary and alternative medicine departments at major hospitals and medical schools.
2. Qigong should be integrated into clinical treatment practices and wellness programs at clinics and hospitals.

Additions:

1. Develop surveys to determine which hospitals, clinics, medical schools, nursing schools, and other accredited health care providers are currently integrating Qigong into their programs.
2. Add complementary and alternative departments at nursing schools and other sites for accredited health care providers.

The Workplace

1. Businesses should include Qigong training and classes as a part of onsite wellness programs.
2. The practice of Qigong leads to the development of greater energy and endurance within individuals. Thus, the promotion of Qigong at the workplace can help to increase worker productivity and enhance peak performance.
3. Health benefit insurance packages for workplace employees should include insurance coverage for Qigong. (Repeated emphasis)

Additions:

1. Market and develop a promotional package on Qigong for the workplace with a percentage of the proceeds to benefit Qigong medical research. Qigong instructors would introduce the package and train the trainers of corporations to continue the process of spreading Qigong to their employees.

Educational System

1. It has been shown that Qigong has helped students improve in focus, self-confidence, and concentration, resulting in higher grades.
2. Curriculum in all schools, colleges, and universities should include Qigong as a required course to enhance students' potential.

Additions:

1. Market and develop a promotional package on Qigong K-grade 12 (age appropriate) to be introduced in schools as a PE offering. Cost effective and efficient use of time to increase productivity.

World Qigong Federation (WQF)/American Qigong Association (AQA):

1. WQF/AQA should establish effective public relations to educate the public and governmental and funding agencies about the benefits of Qigong.
2. WQF/AQA should create a network of practitioners for advice and support.
3. WQF/AQA to hold conferences and conventions, such as this one, on a regular basis to promote Qigong.
4. WQF/AQA should oversee the setting of standards for Qigong practitioners for all of the many, different styles and schools of Qigong.
5. WQF/AQA should act with other Qigong associations to form governing and regulatory bodies to increase public trust by setting guidelines for Qigong practitioners, ensuring standards and requirements are met.
6. WQF/AQA should explore legal consultations on design of informed consent so practitioners can limit liabilities.
7. WQF/AQA to develop a code of ethics, criteria for credentialing and standards of practice and peer review. Qigong Associations should promote the healing aspects of Qigong and also must address the ethical implications of practicing Qigong, including the potential for negative use of Qi.
8. WQF/AQA should promote sound, scientific research on Qigong research to establish the scientific credibility of Qigong, thereby leading to its greater acceptance. Publications of research data in professional journals and books will increase public awareness of the clinical benefits of Qigong.
9. WQF/AQA should develop a consensus on policy as to how to handle reimbursement issues from managed care organizations.
10. WQF/AQA should encourage all potentially interested parties to join the World Qigong Federation and national associations. Varying the amount of dues to join the World Qigong Federation will help to increase membership and therefore further the promotion of Qigong.
11. The health benefits of Qigong should be made available to all peoples, regardless of age, ethnicity, economic status or cultural group. WQF/AQA should provide leadership in ensuring a conscious effort to do outreach to under-served, minority communities.
12. WQF/AQA should develop cooperative support with internationally recognized bodies, such as the WHO.
13. WQF/AQA should facilitate the development of National Associations, such as the German Qigong Association, under the umbrella of the WQF for a unified supportive platform.

Additions:

1. Review and make assignments at the next WQF/AQA meeting at the Fourth World Congress on Qigong and the 4th American Qigong Association Conference to establish what has been done and what needs to be done to activate these well-defined recommendations.

II. Clinical Service Recommendations:

1. In Qigong, the vital life force helps the body maintain harmony, stay free of disease and helps to maintain a healthy body, mind and spirit. Therefore, Qigong should be integrated into health promoting centers and into the therapeutic practices and clinical work of healthcare practitioners to provide better holistic care for people of all ages and nationality, regardless of sex or creed.
2. Instead of focusing on disease and pathology, healthcare practitioners should emphasize the use of Qigong to promote better health, wellness and empowerment.
3. Qigong is an effective form of health promoting therapy for physical diseases, such as cancer, chronic pain syndrome, RSI, tumors, asthma, paralysis and other disabilities.
4. Qigong is an effective form of therapy for mental conditions, such as depression, anxiety, trauma, excessive stress, etc.
5. Qigong is an effective form of therapy for different forms of addictive behaviors such as substance abuse, alcoholism and gambling.
6. Qigong is a powerful tool in the assessment of conditions caused by Qi imbalance, such as fatigue, pain, weight-gain, stress, etc.
7. Qigong can be used in many, different settings, such as hospitals, clinics, nursing homes, rehabilitation centers, public parks and community centers.
8. Mainstream healthcare organizations should promote the use of Qigong for its preventative factor, providing for early diagnosis and detection of illness. This strategy leads to lower healthcare costs and is in accordance with the concept of managed care.

III. Training Recommendations:

Who Should be Trained?

1. Qigong training should be made available to all interested parties, regardless of age, sex, culture, social or economic status because it is essentially a self-help, health promoting practice.
2. Qigong training should be made available to all healthcare practitioners, especially Western-trained medical professionals, such as physicians, nurses, etc.
3. Qigong training should be made available to other non-healthcare providers, such as teachers, social workers, politicians, clergy, leaders in the business world, etc.

Where Should the Training be Provided?

1. Since Qigong approaches can be used to promote health in everyday life, Qigong should be made available in many different settings, such as hospitals, schools, universities, wellness centers, community centers, places of business, in the home, etc.

How to Provide Qigong Training?

1. The dissemination of the knowledge and practice of Qigong should be taught in an innovative and creative manner, utilizing the following recommendations:

    a. Promotion of Qigong through conferences, seminars and workshops.

b. Media exposure of Qigong through TV, as in public service announcements, and special coverage on well-watched TV programs such as *20/20* or *60 minutes.*
c. Publication of articles on Qigong in popular newspapers and journals, such as *TIME* and *Newsweek and Fortune.*
d. Publications in scientific journals of research proving the effectiveness of Qigong.
e. Promotion of demonstration and teaching events by credible, Qigong masters.
f. Use of movies, radio and video for the dissemination of information on Qigong.
g. Integration of Qigong into medical and nursing school curricula and the curricula of other healthcare professions.
h. Development of an inter-disciplinary forum for information exchange, consultation and support.
i. Inclusion of Qigong classes in schools, colleges and universities.
j. Establishment of regional chapters or "Qigong clubs."

2. In addition to Qigong training for use as an assessment and therapy tool, focus should also be on wellness, prevention and health promotion. The practice of Qigong should be integrated into the hygiene of daily life.
3. Training should be affordable, accessible and culturally sensitive.

IV. Research Recommendations:

1. Increase research data or findings on the benefits of Qigong. Carry out an extensive search on research that has been done in other countries, especially in The Peoples' Republic of China.
2. Publish research studies and case reports in peer reviewed, professional journals.
3. Conduct research using good scientific methods to establish the credibility of Qigong within the mainstream. Seek well-known scientists to conduct the research.
4. Set up within WQF/AQA a Center for the Exchange of Research Results, including research on a variety of Qigong masters.
5. Do not generalize the results from one Qigong master to the next.
6. Research on both long and short-term results.
7. Do research in conjunction with conventional, medical authorities.
8. Obtain adequate research funding to carry out research properly.
9. Assess adequacy of research protocols for Qigong research.

FOLLOW-UP OF RECOMMENDATIONS: Follow-up on any further recommendations and or refinement of current recommendations presented at the Fourth World Congress on Qigong and the Fourth American Qigong Association Conference will include further research through the work of the various Advisory Committees of the American Qigong Association (AQA). Once these recommendations are finalized they will be presented to the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP), established by the President in March of 2000. This material will be added to previous data requested by WHCCAMP from the American Qigong Association (AQA) to further document the importance and necessity of medical qigong to be included in the future CAM policies for healthcare for the nation.

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Rationale for the Qigong Summit 2000 and the 3rd American Qigong Association Conference; and now the forthcoming event of the Fourth World Congress on Qigong and the 4th American Qigong Association Conference

I: BACKGROUND:

As part of its mission, the US Public Health Service, Department of Health and Human Services with its working document *Healthy People 2010* is committed to providing top quality service to all citizens. In recent years the cost of health care has spiraled to disproportionate heights. Chronic degenerative conditions, the ten great killers in the nation and communicable diseases of the world are influenced primarily by lifestyle and environmental factors. In the past 15 years there has been a shift in the direction of health care from crisis intervention and "Curing" to health promotion and disease prevention where people are more continuously becoming aware of and requesting the services of complementary and alternative medicine.

The US Public Health Service, Department of Health and Human Services has a central role in providing national leadership and in articulating the importance of diversity in the provision of culturally appropriate primary health care services. Therefore, to support this premise it seemed appropriate for the Qigong Summit 2000 and the 3rd American Qigong Association Conference to be held. This Summit will address these issues and target a broad national audience.

In 1990 research was done and a report published in the New England Journal of Medicine, by Dr. Eisenberg et al. regarding complementary/alternative medicine (CAM). This report indicated that individuals spent around 17.4 billion dollars per year for complementary/alternative medicine. These monies were out of pocket and it was more than had been spent on the cost for surgery for that year. The New England Journal of Medicine Report noted that about 34% of the population utilized complementary/alternative medicine due to the following two factors: cost and non-help with traditional modern medicine. Help was found in the complementary/alternative methods. Also noted in the Report was the fact that modern western medicine had become so technical and technology-oriented, isolated and impersonal that clients sought other options. An option that clients sought was complementary/alternative medicine because it placed emphasis on the whole person and a total approach to holistic health, not just the problem. It integrates the body, mind, and spirit. In 1990, the Office of Alternative Medicine was mandated through congressional legislation and was established in the Director's Office of the National Institutes of Health (NIH). This development brought worldwide attention. Now in the late 1990's it has been stated that over 65% of the population had utilized complementary/alternative medicine. Dr. Eisenberg further reported that 65% of the US Medical Schools provide some form of complementary and alternative medicine program.

Qigong and traditional Chinese medicine are very strong components of the complementary/alternative medicine umbrella. In The Office of Alternative Medicine there was a division specifically designated as ethno-medicine or health practices of the ethnic minority. Our nation is comprised of ethnic minorities rich with great diversity.

In 1972 James Reston, a newspaper magnate, was in China and had an appendix operation utilizing acupuncture to reduce post-operative pain. Excitement and interest in Traditional Chinese Medicine began. This excitement continued into the 1970's and 1980's around the area of acupuncture; and China was opened up to a myriad of visitors. The visitors witnessed 100 million people throughout China daily practicing something new at 6 am each morning. This practice helped to keep people healthy and more resilient from disease. This practice is known as Qigong. Qigong had to go underground during the Cultural Revolution which ended in 1976. Since then the masses have shown great interest in it. It was known that Qigong had been practiced in secret prior to the ending of the Cultural Revolution and that the leaders had their own private Qigong masters. Thus we see many very old, healthy leaders in China.

Two famous personalities in China recovered by the use of Qigong when medicine or other means were ineffectual: one had lung cancer and one had paralysis. This started a massive interest in Qigong. The government, fearing it was a religious cult, spent great amounts of money to carry out "scientific research" into the credibility of Qigong and to establish whether there was a scientific basis for it. Over the past 15 years thousands of completed scientific research studies were reported at major national conferences in China. The government was happy to establish that there was some scientific basis to Qigong. Now in China throughout the hospitals and universities, there exists a Traditional Chinese Medicine and Qigong Department. Patients have a choice whether they pursue traditional Chinese medicine or Western medicine. And Qigong is very much an integral part of the health care.

Academies of Traditional Chinese Medicine and Institutes of Qigong were also established by the government to provide clinical services and to promote continuing research into Qigong. The opening of China to millions of visitors offered a great introduction of Qigong, and was a phenomenon, which caught the international visitor's fancy. Interest in the past 15 years has grown tremendously in the West. Thus East West Academy of Healing Arts (EWAHA), a leader in this area, has been encouraged to focus a great deal of time and attention on the development of programs and conferences, to investigate, to explore, and to educate people about the practice of Qigong. It is a practice ultimately promoting self-care, independence, and responsibility for one's own health. It takes into consideration the whole person and the total approach to body, mind and spirit as well as the environmental factors. These are the underlying factors in the philosophy for practicing Qigong. There are thousands of styles and forms of Qigong in various parts of China. This is due to the vast size of the country and the poor communication technologies at that time. Hence, varying Qigong styles developed in their own particular time, place and fashion.

In1973, EWAHA was established to foster understanding and the integration of Traditional Chinese Medicine and Qigong into the mainstream health care system. It had a great impact in helping to establish acupuncture, one of the dimensions of traditional Chinese medicine. Now it has put vigorous efforts behind establishing the significance of Qigong as an augmentative practice that everybody can learn and use to help them maintain a healthy life style.

EWAHA is a non-profit private agency 501©3 status. There was great interest in Qigong and since 1990, under the leadership of Doctor Effie Poy Yew Chow, EWAHA has been on the forefront honoring public requests as well as client requests. She began to provide services of Qigong to a diversified population of all ages, in all economic ranges, and of all belief systems. The felt need, as expressed by the population, was to concentrate on having major educational conferences to help the people better understand the methods and philosophy of Qigong. Three World Congresses have been organized and held in the past few years with multiple institutional co-sponsorships which included a special letter from President Clinton and the White House, government agencies, universities, national organizations, health care and social service agencies.

The President of EWAHA, Dr. Effie Poy Yew Chow, Ph.D., RN, National Diplomat in Acupuncture, Qigong Grandmaster, is uniquely qualified to proceed with the integration of Qigong into the mainstream healthcare system for many reasons. She has had over 35 years of experience in Chinese medicine and Qigong and has received numerous awards and recognition for her significant contributions in the field of Chinese medicine, acupuncture, Qigong and health care. She has been appointed to many national health care committees within the traditional health care system as well. Some of these committees include the following: US Department of Health and Human Services (DHHS) in the field of cultural diversity, alternative and ethno-medicine; National Advisory Council to The Secretary of DHHS on Health Professions' Education for Medicine, Osteopathy, Dentistry, Veterinary, Optometry, Pharmacy and Podiatry (MODVOPP); first Ad Hoc Advisory Panel of the Congress-mandated Office of Alternative Medicine (OAM) at the National Institute of Health (NIH) and Advisory Council to the Minority Task Force of the National Heart, Lung, Blood Institute for Hypertension and Diabetes for over 20 years with NIH; Scientific Advisory Board of the Richard and Hinda Rosenthal Center for Alternative/Complementary Medicine at Columbia University in New York; visiting lecturer on Qigong and Chinese medicine to the School of Medicine at the University of California San Francisco; and Scientific Advisory Board to OAM Grant of Bastyr University of Naturopathic Medicine in Seattle, Washington. Dr. Chow has been active in many national professional associations and has won some of the following awards: American Nurses Association (ANA) for her work with Minority Doctoral Fellowship Program; Award in Entrepreneurship given by the Human Rights and Minority Fellowship of ANA; Distinguished Award from the National Society of Acupuncturists of the Republic of China; and Distinguished Award from the Ministry of Health, Department of Occupational Health, Republic of China.

Organizations that promote and inform about Qigong are growing throughout the world. Dr. Effie Chow was instrumental in the development of many of these organizations. The World Qigong Federation was established in 1997, and it now has affiliated organizations in different countries such as The American Qigong Association, The German Qigong Association, and The Romania Qigong Association. There are many other associations in development stages. Members from these various associations attended the Qigong Summit 2000 and the 3rd American Qigong Association Conference in April 21-23, 2000 in Washington, D.C.

Members from these various associations will be attending the Fourth World Congress on Qigong and the 4th American Qigong Association Conference in San Francisco, California on May 4-7, 2001.

The aims and purposes of the Qigong Summit 2000 were to explore, educate, and facilitate understanding of Qigong's positive healing benefits and also of the science of Qigong, specifically Medical Qigong and how it can promote health and life so that we can enhance our system of health care to better serve our people. At this Summit we will involve decision-makers from the traditional medical/health fields, leaders in complementary/alternative medicine, legislative policy makers, and world experts in Qigong to evolve some initial plans and strategies for implementing integration. This will be the first step, and it will be a truly inspirational event as we direct our energy toward health and holism.

The following purposes are also important for the advancement of Qigong:

-To enhance our system of health care by further integrating Qigong into the mainstream of life and health care to better serve the people.
-To evolve some initial plans and strategies to better implement the short term and long term process of health care through the use of Qigong.
-To devise some means of on going consultation and cooperation among the World Qigong Federation, The American Qigong Association and EWAHA in acting as a resource for information and experts on the subject of Qigong.
-To work closely with government, the private sector and non-profit agencies in designing and implementing further plans for the teaching and practice of Qigong.
-To establish a resource pool of Qigong experts, policy makers, administrators, professional clinicians and educators.
-To establish a set of recommendations, plans and strategies for implementing and integrating Qigong into the nation's health care system.

The Summit 2000 program had the following five tracks: 1) Client Centered Experiences; 2) Scientific Research; 3) Demonstration/Experiential for All Ages and Conditions; 4) Integration of Qigong into Mainstream Life and Health Systems: Administration, Policies, Funding; 5) Qigong Programs Existing in the System.

In dealing with a diversified culture the exciting aspect about the exploration of Qigong, as a beneficial factor, is this. Traditionally the West has looked at the various cultures and tried to see how it could apply western medicine to different cultures even though their belief system is very different. And now we're taking a 180-degree turn and saying that this particular culture, in this instance Chinese, has something that is exciting, very beneficial, very effective and cost effective to offer the whole population, not just the Chinese. The Chinese are proud to know that they have something to offer to the general population that will improve the health of everyone and can provide more effective and humanitarian health care.

The Qigong Summit 2000 and 3rd American Qigong Association Conference was held in Washington D.C. April 21-23, 2000 at the Omni Shoreham Hotel. There were 35 presenters representing some of the top world-renowned Qigong Masters from China and other parts of Asia; Europe, including the Netherlands, Germany and Romania; Canada; and USA; scientists; and clients with adverse physical conditions who have experienced the values of Qigong. Also present were policy makers, administrators, professional clinicians and educators of both the traditional medicine community and leaders in complementary alternative medicine. The Qigong Summit will involve individuals with the expertise in primary health care. The exciting opportunity with Qigong is that it is a minority population that offers it and it can be used to enhance the involvement of the majority of the population. Keeping this in mind, the health care work force needs to be diversified and involved in developing sensitively appropriate health care policies that address increased health care service delivery to ethnic minorities, and other medically under-served and vulnerable populations.

The Summit established a set of recommendations, plans and strategies for the implementation and integration of the beneficial aspects of (Medical) Qigong into the nation's health care system. Included in this material is information on resources and experts; and audio and videotapes of certain selected panels and speakers. There will be continued contact with the US Public Health Services, Department of Health and Human Services to make them aware of this material. These recommendations from the Summit will be disseminated to relevant policy makers, health professions, educators, and scientific organizations upon their request.

Dr. Chow has committed herself to the effective outcome of numerous Qigong programs and conferences over the past twenty years. Because of her involvement in national and international policies as well as being a practitioner, an organizer and community-action person, she is well qualified and committed to the efficiency and success of such conferences.

II. The Fourth World Congress on Qigong and the 4th American Qigong Association Conference -- Plans:

It is expected that the Fourth World Congress on Qigong and the 4th American Qigong Association Conference in San Francisco, May 4-7, 2001 will have a larger attendance, over 70 international presenters, and a more expansive array of workshops than at the Qigong Summit 2000.

III. The Fourth World Congress on Qigong and the 4th American Qigong Association Conference -- Follow-up:

It is anticipated that further action will be taken on previous recommendations from other Congresses, Conferences and the Summit; and any new recommendations from the Fourth World Congress on Qigong and the 4th American Qigong Association Conference. The American Qigong Association (AQA), Special Advisory Committees, will review and refine the recommendations and forward the information to the White House Commission on Complementary and Alternative Medicine Policy (WHCCAMP) to accompany previously requested information on the AQA.

Tab 12

White House Commission on Complementary and Alternative Medicine Policy

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E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 31, 2001

Ms. Kathy M. Demetrius
Office Manager
American Society for the Alexander Technique
P.O. Box 60008
Florence, MA 01062

Dear Ms. Demetrius:

I am writing this letter on behalf of the White House Commission on Complementary and Alternative Medicine Policy, established by the President in March of 2000. In carrying out its mandate, the Commission is addressing: (1) coordinated research on complementary and alternative medicine (CAM) practices and products; (2) appropriate education and training of CAM and conventional health care practitioners; (3) dissemination of reliable information on CAM to health care providers and the general public; and (4) delivery and public access to CAM services. Additional information on the Commission is available at its Web site at <http://www.whccamp.hhs.gov>.

The Commission will meet on February 22-23 to discuss complementary and alternative medicine in terms of education and training of health care practitioners, quality of care, and accountability. To accomplish its goal, the Commission needs your organization's input before it begins its deliberations. Therefore, we would very much appreciate receiving your advice and comments on these issues by **February 13, 2001**, preferably by e-mail or otherwise by fax, so that the Commissioners have enough time to review them before the February 22-23 meeting.

The questions that follow were developed to guide the Commission's deliberations.

1. Are there national educational standards for Alexander technique undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than Alexander technique?
2. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
3. Should the numerous bodywork organizations come together to form "a community?" If so, how and by whom should that "community" be formed?
4. Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?

5. Are your members concerned about malpractice liability associated with providing CAM practices and products?
6. Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?
7. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?
8. What information should a conventional health care provider communicate to a CAM practitioner? What information should a CAM practitioner communicate to a conventional provider either with a referral or without a referral as when a consumer self-refers?
9. What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

Thank you for your invaluable assistance. Please send your written comments to Dr. Joseph M. Kaczmarczyk (e-mail: KaczmaJo@mail.nih.gov, fax: 301.480.1691, phone: 301.435.6197 or 7592), and contact him with any questions you may have.

The February meeting will be held in the Hubert H. Humphrey Building, 200 Independence Avenue, in Washington, DC. You are welcome to attend.

Sincerely,

Stephen C. Groft, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

The American Society for the Alexander Technique
PO Box 60008
Florence, MA 01062
800-473-0620
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February 10, 2001

Dear Dr. Kaczmarczyk:

This letter will elaborate on a number of points I made in my remarks to the Commission on Jan. 23 in NYC. It will also address the additional questions you sent to us on Jan. 31. I apologize in advance for the length of this letter, but you have asked for our responses to nine very complex questions.

I represent AmSAT, the American Society for Teachers of the Alexander Technique. In addition to speaking to the commission and providing the text of my remarks to commissioners at that time, I brought copies for each commissioner of: AmSAT's Organizational Handbook, Teacher Directory, and our letter to the NIH's CCAM in response to a call for comment on their Draft Strategic Plan. I draw your attention to this letter, in particular, because it lays out in careful detail some of our views on Complementary and Alternative Medicine and the placement of the Alexander Technique within this context. The Handbook also spells out our professional standards for: teacher training; approval of teacher training courses and their periodic review; teacher certification and membership; affiliation with similar societies worldwide; and our code of professional conduct and adjudication procedures. I want especially to emphasize that since 1987 AmSAT has been working to voluntarily and responsibly self-regulate our profession, and to promote the Alexander Technique in the public's awareness through accurate representation of our method without claims to cure, diagnose, or treat disease.

First, then, let me elaborate on some of my points at the hearing. Through AmSAT, Alexander teachers are working to promote and develop our profession as an independent and autonomous discipline. We are teachers, not health care practitioners--traditional, alternative, or complementary. However, because we teach students to restore and enhance optimal psychomotor coordination, some conditions that are caused by habits of malcoordination--such as joint and muscle pain, and overuse syndromes--frequently improve over the course of lessons. The overall objective of a course of lessons, however, is not the alleviation of symptoms but acquiring conscious skills that enable the student to prevent subconscious habits. We do not suggest that a student should forego appropriate medical care in favor of our method. We are also not complementary in the sense that, for example, physical therapy is complementary to western medicine. That is to say, doctors oversee and recommend a course of physical therapy within the patient's overall treatment plan. In our case, doctors are not trained in or educated about the Alexander Technique, and thus are not equipped to oversee how it is taught, to judge when it is appropriate, or to determine the level of skill of a teacher. If 'complementary' is meant simply to mean an adjunct to western medicine that supplements western care yet stands separate and independent in its own right, then we could be termed complementary.

If the latter is your intended definition of complementary, then the circumstance under which we could envision that the Alexander Technique might be suitable as a discipline within the

CAM framework would be if CAM included a sub-category for "Health Education," or "Health-Related areas," as distinct and separate from "Health Care." In this case, we would be pleased to contribute to the discussion of the development of the field of Health Education, and its many concomitant aspects.

However, as we explain in our letter to the NIH, we are especially concerned at what appears to be a sudden surge to embrace any practice that claims to provide health benefits but isn't western medicine and sweep it under the CAM umbrella. And, further, to attach all of CAM to western medicine in one big polyglot, complete with western approaches to licensing and regulation, all without first carefully defining CAM or delineating what practices are appropriate to it. Recently we have experienced strenuous efforts by the Massage Therapy profession to license all hands-on practitioners under the massage banner by introducing bills at the state level that broadly redefine massage. This is a blatant attempt to benefit massage schools by forcing a large number of practitioners to attend massage school and obtain massage licenses even though this training is entirely unnecessary for these disciplines. Due to this, we are frankly skeptical and cautious about similar notions of creating one big CAM amalgam, complete with a single regulatory system that attempts to be appropriate for all. Our letter to the NIH raises further concerns about this problem.

While we recognize the importance for, and actively support the effort to develop, suitable regulation of non-traditional health care and health-related practices, we feel that this goal demands a careful consideration of the differences among these many modalities. The Alexander Technique, for example, is an educational discipline with extremely low risk. Many teachers work in educational settings, such as colleges and performing arts schools at the graduate and post-graduate level. If you review our organization carefully, and our history of complaints from the public, we believe you will better appreciate that voluntary self-regulation can be highly cost-efficient, relatively uncomplicated, and highly suitable as a means of protecting the public, all without incurring the many disadvantages of national licensing regimens.

During my comments to the commission in January, commissioners expressed surprise in learning that we are not particularly interested in health insurance reimbursement. As the health insurance system is organized at this time, we view this as an inappropriate avenue for reimbursal for our services. While it would, at first glance, seem to be an appealing way to offer the unique benefits of the Alexander Technique to a population of lower economic strength, it would fundamentally alter the nature of the teacher/student relationship which is essential to the learning process, and create undue expectations for treatment and cure in students rather than encouraging them to take greater responsibility for learning to change harmful behaviors. It also, of course, invites the licensing strictures typical of the medical system onto our shoulders, which in our view carries the potential to limit our right to practice and be self-determining as professionals and to stand independently of the health care system. [I am sending you, via hard copy, an interesting article on some of the financial problems inherent in the current insurance system.]

Now, to address your specific questions:
1. There are no national standards for the Alexander Technique.
However, as we've said, through AmSAT our professional standards are extensive and rigorous. We are also working at this time to institute requirements for continuing education, although

most teachers already do this voluntarily. There are no other training requirements that are suitable for Alexander Teachers. Training courses offer some basic gross anatomy, but this is not strictly necessary for teaching. It is more of an enrichment, and directors of training courses are either self-taught and offer basic level instruction or hire other professionals, such as physical therapists, to offer this within the curriculum. There is no other CAM study that is necessary for Alexander Teachers.

2. As I have already explained, we're of the opinion that no single system for regulation of all the CAM disciplines could be appropriate or meaningful. In the United Kingdom, the government is developing guidelines for voluntary self-regulation which CAM modalities are being asked to fulfill through their own self-governing organizational structure, just as we are already doing with AmSAT. We recommend that you review this model. It is efficient, cost-effective, and minimally bureaucratic, and especially suitable for disciplines, such as those within the health education or related areas framework, that are primarily educational and very low risk.

3. You ask if the numerous 'bodywork' organizations should come together to form a community. This question perpetuates the problem of lack of definition already mentioned. Unfortunately, 'bodywork' is a vague term, generally applied to any discipline that involves a hands-on component and deals with muscles and movement. But this is an unduly simplistic categorization. Despite the fact that the Alexander Technique is frequently lumped under the bodywork banner by others, it is emphatically not a category that we consider suitable for us. In contrast, massage is 'bodywork.' The massage client lies passively on a table while the practitioner rubs muscles in a variety of ways. The client does not attend a massage session to engage in a learning process that involves examining his own habitual behavior and learning how to change. Further, the Alexander teacher undergoes a very extensive and specialized training involving a particular use of the hands which is completely unlike massage. The Alexander teacher's hands function to guide students as they move to help them experience an improved coordination. They then learn to consciously inhibit this malcoordination. To maintain this over time, the student must learn specialized cognitive skills and experience gradual retraining of proprioceptive feedback. The student is engaged in a learning process that he must practice and choose to engage in, if there is to be change and improvement. This is distinctly different from massage and other types of bodywork, both in goals and in methods. Most bodywork is just that--work on the body. The Alexander Technique, on the other hand, is a unique method for observing the interaction of thought, habit and perception, and then changing mental activity in order to improve psychophysical coordination. What would be the point of creating a bodywork community? These disciplines must each speak for themselves and, in our view, would be better served by creating their own professional organizations. Alexander teachers can't be assessed by other types of practitioners, nor can we assess them, and our training standards would not be appropriate for them as theirs would not be appropriate for us.

4. Again, we recommend that rather than developing overarching regulation, the commission develop requirements for self-regulation--as in the UK--that each discipline must fulfill, such as: a national professional organization which all practitioners of a discipline must join in order to be 'registered' in their field; a code of ethics suitable to their discipline with accompanying adjudication procedures; standards for approving training programs and re-evaluating programs periodically, as well as for handling complaints from students; standards for membership; a scope of practice; an informational pamphlet for the public to learn about the profession's

standards and avenue for redress of complaints; and continuing education standards.

5. We are not particularly concerned about malpractice. I know of not a single instance of a malpractice suit being brought against a teacher, and I have been a teacher for over twenty-five years and have been involved at the organizational level nationally and internationally for fifteen years as a founder of AmSAT.

6. In my view there are modalities under the CAM label that are extremely questionable in terms of their legitimacy and safety. Others make claims that ought to be better substantiated. Our other concerns are: the massage therapy effort to subsume the Alexander Technique within massage and require teachers to have a massage training; the misrepresentation of the Alexander Technique by CAM practitioners and by western physicians; and the potential for loss of our autonomy, which includes the right to determine our own standards and assess the competency of Alexander teachers ourselves, and to be viewed as an independent profession.

7. Consumer concerns or complaints could be addressed through the self-regulatory guidelines described above. AmSAT has an extensive ethical code and detailed procedures for processing complaints that has been successful in handling complaints from members, students, and the public. (Such complaints have been few, however.)

8. This question is so broad I'm not really sure of your intent. CAM encompasses so many practices, I don't think it's useful for doctors to just recommend CAM, carte blanche. It depends on the discipline. In order for doctors to do a good job of appropriately recommending types of CAM, the best thing would be for doctors to experience these modalities themselves. If physicians were to have ten Alexander lessons or so, this would be the very best way for them to appreciate what it is about, to be able to speak about it effectively to patients, to understand what patients who are studying the Alexander Technique are learning, and to make more appropriate recommendations to patients for undertaking lessons. Alexander teachers do not refer students to specific doctors. If a student has a health complaint, we tell the student to see their doctor. But students don't really need to hear this from the Alexander teacher, they already know it.

9. The most important aspects for ensuring quality of CAM practices are: (1) further research to determine efficacy and legitimacy of claims; (2) better definition of CAM itself and a system for determining a modality's suitability for inclusion as a type of CAM; (3) to institute requirements for self-regulation; (4) to encourage the western medical community to experience a wide variety of CAM modalities for themselves.

Thank you for your attention and consideration of our concerns.

Sincerely,

Missy Vineyard
Chairman, AmSAT's Professional Identity Project
Director, The Alexander Technique School of New England

AmSAT
American Society for the Alexander Technique

June 21, 2000

Dr. Strauss, Director
National Center for Complementary and Alternative Medicine
National Institutes of Health
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Building 31, Room 5B37, MSC 2182
Bethesda, MD 20892

Dear Dr. Strauss:

This letter is in response to your call for comment on the National Center for Complementary and Alternative Medicine's Draft Strategic Plan. I'm writing on behalf of the American Society for the Alexander Technique (AmSAT) and the more than five hundred teachers and teachers-in-training which it represents. We hope you'll give this your attention and contact us for further explanation or with additional questions.

AmSAT was formed in 1987 as a professional organization for teachers of the Alexander Technique in the U.S. AmSAT establishes and maintains national standards for the training and certification of Alexander teachers with an aim to protecting the public we serve through responsible self-regulation. AmSAT has a Code of Ethics and adjudication procedures, a periodic three-year review of teacher training courses and training course directors, and is affiliated with societies worldwide upholding similar standards. In addition, we seek to educate the public about the Alexander Technique, promote research, and provide services to our members. We will be sending you via post AmSAT's handbook for your perusal.

Upon receiving your Strategic Plan and the Classification of CAM Practices, we were surprised to find the Alexander Technique listed as a form of Complementary and Alternative Medicine under the category of "Massage and Body Work." As we will explain in this letter, we do not belong in this category nor do we consider the Alexander Technique a form of Complementary and Alternative Medicine as currently defined in this document.

The Alexander Technique is an educational method that promotes conscious awareness and control of the self. Through the teacher's verbal feedback and hands-on guidance as the student performs everyday movements such as standing and sitting, the student becomes aware of habitual psychophysical reactions and the impact these reactions have on his/her overall coordination. Students are taught three specialized skills: 1. inhibiting, which is the capacity to cease maladaptive patterns of reaction; 2. directive thought, a precise type of thinking that aims the body in movement to optimize coordination; and 3. accurate sensory awareness and perception. Utilizing these skills, students learn to maintain a more integrated psychomotor coordination of themselves in any activity. Practiced over a period of time, students experience:

a. an improvement in conditions created by chronic malcoordination;
b. greater conscious understanding and control of habitual reactions;
c. enhanced ability to learn and perform complex motor skills.

We want to emphasize that the Alexander Technique is not Complementary and Alternative Medicine as defined in the Strategic Plan. First, it isn't "medicine," which is usually defined as a practice for

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the treatment of disease. The Alexander Technique does not treat disease and it isn't treatment. It is an educational process that must be learned and consciously put into practice over time by the student in order to be of benefit. It is more akin to the process of learning to play the piano or play tennis. The better you are taught, and the more you learn and apply what you learn, the higher your skill and performance level.

The Alexander Technique also is not "alternative." An Alexander Technique teacher would never recommend that a student study the Technique instead of seeking appropriate care for an illness or other physical symptoms by a competent physician. We make no claim that we are another form of medicine, nor that we are a replacement for medical care of any kind.

The Alexander Technique is not in our view "complementary" either. For over 100 years, the Alexander Tecnique has been practiced as a discipline unto itself, studied for the sake of the process of self-discovery and self-awareness that is its hallmark. Neither physicians, massage therapists or body workers can do what Alexander teachers are methodically and thoroughly trained to do, nor can they assess the competency of teachers, or the correct application of the Technique. Alexander teachers are highly skilled professionals in their own right. The Alexander teacher training course is a three-year program consisting of 1600 hours of in-class study; a five to one student/teacher ratio is maintained; and the course director must meet rigorous requirements.

The Alexander Technique is not massage or bodywork. While the teacher uses her hands to guide the student in movement, the purpose of the hands is not to manipulate or treat muscle tissue but to provide physically directive, and consciously educational, guidance. To receive a massage is to lie passively on a table (perhaps even fall asleep), while receiving the manipulative techniques of the practitioner. Conscious thought, education, active participation, or engaging in a process of learning to change psychophysical behaviors are not aspects of massage. In contrast, in an Alexander lesson the student is awake and alert, generally standing rather than lying down, fully clothed, and engaged as an active participant in a learning process. Bodywork also involves a primarily passive recipient who is moved or manipulated in some manner by the practitioner but the use of the practitioner's hands is not at all comparable with the Alexander teacher's. Unlike in various types of bodywork, correct movements or positions of parts of the body are not the goal of the Alexander Technique. Instead, the body is the vehicle through which students learn to become aware of interfering psychophysical habits that affect both their movement coordination as a whole and their overall behavior. Although practitioners in the massage and bodywork areas often refer to their disciplines as "mind/body," and may on initial inspection appear to be similar to the Technique because of the hands-on contact, these disciplines are in fact primarily about the body and not the mind.

The Alexander Technique is a true "mind/body" discipline. Through becoming aware of how he or she is moving, the student becomes aware of how his or her habits of thinking have created particular patterns of movement coordination, and how to use inhibiting and directing to change maladaptive patterns of coordination. Thus it is the thought, not the movement, which is the key for making successful change and improvement. (Imagine a baseball pitcher who is aiming his throw at the catcher. This physical act involves much more than muscle strength. In some way, the pitcher's mind must also have absolute clarity about where and how the ball is to travel. Similarly, the Alexander Technique teaches students how to think differently in order to perform differently.) The student's participation in this educational process includes practicing outside of the lesson what has been learned during the lesson, sustaining his or her practice over a long period of time, successfully acquiring new cognitive skills, and applying these skills to change habits of behavior.

The unique position--and dilemma--of the Alexander Technique is precisely that it doesn't fit into existing categories of classification. It isn't medicine, treatment, or therapy. It isn't alternative or complementary. It also isn't simply analogous to a piano or tennis lesson. The Technique is an approach to self-study in which improvements in health occur indirectly but aren't the single or main objective. While a student may come to a teacher complaining of a knee problem, the teacher explains to the student: 1. that he should be thoroughly examined by a physician; 2. that the purpose of the technique is to educate not to treat; and 3. that in the process of learning to improve his overall psychomotor coordination the knee problem may or may not resolve. This depends on the

cause of the problem and on his own ability to make use of what he learns. If the knee problem is caused by harmful habits of malcoordination, then the Alexander Technique is an appropriate avenue to help the student learn tools for changing behaviors of malcoordination which, once successfully prevented, allow a natural process of healing to occur. If the underlying cause of the knee pain is something else however, such as a torn cartilage, then the Alexander Technique can't address the problem. These facts and limitations are clearly explained to the student by the teacher. Often a student begins Alexander lessons because of a musculo-skeletal problem but continues his study because, after a number of lessons, he discovers that the benefits he experiences encompass many other areas of his life. Does a patient who goes to a physician for knee pain continue to see the physician even after the pain goes away? Certainly not. On the other hand, many Alexander students continue to study the Technique for years because of its continuing and broadening impact on their lives. This is an example of why we say that the Technique is not healthcare as commonly defined but education. In some cases, improvement of conditions caused by chronic malcoordination can be significantly improved but the goal of the Technique is larger in scope, and goes beyond, the aims and objectives of medical practice.

Following are some broader questions and concerns regarding the Strategic Plan itself:
* You have included the Alexander Technique in the NCCAM's Strategic Plan as massage and bodywork without asking Alexander teachers, as far as we know, for their input. We would appreciate knowing more about how you've decided which disciplines are CAMs, and how you've created and defined CAM's subcategories.

* There are so many types of practices listed in the Classification of CAM Practices, it begins to appear as though anything that might cause someone to feel better--and isn't already considered western medicine and healthcare--is a CAM. This weakens the seriousness of NCCAM's purpose by the sheer quantity of what the NCCAM considers to be CAM and proposes to investigate. Can the NCCAM possibly do sufficient justice to all of these practices for the purpose you state of determining each discipline's effectiveness and validity?

* In this country "healthcare" is everything from heart surgery to antibiotics, acne medication, breast implants, and back exercises. Western medicine's lack of clarity about what it means to be healthy contributes significantly to the ongoing confusion and debate about what is healthcare, and about appropriate reimbursement for healthcare. Currently, anything that is done by a licensed healthcare provider is healthcare. By extension, it now seems that anything that isn't healthcare but helps someone feel better is CAM. Could the NCCAM investigate and develop a definition of health as a better beginning from which to define and limit the scope of CAM? Toward this end, the NCCAM might ask practitioners of each of the CAM disciplines to submit the criteria for health that exist within their system and detail how these criteria are determined and maintained.

* The NCCAM also might consider asking NIH investigators and researchers to experience and practice some of these non-traditional disciplines in order to better understand them first hand. While this may seem at first to violate science's tenets of maintaining objectivity and eschewing empiricism, such direct experience could provide an interesting basis for designing appropriate research protocols. It might also promote more in-depth communication between scientists and CAM practitioners. Personal experience is a different but no less valid means of gaining knowledge and can add a vital piece to the process of learning about--and determining the effectiveness of--these disciplines.

* By declaring that the Alexander Technique and other disciplines are CAMs and therefore healthcare modalities, NCCAM is taking a serious step with potentially damaging impact. In this country healthcare providers must be licensed and practicing healthcare without a license is against the law. Many of the smaller, lesser known hands-on disciplines you list are currently being threatened by the national massage therapy organization (AMTA), which is submitting bills at the state level requiring practitioners who use touch to obtain massage licenses through expensive, lengthy, and irrelevant training as massage therapists. In the absence of other systems for regulation of non-traditional modalities, state lawmakers are seriously considering these bills. (Over the last several months, for example, AmSAT has had to defend the Technique against the New

York State Massage Board's effort to classify the Alexander Technique as massage. We have just won a favorable determination----at considerable time and expense--that the Alexander Technique is NOT massage.) While AmSAT is seeking to responsibly protect the public we serve through self-regulation, if the NCCAM defines disciplines such as the Alexander Technique as healthcare, then the AMTA's case for licensure is significantly strengthened. Your actions put practitioners of disciplines such as the Alexander Technique, Feldenkrais, and even tai chi in a tight squeeze. In short, have you given careful thought to the legal and legislative ramifications of your categorizations?

* Although on initial reading the stated purpose of NCCAM's Strategic Plan appears to be to develop and implement a system for funding and promoting research of non-traditional healing practices to better understand the mechanisms by which they affect health, on rereading it seems more accurate to say that your purposes also include determining which CAM practices are legitimate and effective, and which are not. Further, the document states that those that are legitimate should be "integrated" into mainstream western medicine. But if this is your intent, then the NCCAM needs to give further thought to the implications and impact of these determinations, including which unnamed group at some unnamed time in the future will be empowered to determine how this information will be used and how these disciplines will be permitted to be conducted. Who is going to do the integrating and how? Why do you assume that the practitioners of the modalities that are listed as CAMs want to be integrated, that the public would be better served by this, or even that systems which are derived from an entirely different premise than western medicine can or should be integrated with it?

* The Strategic Plan needs to better distinguish between conducting relatively straight forward clinical trials for researching the efficacy of an herbal remedy, and the much greater complexity of attempting to determine the "validity" of an entire discipline, such as Reiki or the Alexander Technique. We would like to point out that a fair and responsible determination of what is "safe" and "effective" is not necessarily achievable simply by funding some studies over the next five or even ten years. You are proposing to study disciplines that are not allopathic, and that have been developed by means very different from the usual approaches of western scientific research. You seem to assume that this will in itself be a sufficient means for determining validity, and the only necessary basis on which to judge these systems' efficacy and value. Non-western, ancient medical practices were created by just the means that the Plan describes as inadequate: anecdotally, experientially, empirically. These systems have been derived from ways of thinking, knowing and perceiving that are as yet largely unknown and little understood by the west. It is likely to be difficult to research capabilities that remain unknown to western researchers and physicians, and for which western technology has yet to develop a means for measuring, without first seeking to understand and learn about the skilled perceptions, training, and non-verbal experiences of the practitioner. (As an example, we would cite the Chinese tradition of diagnosis based on feeling the patient's pulses. In the west there is thought to be only one wrist pulse, and it has long been abandoned as a means of diagnosis. In Chinese medicine, however, the wrist contains twelve pulses, there are lengthy treatises on the nature of these pulses and on the process of training practitioners to feel and identify their meaning, and from which the Chinese physician can know, for example, whether a woman is pregnant within the first few weeks of pregnancy.)

Despite this expression of our reservations, we want to emphasize that we are entirely in support of research being conducted to shed greater light on the physiological mechanisms underlying the theoretical basis of the Alexander Technique. F. M. Alexander's empirical observations led him to theorize that, for all vertebrates, an important dynamic relationship exists between the head and the spine which is important for controlling coordination and other physiological functions. However, Alexander was not a scientist and did not appreciate the need for experimental research to verify what he could see with his eyes and feel with his hands. Frank Pierce Jones, an Alexander Teacher and classics scholar turned scientist devoted himself to experimental research on the Technique throughout the 50s and 60s at Tufts University. He sought to find ways to demonstrate the validity of Alexander's theory. Using multiple image photography, Jones showed that subjects' head and neck coordination was statistically correlated with distinct patterns of movement as subjects stood up from a sitting position. (1) In a clinical trial he found that Alexander's particular head-neck relationship improved vocal quality. (2) In other research, it has been shown that students of the Alexander

Technique experience improved respiratory functioning (3) and improved functional reach. (4) And in a clinical trial currently under way in England, preliminary results indicate that motor patterns in Parkinson's patients are significantly improved after a course of lessons in the Alexander Technique as compared with subjects receiving massage. (5)

Thus, while we must emphasize that we do not practice medicine and are not healthcare providers but teachers of an educational, mind-body discipline, we would like to suggest further discussions between ourselves and your department to determine if a suitable category can be developed within the Strategic Plan,or if your existing mind-body category could be redefined in a way so as to include the Alexander Technique as an educational modality, in order to enable qualified scientists to obtain grants for research. In addition, we would like to suggest for your consideration the term which Alexander used to define his work, "psychophysical reeducation."

In summary, we want to state our support for the creation of the NCCAM, and to applaud you for your efforts to recognize the importance and contributions of non-traditional healing practices. We hope this letter clarifies what the Alexander Technique is and is not. In addition, we respectfully suggest that the NCCAM strive for better definitions for health and healthcare, as well as the meaning of, and discrete boundaries for, complementary and alternative medicine. In our view, research for the purpose of expanding mankind's knowledge and understanding of the human organism is to be commended. But research for the purpose of determining the overall validity of many of the disciplines you have listed in the Plan is a complicated undertaking that requires further thought in regard to both approach and impact, and demands a great deal of care and respect for the uniqueness and integrity of these disciplines.

Finally, we wish to express our appreciation of this enormous undertaking. We thank you for your consideration and look forward to further discussion of these many complex issues.

Sincerely,

Missy Vineyard

Missy Vineyard
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(5) Stallibrass, Chloe, unpublished manuscript, 1999.

cc: Dr. Michael Cantwell, Ms. Mary Chung, Dr. Richard Grimm, Ms. Susan Holloran, Dr. Janet Kahn, Dr. Konrad Kail, Dr. Ted Kaptchuk, Dr. Dana Lawrence, Ms. Diane Manley, Dr. William Meeker, Dr. Karen Olness, Dr. Herbert Pardes, Dr. Gilbert Ramirez, Dr. Everett Rhoades, Dr. Marilyn Schlitz, Dr. Leanna Standish, Mr. James Williams, Dr. Richard Nahin