Tab 13-H

Tab 13

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 1, 2001

Margaret Knight
Executive Director
Association of American Indian Physicians
1225 Sovereign Row - Suite 103
Oklahoma City, OK 73108

Dear Ms. Knight:

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. Who should be allowed to use the "Traditional Healer" designation?
2. How and by whom should Traditional Healers be selected and credentialed?
3. Should Traditional Healers be licensed or exempt form licensure?
4. Should Traditional Healers be allowed to charge for their services? If so, how should this be accomplished?
5. Should Traditional Healing be integrated with conventional medicine or should it be kept separate?
6. How should Traditional Healing be preserved and perpetuated?
7. To whom and how should Traditional Healing be taught?
8. Should there be communication between a conventional health care provider and Traditional Healer when both are involved in the care of the same patient? If so, what information should be communicated?
9. What policy recommendations would you like to make to the Commission about Traditional Healing?

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

Thank you for the request for assistance from the Association of American Indian Physicians (AAIP) regarding Native healers by the *White House Commission on Complementary and Alternative Medicine.* To address the questions, I have sought out the input of the Association of American Indian Physicians (AAIP) Executive Board members and other AAIP members committed to the protection and preservation of traditional medicine. It is our consensus that the following opinions and recommendations be respectfully acknowledged.

The U.S. Government recognizes American Indian and Alaskan Native (AI&AN) nations as sovereign entities. The sovereign status was created by treaties signed by both AI&AN nations and the U.S. dating back to the 1860's. Sovereignty is a political term. It denotes the respect governments afford one another in a government-to-government environment. Sovereignty is the ability to legislate your own laws including basic inalienable human rights – freedom of religion, freedom of speech, and freedom of choice. Inherent to the Native healing process is spirituality. There is no separation between healing methodology and spirituality – these are one. It is therefore not possible to legislate or otherwise control Native healing science. The practice of native healers is a culturally competent process and cannot be subjected to existing or proposed protocol or control by non-practitioners.

The heterogeneous nature of Native healing and practice does not allow for standardization of practice procedures. There are over 500 American Indian and Alaskan Native groups with distinctive healing practices. It would be unjust to subject Native healing practice to any standardization scheme or categorization.

We submit the following recommendations:

1. Traditional healers should be addressing these issues. Individuals who represent on the issues should be identified by the Native communities. Input should be requested from a broad representation of the 500 Native groups.

2. The Commission needs to be educated about traditional medicine practice.

3. A collaboration of traditional healers and Native health organizations should be assembled to provide guidance and direction on these and other issues. AAIP is prepared to facilitate the formulation of this collaborative effort.

4. The AAIP leadership would be willing to address the Commission on all these issues and recommendations.

5. Discretionary money to fund the dialogue would be needed.

Categorization of Native healers is not a policy issue.

Melvina McCabe, M.D., President
Association of American Indian Physicians

Tab 14

White House Commission on Complementary and Alternative Medicine Policy

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February 1, 2001

Francine Butler, Ph D
Executive Director
Association of Applied Psychophysiology and Biofeedback
10200 West 44th Avenue-Suite 304
Wheat Ridge, CO 80033-2840

Dear Dr. Butler:

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

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

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Sincerely,

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

From: Francine Butler [mailto:fbutler@resourcenter.com]
Sent: Monday, February 12, 2001 10:19 PM

Thank you for inviting the Association for Applied Psychophysiology and Biofeedback to present written testimony to the White House Commission on CAM. Our responses to your questions are offered below.

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

RESPONSE: No. We have found that educational standards are developed after questions of practitioner competence and certification are solved. The biofeedback field has addressed this issue and has spent years in developing their body of knowledge. National educational standards are an issue we are only beginning to grapple with after setting standards of competence. So long as patients are being seen for medical disorders there should be a knowledge of western medicine and CAM.

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?*

RESPONSE: Definitely yes. It is incumbent upon the various membership associations to take on the responsibility of defining the knowledge of the field and to design minimal competency requirements to insure the public safety. We can share the experience of the Association for Applied Psychophysiology and Biofeedback (the membership organization) in their creation of the Biofeedback Certification Institute of America (the credentialing organization) with anyone who is interested.

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

RESPONSE: Probably yes. First of all there is power in numbers and an organization would help to enhance communication among and between one another. In 1996 AAPB hosted a meeting in Albuquerque in which 20 CAM organizations were represented. There was great energy and enthusiasm about our united efforts--but the impetus to move forward with a solid coalition died for lack of funding. A new effort could be mounted by having the key leadership of the CAM organizations meet to discuss common issues. Organizing the meeting is not difficult. Determining the agenda and the goals to yield an outcome worthy of support would be the challenge.

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?*

RESPONSE: Yes-this would be helpful. Such a set of guidelines would constitute practice guidelines for a field. Guidelines imply enforcement and thus the need for an ethics committee. We endorse and have undertaken the development of guidelines. Again, this is a primary responsibility of the membership association.

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

RESPONSE: Yes. If practitioners are licensed, this may not be a problem. If they are not licensed, it is definitely a problem. CAM should be concerned and should be familiar with state licensing laws. Unlicensed practitioners should work under the supervision of a licensed practitioner. Both licensed and unlicensed practitioners should be credentialed (certified) in the CAM area to demonstrate their knowledge in that field.

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?*

RESPONSE: We can only respond with regard to biofeedback. We regard biofeedback as a therapeutic intervention between client and practitioner which needs to be guided by professional ethics. The risk for this field is minimal. However, mechanisms to reduce risk are good educational practice, abiding by ethical and practice guidelines and credentialing.

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?*

RESPONSE: Yes If individuals are licensed, grievances can be made to the state licensing board. If not, there should be an ethics or practice review committee within the membership organization or credentialing agency to which the individual belongs or holds a certificate. Ultimately there will be practitioners who do not subscribe to any of the above criteria. When these practitioners behave badly, the entire discipline suffers because there is no one to handle a grievance and the consumer is left helpless. The discipline suffers because the consumer complains that the therapy did not work.

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

RESPONSE: The provider should share any information that impacts the health of the patient including a full health history in order to rule out any factors which might negatively affect treatment. It serves everyone well if there is a good relationship between a CAM provider and a traditional provider.

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?*

RESPONSE: Ensure good training, continue professional education, support credentialing, develop accepted procedures. Be cautious about the term self-care. It is contrary to developing qualified practitioners.

Tab 15

White House Commission on Complementary and Alternative Medicine Policy

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January 31, 2001

Ms. Barbara Brennan
Founder and President
Barbara Brennan School of Healing
P.O. Box 810035
Boca Raton, FL 33481-0035

Dear Ms. Brennan:

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 Brennan Healing Science or Hands of Light Healing undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than Brennan Healing Science or Hands of Light Healing ?
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 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, Pharm. D.
Executive Director
White House Commission on
Complementary and Alternative
Medicine Policy

Barbara Brennan, MS. & Sherry Pae, RN

Barbara Brennan School of Healing

1. Are there national educational standards for Brennan Healing Science® or Hands of Light Healing® undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than Brennan Healing Science® or Hands of Light Healing® ?

ANSWER:

We have educational standard for Brennan Healing Science Practitioners, in the training offered at the Barbara Brennan School of Healing. These educational standards are established through the comprehensive curriculum, skills, and graduation requirements of the Program. We do not currently have educational standards for continuing education for our graduates, however, this is something we plan to develop in the near future. There are no national standards set by any other body or national organization for Brennan Healing Science.

It is important that healers are educated, informed, and exposed to conventional medicine and CAM, and that national education standards should be based in both the Integrative and Holistic approach to health care as defined below under question # 8.

As part of our training we offer other courses that include Anatomy & Physiology, ethics, professional practice, and an overview of CAM. We are developing additional classes in pathophysiology and the etiology of disease, how CAM and conventional therapies interact with Brennan Healing Science, basic medical terminology, and working with patients in hospital settings including: acute care, intensive care, pre/intra/ and postoperative. We are also beginning to have our students in advanced studies intern in hospital CAM centers as part of their program.

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?

ANSWER:

This is a more difficult question because many CAM practices differ so much. I would say this needs to be clarified by the various types of CAM providers, just as various conventional medicine practitioner groups (like MDs, RNs, Physical therapists, etc.) have developed national organizations and national standards of education and practice.

In our case there are various energy healing modalities, besides Brennan Healing Science. Since these modalities vary greatly in terms of curriculum, length of training, healing procedures, examination and graduation requirements, and standards, it would be difficult to establish standards and certification for energy healing in general.

Brennan Healing Science focuses on the structure and function of the human bio-energy field as a basis for establishing healing practices and procedures. In our view, the human bio-energy field is the vehicle for the mind body connection, and plays an essential role in the mechanism of transfer for healing. The development of instrumentation to measure the human bio-field will eventually provide a scientific basis for the process of healing.

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

ANSWER:

There is currently a group consisting of individuals from various energy healing organizations who have come together. The problem is language and establishing a basis for understanding the mechanism of energy healing that can help build grounds for communication. This is another reason why we at BBSH work with the human bio-energy field structure and function. We need to choose the best, clearest people in each established major energy healing area, say, Brennan Healing Science, Therapeutic Touch, Rosalyn Brueyers work at the Healing Light Center, and Healing Touch. (moved from under question #4)There are several ways they can come together. For example, a forum composed of the founders/leaders of each of the major energy healer organizations could come together with a set agenda and a set number of goals to be accomplished within a set reasonable time frame. Otherwise things drag out and nothing gets done, the leaders replace themselves with less experienced people, and the whole thing gets dragged out more.

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?

ANSWER:

This is a complicated question. As long as we view each patient with a Holistic perspective, as a unique individual, we could benefit from condition-specific and modality-specific guidelines that are integrative, and facilitate the practitioner and the patient in developing the best possible plan of care. For instance, we do have both condition-specific and modality-specific guidelines, and Brennan Healing Science focuses on the structure and function of the human bio-energy field as a basis for

establishing healing practices and procedures. We train Brennan Healing Science Practitioners to continually monitor and assess the patient's response to these healing practices and procedures as the basis for determining treatment and/or referral.

It would be difficult to establish across the board guidelines for CAM in general. Each group of practitioners could establish and implement such guidelines on a national organization level as described in question #3.

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

ANSWER:

We require all teachers to carry malpractice liability insurance, and recommend it to our students, as well as getting a "license to touch license people" such as massage, in the particular geographical area in which they wish to practice energy healing.

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?

ANSWER:

The main risks in energy healing in my opinion come from inadequate training, that leads to fantasy, giving misinformation and trying to do a skill/procedure without training and possibly, very rarely, hurting someone in the process. I say rarely, because an untrained energy healer is usually an ineffective one, i.e. not much affect on the client (can't help, can't hurt.)

Giving wrong information or bad advice to a client, who then does not follow through on important medical treatment that is necessary for healing can be dangerous. The way to minimize the risks involved is through training and education. Energy healers need a great deal of information and education that many of them do not have. This is why we have developed such a comprehensive curriculum and course of study in our 4 year healership training program.

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?

ANSWER:

Yes, through a national 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?

ANSWER:

Everyone involved in providing care and referring should be able to communicate their assessment of the patient, how the patient is responding to their treatment/therapy, the expected outcome, side effects, and plan of care. Both CAM and conventional providers need to be educated about when and how to refer to one another, as well as establishing continuing education related to all various modalities/therapies, treatment systems, and communication. This is difficult because the languages and information systems of care are so different. First we need to build bridges of communication between the different systems of health care, and then develop standard ways to communicate the information that is the most vital to convey and receive according to the practitioners in each treatment modality.

If we change our focus somewhat and clarify our terms, many prefer to use the term holistic to refer to the approach to the patient and integrative to refer to the practice of selecting specific therapies from the vast array that are available. In this way, we stop the separation that supports conflict, and recreate a more congenial setting for communication. Obviously more rigorous double blind studies have been done in conventional treatment modalities, and a great deal of work needs to be done in "CAM" area's, but that should not keep us from looking at the bigger picture. The best large scale model for integration I have seen was written by Dr. Kathi Kemper. Her paper, "Separation or Synthesis: A Holistic Approach to Therapeutics" published in "Pediatrics in Review" Vol. 17 no. 8 August 1996,is the best model for synthesis I have seen. It groups all therapies into four categories: biochemical; Lifestyle; bio-mechanical; bio-energetic. These four categories include all treatment therapies, both mainstream and CAM into an Integrative Medicine model. I think this is a very good place to start. If we look at the issues from the perspective of Integrative Medicine, and Holistic approach to the patient, (meaning treating all aspects of the patient), and utilizing all four aspects of Dr. Kemper's Integrative Medicine Model, we will have taken a great step forward into utilizing all the information we have about health care treatment.

Dr. Kemper has also written a paper about how to talk to families about Integrative Medicine in acute care settings, in the Office and Emergency Pediatrics Vol. 13, No. 2, 2000, which can be very helpful to families in that situation. In addition to this, Dr. David Eisenberg has written a paper describing how a conventional physician can communicate with his/her patient re CAM. It was published in Annals of Internal

Medicine vol. 127, no. 1, July 1, 1997. It is also on the internet.

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?

ANSWER:

Policy should recommend Holistic and Integrative treatment as defined above for all patients, with one primary care person who is trained in all areas informing/coordinating the treatments. There, of course is a tendency to make that the primary care physician, however, most physicians have little or no knowledge about CAM treatments and are not qualified (DELETED SENTENCES). At this point in time, it is very difficult if not possible to find qualified people to inform and coordinate a patient's care because of the tremendous lack of understanding between groups. As it is, we have all kinds of treatments going on at the same time and no-one but the patient knows what they are. Very few people are knowledgeable in how one type of therapy may interfere with, potentiate the effects of, or be contraindicated with another, and this poses a potentially serious risk to the patient.

Tab 16

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

Elizabeth Goldblatt, MPH, PhD
Council of Colleges of Acupuncture and Oriental Medicine
The Maryland Trade Center #3
7501 Greenway Center Drive-Suite 820
Greenbelt, MD 20770

Dear Dr. Goldblatt:

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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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 acupuncture and oriental medicine 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?
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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.

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Sincerely,

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

February 13, 2001

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

Thank you for the opportunity to respond to the questions set forth by the White House Commission on Complementary and Alternative Medicine. Although many of the questions refer to CAM in general, the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) can only respond from the perspective of acupuncture and Oriental medicine. The issues raised are complex, and we look forward to engaging in active dialogue with the Commission.

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

There are national standards for acupuncture and Oriental medicine education. Accredited and candidate acupuncture and Oriental medicine programs are recognized at a Master's level by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM). ACAOM is given the authority to grant Master's level training through the U.S. Department of Education and the Council on Higher Education Accreditation (CHEA). Since acupuncture and Oriental medicine training is only recognized at a Master's level, there is no undergraduate training in this field. Currently, we are developing an optional clinical doctoral degree, which will be postgraduate training. We anticipate that the first doctoral programs will begin within the next two years.

'ontinuing education is required by the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM) to maintain active national certification in acupuncture, and by a few state boards to maintain licensure. Consequently, the NCCAOM and/or state boards recognize continuing education classes. While there are no *accredited* national standards put forth by ACAOM for continuing education classes, NCCAOM has clear guidelines for its required CE credits.

To answer the second part of question #1, ACAOM already requires a specific level of education in western medicine. The intended outcome of such a course is to teach practitioners when to refer and how to communicate with western medical providers. Acupuncture students are not taught western medical disease diagnosis. The majority of acupuncture colleges also include survey courses on complementary and alternative medicine practices outside of our field; however, such courses are not required for accreditation.

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, we can only respond from the perspective of acupuncture and Oriental medicine. The CCAOM strongly endorses national standards for practitioners. The CCAOM has recommended the following standards to all state boards as the basis for licensure.

1. Graduation from an accredited or candidate program
2. NCCAOM Certification (national certification in acupuncture)

The CCAOM is currently working with Senator Harkin's office and the FDA to request that an Office of Natural Products be established in the U.S to oversee herbs and supplements. Such Offices have already been successfully established in the U.K., Canada and Australia. If established, it would be essential for practitioners from our field, familiar with Chinese pharmacopoeia, to actively participate in setting standards and regulations. The reason for such an office is to insure public safety. For example, a government agency overseeing Chinese herbs could protect the public from contaminants and adulterants. In addition, there are a very limited number of Chinese herbs that can prove toxic if misused and therefore should not be available over the counter. An Office of Natural Products could assure that only properly trained and certified AOM practitioners could have access to the full array of healing herbs.

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

Our field has already developed a cohesive AOM community. Twice each year five national organizations meet to discuss issues that affect our profession. The organizations include, the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM), the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), and the two professional organizations -- the Acupuncture and Oriental Medicine Alliance (AOMA), and the American Association of Oriental Medicine (AAOM). The NAFTA Acupuncture Commission, with representatives from the United States, Canada and Mexico, includes members from each of the five organizations plus the American Academy of Medical Acupuncturists (AAMA). The AAMA represents medical doctors performing acupuncture.

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?

On the whole, the CCAOM does not support condition specific or modality specific guidelines. The most effective practitioner, as in all fields, is comprehensively educated, has graduated from an accredited or candidate college in their field of specialty and is nationally certified. Our field has come to respect diversity. Our schools teach different modalities: Traditional Chinese Medicine, French Energetics, Korean Acupuncture, Japanese Acupuncture, and Five Element Acupuncture, to name just a few. Our graduates may effectively practice different treatment styles for the same condition. Acupuncture and Oriental medicine is as much an art as it is a science. We believe that practice guidelines, when established, must be developed with significant input from health care providers in their respective CAM fields.

The only area where a specific modality has proven effective, and a stringent protocol is followed, is in acupuncture detoxification. The standardization of this treatment has allowed health care providers outside of our field to administer this simple five-ear needle treatment under the supervision of a licensed acupuncturist.

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

Acupuncture and Oriental medicine in this country has a superb safety record. To date, malpractice suits have been rare, and as a result, not of significant concern in our field. Malpractice insurance in our field is one of the lowest in any medical profession.

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?*

Acupuncture is an exceedingly safe medical modality when practiced by a comprehensively trained acupuncturist. We have identified the most common risks as 1) herb drug interactions; 2) pneumothorax and 3) blood borne pathogen transmission. To address these risks, practitioners trained to use the full herbal pharmacopoeia are educated in herb drug interactions. Needling safety and techniques are also included in every accredited and candidate curriculum, reducing the possibility of patient injury through improper needle use. The CCAOM runs a nationally recognized course and examination in clean needle technique. Students must take this coursework at some point in their academic career. This course covers proper use and disposal of needles, blood borne pathogens, and other relevant safety issues. The CCAOM CNT course is a requirement for NCCAOM certification and is also required for licensure in many states. Our excellent safety record reflects the effectiveness of our programs to minimize risks associated with the treatment process. While the vast majority of the Chinese herbal pharmacopoeia should remain available over the counter, there are a few Chinese herbs that can be misused and only nationally certified practitioners should have access to them.

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?*

Our field already has a mechanism in place for consumer concerns and complaints through state medical boards or acupuncture boards. Acupuncture is licensed in forty-one states and the District of Columbia. Concerns or complaints should be brought to the attention of the state board governing acupuncture licensure.

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?*

This question is part of a much larger discussion and we look forward to speaking with the Commission on this topic. However, to best answer your question, the CCAOM believes that every western medical college should provide survey courses in CAM. Our colleges already teach survey courses in western medicine. The desired result of this education for all medical fields is to know how to communicate with other health care providers, what to expect from the rich variety of medical traditions we have available in the U.S., and when to make a referral.

For example, expected information from a western M.D. would include a diagnosis, treatment, and medications. An acupuncturist in turn, would describe expectations from treatment and information and discussion on potential herb drug interactions. In depth conversations are always useful in order to identify and implement the best course of treatment for the patient. The patient should always be our priority. Often a combined approach offers the best medical care.

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?*

Our field has already implemented numerous quality control devices. The Accreditation Commission for Acupuncture and Oriental Medicine assures quality in our education; the National Commission for the Certification of Acupuncture and Oriental Medicine assures basic competency in diagnosis, treatment and safety; the Council of Colleges of Acupuncture and Oriental Medicine provides the

CCAOM CNT Course that assures the safe handling of needles, and our extensive licensing system provides consumer protection at the state level.

The CCAOM would like to see acupuncture and Oriental medicine available to all Americans. We ecommend that

- Acupuncturists are specifically included as a provider eligible to participate in the National Health Service Corps loan repayment program.
- Acupuncturists are included in Federal Employment Insurance.
- Acupuncturists are added to Medicare and Medical
- An Office of Natural Products at the government level with CAM providers active on the board is established.
- Private insurance companies are encouraged to cover our services.
- All medical colleges are required to include survey courses on medical systems practiced in our country in order to know when to refer and how to communicate with other healthcare practitioners.

I hope you find this information useful. We would be delighted to elaborate on any of our answers and engage in further discussion on these issues. If you have further questions, please contact me directly at the Oregon College of Oriental Medicine 503-253-3443 x 111.

Elizabeth A. Goldblatt, Ph.D., M.P.A./H.A.
President, CCAOM

Amy Kaufman, M.Ac., L.Ac.
Administrative Director

Tab 17

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 29, 2001

Ms. Barbara LaScola
Executive Director
Federation of Straight Chiropractors and Organizations
642 Broad Street
Clifton, N.J. 07013

Dear Ms. LaScola:

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 chiropractic undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM?
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 chiropractic 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 memebers 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

Prior to answering your specific questions, we would offer a word or two to clarify the FSCO's position in general. We think this will help you better understand our responses to your specific questions. The FSCO represents a group of chiropractors, mostly in this country but a growing number abroad as well, who offer chiropractic to people as a means of allowing the nerve system to function optimally thus improving the overall function of the body. We provide this service and this service exclusively to all people, man, woman or child, regardless of the presence or absence of disease. We adhere to a relatively conservative definition of chiropractic that states our objective as the location, analysis and correction of vertebral subluxation because it in and of itself is a detriment to the fullest expression of life. Conversely, the objective in medicine is to diagnose and treat diseases and conditions. If a person does not have a subjective complaint there is usually little that can be done for them. Since our chiropractic objective is exclusive for the detection and correction of vertebral subluxation, we do not consider ourselves to be "complementary or alternative medicine." Our objectives are unique and non-duplicative. The fact is chiropractic is a separate and distinct profession, no more a replacement for medicine than medicine is a replacement for us. Having said this our responses to your questions are listed below.

1. Regarding the national educational standards for chiropractic, undergraduate and postgraduate studies are governed by the Council on Chiropractic Education, a federally recognized accrediting agency. Specific standards, licensure requirements and continuing education standards are already currently established for each state by individual state chiropractic licensing boards. Since our objective as a profession is unique and non-duplicative, the need for exposure to or teaching of conventional or western medicine in chiropractic is unnecessary.

2. The FSCO feels strongly that to remain a separate and distinct profession we must offer a unique and non-duplicative service. The specificity and skill required to deliver a safe and effective chiropractic adjustment certainly requires some standards and certification, (which are already established by state chiropractic licensing boards), however, we do not believe that they should be those of the medical profession or medical boards. It makes sense that all practices and products, alternative to medical procedures or otherwise, should have certification but that is approved by a consensus of those within that field of care.

3. It has been our position that unity for unity's sake is destined to fail. The fact is we have four different organizations because we have different schools of thought in chiropractic. We do not believe that those of us with a non-therapeutic approach to chiropractic could or would ever join an organization whose approach is therapeutic in nature just so we could have one organization. We are confident that the same holds true for everyone. We are however entirely for the idea of formulating coalitions that might work together for a specific common goal(s).

4. Because our practice is subluxation-exclusive, condition-specific or modality-specific guidelines would not apply. Of course we would quickly add that if your approach is condition-based, which is the case for many in chiropractic, that practice should have condition-specific guidelines that dictate the appropriateness of such care. These guidelines would differ significantly from those applying to subluxation-exclusive practitioners. Specific

guidelines should be developed by practitioners within that field of care and should be based on the minimal standards of care as taught and practiced within each respective profession.

5. We can honestly say that our members concern over malpractice liability is rare or non-existent because of our focused objective and practice procedures used to locate and adjust vertebral subluxation. Inasmuch as we do not provide care as an alternative to medical care or perform medical procedures, the risk factor and liability are minimal as demonstrated by insurance actuarial records.

6. While FSCO members are generally not concerned with risks due to a specific chiropractic adjustment, we can see how some alternative procedures and products might result in such concern. By definition a subluxation is a malpositioned vertebra that results in dysfunction in the nerve system. An adjustment is a non-invasive procedure that lends itself to the correction of the vertebral subluxation. When this is done specifically and skillfully by a chiropractor the risk factor is basically non-existent.

7. We believe that the judicial system as well as already existing state regulatory agencies appropriately and expeditiously address consumer concerns regarding the chiropractic profession.

8. Again, because we do not consider chiropractic to be an alternative to medicine, the importance of communicating information back and forth is minimized. Those engaged in a similar objective (i.e., the treatment of disease) would require a free flow of information between any and all providers, regardless of the condition they are treating and with or without a referral.

9. To assure the quality of CAM practices and products, state-organized agencies (new or already established) should be available to oversee the proper practice of these practitioners. Regarding chiropractic, these agencies already exist and we do not see the need for any additional federal or state agencies at this time.

We appreciate your desire to hear our opinion. If we can be of further assistance to you please do not hesitate to contact me.

Sincerely,

Judith Nutz Campanale, D.C.
FSCO President
judycampdc@aol.com
215-946-6815

Richard Plummer, D.C.
FSCO Chairman, Board of Directors
redplummer@aol.com
864-578-1181

Tab 18

White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-169
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

January 31, 2001

Ms. Andre Weiner
Assistant Director
Feldenkrais Guild of North America
3611 SW Hood Avenue-Suite 100
Portland, OR 97201

Dear Ms. Weiner:

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 Feldenkrais undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than Feldenkrais?
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

FGNA FELDENKRAIS GUILD® of North America

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February 12, 2001

Joseph M. Kaczmarczyk, DO, MPH
White House Commission on Complementary
And Alternative Medicine Policy
6701 Rockledge Drive
Suite 1010, MS-7707
Bethesda, MD 20817

Dear Dr. Kaczmarczyk,

Thank you for contacting our organization. We appreciate the opportunity to comment on the questions sent by Dr. Groft on January 31, and hope to send a representative to your February meeting. This response is being sent by fax and email, and I am mailing a hard copy with a packet of background information about our organization and about the *Feldenkrais Method*® of somatic education.

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

Yes. The FELDENKRAIS GUILD® of North America accredits and sets minimum standards for all teacher training programs in North America. All teachers in North America must be certified. Our certification program describes acceptable continuing education. Please see enclosed information packet which contains relevant information on training accreditation and certification.

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

It is not necessary to include exposure to conventional or alternative medicine in training *Feldenkrais*® teachers. The *Feldenkrais Method*® is a method of somatic education, and is not medically or therapeutically oriented. The method does not address specific maladies or diagnoses but rather aims to improve the functioning of the person. Both conventional and alternative medicine are outside the approved standards of practice for this method of somatic

education, which is used in dance, music and acting schools as well as other educational settings, and private practice.

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?

If there are national standards or certification, they should be appropriate to each discipline to which they are intended to apply. If there is no danger to public health, certification should be optional, and developed within the discipline. Disciplines whose scope does not include medicine should not be included in standards set for traditional, complementary or alternative medicine.

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

We are not a bodywork organization, so we don't have an opinion on this specific question. However, we have found it invaluable, and believe it essential for representatives of disciplines which include the use of touch (either centrally or incidentally) to work cooperatively on regulatory issues which may affect them. We actively participate in the Joint Governmental Relations Committee of the Federation of Therapeutic Massage, Bodywork, and Somatic Practice Organizations (founded in 1991) and participate in meetings twice yearly with other members to discuss other mutual concerns. (See enclosed information.)

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?

Such guidelines should be developed by each profession or discipline. The practice of the *Feldenkrais Method* does not address specific conditions. The guidelines for *Feldenkrais* teachers are set forth in the Standards of Practice for the *Feldenkrais Method*, and in the FGNA Code of Professional Conduct. All *Feldenkrais* teachers receive instruction in general prudent practices as part of their training, and are instructed to educate themselves regarding specific contraindications for touch and/or movement for students who are have received a diagnosis or are under a physician's care.

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

Feldenkrais teachers provide educational services and not CAM practices. Professional liability insurance is available at low rates because the *Feldenkrais Method* is a safe, educational system, and its practice is not invasive or forceful.

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?

Because the practice of the *Feldenkrais Method* is non-invasive, and non-forceful, risk of physical injury is minimal. In any profession involving personal services, there is some risk of sexual misconduct or other inappropriate behavior. All *Feldenkrais* teachers are required to abide by the Standards of Practice for the *Feldenkrais Method*, and the FGNA Code of Professional Conduct. FGNA has an Ethics and Grievance Protocol for the investigation of complaints of violations of these policies, which may result in sanctions including de-certification and loss of right to use the service marks associated with the practice of the *Feldenkrais Method* (*Feldenkrais, Feldenkrais Method, Awareness Through Movement, Functional Integration, Guild Certified Feldenkrais Teacher, Guild Certified Feldenkrais Practitioner.*).

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?

Such mechanisms should be developed by each discipline or profession. (Please see our answer to #6.)

8. What information should a conventional health care provider communicate to a CAM practitioner?

Any contraindications or cautions relevant to the specific practice. Information about prescribed medications, and about specific conditions or diagnoses that may affect an individual's response to the practice.

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?

Information about the specific practice and potential benefits. Information about changes in an individuals symptoms as observed by the practitioner. (This may be quite different for a CAM practitioner than for a *Feldenkrais* teacher)

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?

We recommend that policies which may affect professions and practices which are not included in CAM are not developed without knowledge and input from those who might be affected–for instance, ourselves.

Thank you again for the opportunity to respond to these questions. We look forward to hearing about future activities of the Commission.

Sincerely,

Andrea Wiener
Assistant Director

FELDENKRAIS GUILD® of North America

CERTIFICATION & TRAINING ACCREDITATION

The FELDENKRAIS GUILD® of North America (FGNA) is the organization which sets standards for and certifies all *Feldenkrais*® practitioners in North America. It is affiliated with the International *Feldenkrais* Federation (IFF). The IFF works to keep the practitioner requirements standardized throughout the world. The Guild has Standards of Practice, a Code of Professional Conduct and a grievance process. FGNA accredits all North American training programs. It is licensed to protect the following service marks: *Feldenkrais®, Feldenkrais Method®, Functional Integration®,* and *Awareness Through Movement®* are registered service marks; and *Guild Certified Feldenkrais Practitioner℠* and *Guild Certified Feldenkrais Teacher®* are certification marks of The FELDENKRAIS GUILD®.

In order to practice and use the service marks, a practitioner must be a graduate of a FGNA accredited training program (a minimum of 800 hours over a three- to four-year period), follow the Code of Professional Conduct, and the Standards of Practice, and maintain certification. (See the Certification Requirements for details.) To maintain certification, a practitioner must fulfill continuing education requirements. The certification status of each practitioner is reviewed every two years.

There is a FGNA Ethics Committee which enforces the Code of Professional Conduct. FGNA also vigorously pursues unauthorized use of the service marks.

CERTIFICATION POLICY

FELDENKRAIS GUILD® of North America (FGNA), in certifying a person as a "*Guild Certified Feldenkrais Practitioner*℠" or as a "*Guild Certified Feldenkrais Teacher*®" is certifying to the public that the person has met the requirements for training, experience, and professional development, and that the person is committed to continuing development and to abiding by the Standards of Practice and the Code of Professional Conduct. (Either term being applicable to the work, the person certified may use either "practitioner" or "teacher.")

The requirements for Certification by FGNA are completion of a professional training program that has been accredited by FGNA as providing the necessary preparation for the practice of the *Feldenkrais Method*; active practice of the Method; continuing educational experiences for the first twenty years of active practice; an agreement to maintain accepted standards of practice and code of professional conduct and to refrain from any use of the service marks not expressly authorized.

Certification authorizes the use of the legally service-marked terms *Feldenkrais*®, *Feldenkrais Method*®, *Awareness Through Movement*®, *Functional Integration*®, *Guild Certified Feldenkrais Practitioner*℠, and *Guild Certified Feldenkrais Teacher*®. These terms can be used only as authorized by **FGNA**.

Guild Certified Feldenkrais Practitioners in good standing are authorized to use the service marks in accord with FGNA's Standards of Practice, Code of Professional Conduct, and Guidelines for the Use of the Service Marks:

1. On items directly related to their practice of the *Feldenkrais Method*, including business cards, brochures, flyers, posters, business stationery, signs, and other informational, promotional or advertising materials.

2. On items directly related to training programs accredited by FGNA. All promotional materials for training programs must be reviewed by FGNA for correct use of the service marks before publication.

Certification is not limited to members of FGNA; eligible non-members must sign a licensing agreement accepting the above requirements.

Review of this policy is required to be carried out by the Regional Council and the Board of Directors every five years, using information and recommendations solicited from all practitioners/teachers and from the public.

CERTIFICATION PROCEDURES

Upon notification of graduation by the Educational Director of an Accredited *Feldenkrais* Professional Training Program, FELDENKRAIS GUILD of North America will issue the Certificate to the graduates.

Length of Initial Certification - Initial certification will be extended through Dec. 31 of the year following the year of graduation (end of the 2nd calendar year). To qualify for certification renewal requirements are prorated based on graduation date as follows:

Grads in Jan.-Mar. receive certification through that year and all of the next (21-23 months) and have to fulfill a requirement of 30 hours of continuing education and 150 practice hours.

Grads in Apr.-Jun. receive certification through that year and all of the next (18-20 months) and have to fulfill a requirement of 25 hours of continuing education and 125 practice hours.

Grads in July.-Sep. receive certification through that year and all of the next (15-17 months) and have to fulfill a requirement of 20 hours of continuing education and 100 practice hours.

Grads in Oct.-Dec. receive certification through the rest of that year and all of the next two years (24-27 months) and have to fulfill a requirement of 40 hours of continuing education and 200 practice hours.

Recertification is effective for two years. FGNA will then issue the renewal Certificate to those eligible who sign a statement attesting the requirements have been met for both professional experience and continuing education, and that he/she agrees to maintain accepted Standards of Practice and Code of Professional Conduct. The person will keep his own records of experience and education and provide information to FGNA if requested. The renewal fee is included in FGNA membership dues. A separate fee for renewal will be charged eligible nonmembers.

Lifetime certification, not requiring further renewal, will be granted when you have continuously practiced the *Feldenkrais Method* for twenty years or more since graduation, providing you continue to meet the Standards of Practice and Code of Professional Conduct.

FGNA may decertify you as part of penalties imposed for violations of Standards of Practice or Code of Professional Conduct, or for any use of the service marks not expressly authorized. Reinstatement may be made only in keeping with the provisions of the prescribed penalties.

Lapse of Certification — Practitioners whose certification expired less than two years before applying for certification renewal must furnish documentation of completion of a minimum of 20 hours of: a) advanced training taught by a Guild Certified Feldenkrais Practitioner with at least four years of professional experience; or b) attendance at a Guild accredited professional training program. These practitioners will then be eligible for Provisional Certification.

Practitioners whose certification expired more than two years before appying for certification renewal must furnish documentation of completion of a minimum of 50 hours of: a) advanced training taught by a Guild Certified Feldenkrais Practitioner having at least four years of professional experience since graduation; or b) participation in a Guild accredited professional training program. These practitioners will then be eligible for Provisional Certification.

Provisional Certification— If certification has expired or a practitioner is decertified, and the above requirements are fulfilled, Provisional Certification may be granted for a period of up to two years. This allows practitioners to use the terms protected by FGNA while fulfilling the requirements for professional experience and continuing education. After fulfilling the requirements for two years, practitioners are eligible for full certification.

Sabbatical — you may take a"sabbatical" leave for up to one year out of any seven year period for various reasons such as health, child care, travel, study, work, etc. During your "sabbatical" you are exempt from meeting continuing education and professional experience requirements, without jeopardizing your certification status. Only you can justify the reason for "sabbatical." You must notify FGNA of the reason, and the beginning and ending date.

REQUIREMENTS FOR CERTIFICATION RENEWAL

1. **Professional Experience** — Each year you must be engaged in at least 100 hours of professional practice of the *Feldenkrais Method.*

2. **Continuing Education** — 40 hours every two years, in whole or in part in any of the following ways:

   a. ***Feldenkrais* Advanced Training** — attendance at seminars, workshops, and accredited professional training programs offered by any Guild Certified Practitioner having four or more years of professional *Feldenkrais* experience since graduation.

   b. **Self-Directed *Feldenkrais* Study** — participation in peer study groups (practitioners gathering to demonstrate their skills in FI and ATM, giving and receiving constructive feedback, as well as analyzing issues related to understanding *Feldenkrais* and the professional practice of the Method); study with another *Feldenkrais*

practitioner in order to learn additional application of the Method; and review of Moshe Feldenkrais' Amherst Training and Functional Integration videotapes.

c. **FELDENKRAIS GUILD of North America Annual Conference** — it is intended that this will meet the 20 hours requirement for the year.

d. **Teaching Experience** — *Guild Certified Feldenkrais Practitioners/Teachers* with at least four years of professional experience since graduation may meet up to half of the continuing education requirement by teaching an equivalent number of hours of classes, workshops or seminars to other members of the *Feldenkrais* community. One does not have to be an authorized Trainer or Assistant Trainer in order to teach advanced trainings.

Trainers and Assistant Trainers may meet the continuing education requirement by teaching an equivalent number of hours in an FGNA accredited professional training program, or an advanced training.

Adopted by FGNA October 1997

Revised 6/99, 11/99

FELDENKRAIS GUILD® of North America

PROFESSIONAL TRAINING IN THE *FELDENKRAIS METHOD®*

Understanding *Feldenkrais®* work requires learning how to learn. By intimately understanding the learning process, the *Feldenkrais* trainee comes to know how to create the conditions for others to learn. An extended in-depth period of apprenticeship and guidance is needed to appreciate and utilize the infinite variety of possible human movements. During this apprenticeship one acquires the sophistication necessary to create, in oneself or others, new behavioral patterns while inhibiting destructive and limiting patterns. The Method has two teaching modalities: *Awareness Through Movement®* and *Functional Integration®*.

An *Awareness Through Movement* lesson is one in which instructions are given verbally. Each contains highly sophisticated movement sequences that create new movement skills in the individual, or improve existing ones. These movement lessons stem from a deep understanding and integration of physics, especially Newtonian mechanics and thermodynamics, neurology, biology, evolution, and conditions necessary for learning. The lessons evolve from early basic movements, gradually developing into highly complex human skills. Through these lessons, the individual dramatically improves the quality of habitual daily movements and acquires new movement skills and coordination. Over time the individual discovers an increasing ease of forming intentions and acting upon them and what seemed impossible often becomes possible.

The process is gradual and supportive to ensure successful learning. Eventually, the lessons can be done alone, gradually building self-sufficiency and independence. Lessons are fun to do, instill a feeling of well-being and are always new.

In *Functional Integration* the practitioner creates a movement lesson custom-tailored to the unique needs of each student. The trained practitioner has learned to use his/her hands to communicate movement in a way that new sensory configurations and new motor organization will be experienced and learned by the student. The student learns to recreate these new sensory and motor patterns which then create a new movement organization beyond his/her previous repertoire of movements. Learning these additional movements gives the students more freedom of choice and action. The lessons are given with extraordinary gentleness and sensitivity to students who range from a few days old to people of advanced age. This is not a curative process; the purpose of touch is to communicate movement.

The *Feldenkrais* practitioner spends hundreds of hours studying a vast repertoire of movements and learns to recognize the finest details in the gestalt of each of these movements. The practitioner also learns to understand and recognize complex psychological, biological and neurological components of the learning process. This unique knowledge, combined with highly trained and sensitive hands, is used to communicate to the student new ways to move.

The training process is structured as an integrated gestalt lasting over the entire course of the training period (four years, 200 hours per year). The formal *Feldenkrais* Training differs from regular schools in that the trainee is involved in a continuous experiential movement process rather than presented a certain number of independent courses. Conceptual and theoretical information is introduced while the student is doing pertinent, associated movement processes.

In the long run, the academic knowledge we deem necessary is fully presented; the difference is that it is not presented separately. For example, while learning to do a movement of early childhood, there will be lectures in developmental neurology that address the experiential aspects from a theoretical point of view.

The main purpose of the training is for the trainees to acquire for themselves a deep understanding in awareness of movement and its formation, to become aware of the movement in themselves, to become astute observers of movement in others, and to be able to teach other people to enlarge their awareness and movement skills. The training process is based upon the vast body of knowledge Dr. Feldenkrais introduced. Since he integrated into his body of learning theory aspects from a variety of scientific fields, such as Newtonian mechanics, physics, neurophysiology, movement development, biology, and learning theories, we present some of these aspects in the training program for the trainee to comprehend the theoretical background of the method.

Learning Experiences - Trainees participate in *Awareness Through Movement* and *Functional Integration* lessons, lectures, discussions, group process, and videos of Dr. Feldenkrais teaching, as well as seminars with visiting teachers. Eventually students teach *Awareness Through Movement* and *Functional Integration* under supervision. Trainees gradually acquire knowledge of how movement and function are formed and organized. This extensive subjective experience forms the basis from which he/she will learn to work with others.

Location, Dates, Duration - Programs are held in various parts of the USA and Canada as well as in several European countries, Australia, Israel, Mexico, Japan, and South America. Usually two to four programs begin in the USA each year and span a period of 38 to 46 months, eight weeks a year. A minimum of 800 hours of training, usually comprising 160 days, is required. Usually several segments, from two to four weeks in length, are held each year. Occasionally, a program will hold eight weeks (40 days of training) consecutively.

Faculty - Each program has an experienced Certified *Feldenkrais* Trainer as the Educational Director, who serves as the lead teacher and is responsible for coordinating the teaching plan and for assembling the training staff. A minimum of four different Guild Certified Trainers is required in each program. A diversity of teaching styles is valuable in the process of learning the *Feldenkrais Method* and in developing your own understanding and expression of the work.

Requirements - Knowledge and experience from a variety of professional and occupational fields is encouraged. Generally no specific academic background is required. The process of application may vary from program to program, and interested persons are encouraged to contact the training organizers directly for detailed application information. Additional specific requirements may be needed to practice in some states and countries.

The FELDENKRAIS METHOD®

Taught by a *Guild Certified Feldenkrais Practitioner*[cm] , the *Feldenkrais Method*® is an educational system which uses movement to bring about improved functioning. It does this by, first, helping the student become aware of his/her existing patterns of action and, second, guiding the student in the discovery of additional possibilities for action.

The *Feldenkrais Method* has a broad range of applications. For example, this approach to learning may reveal and alter habitual behaviors responsible for chronic tension and pain; it facilitates recovery of movement diminished by injury or trauma; it can also improve skills for athletes, dancers, musicians, etc. The intent of the Method is to assist students to live more fully, comfortably and effectively by expanding their repertoire of possible movements and actions.

There are two forms of *Feldenkrais*® lessons:

Awareness Through Movement® **(ATM)**, the verbally directed form of the *Feldenkrais Method*, consists of gentle exploratory movement sequences organized around a specific human function, (i.e.: reaching, bending, walking) with the intention of increasing awareness of multiple possibilities of action.

ATM lessons are usually taught to a group of students whose attention is directed to a generally slow and delicate exploration of an action. This is often done standing, sitting or lying on the floor, but can be conducted in other settings. Thinking, sensory perception and imagery are also involved in examining each function. Complexity of lessons may vary according to the movement ability of the student(s).

Functional Integration® **(FI)** lessons consist of a practitioner using words and gentle, non-invasive touch to guide an individual student to an awareness of existing and alternative movement patterns. The teacher communicates to the student how she or he organizes her or himself and suggests additional choices for functional movement patterns.

In FI the intent of the touch is to communicate, not to correct. It evolves out of the immediate need to convey information to the student. It is designed to enhance personal awareness and produce explicit changes in functioning that will manifest in the student's actions. The student is clothed and might be lying, sitting, standing, kneeling, or in motion. As in ATM, lessons may be organized around a specific human function, (i.e.: reaching, bending, walking) with the intention of increasing awareness of multiple possibilities of action.

* * * * * * * * * * * * * * * * * * * *

A means of learning more effective use of one's whole self, the *Feldenkrais Method* does not diagnose or provide a cure for any medical condition, nor is it a substitute for medical or therapeutic care. There are no specific techniques of pressing or stroking (such as petrissage or effleurage) involved. The relaxation,

greater comfort and lessened pain people often feel after a lesson are secondary to the improvement in personal organization.

Feldenkrais Method® SCOPE OF PRACTICE

The *Feldenkrais Method* is a system of somatic education. It uses movement and attention to bring about increased awareness and improved functioning through learning. *Feldenkrais*® practitioners help their students to become aware of existing patterns of action and guide the discovery of additional possibilities for action. Touch and words are vehicles to help eliminate faulty habits, learn new patterns of self-organization and action, and improve the person's own natural mechanisms of healing and self-regulation. The Method is based on principles of physics, bio-mechanics and an understanding of learning and human development.

Practitioners of the *Feldenkrais Method* actively use this approach in many working settings, such as educational institutions, the Arts, corporate and business; personal growth and wellness, the helping professions, physical fitness, athletics, and martial arts, and independent private practice.

The *Feldenkrais Method* is not a form of massage. There are no identifiable or recognizable massage techniques used in the *Feldenkrais Method*. Many *Feldenkrais* lessons do not involve touch at all. In those lessons which do involve touch, the intent of the touch is educational; the student is fully clothed, and the touch is gentle, non-invasive and non-corrective.

The *Feldenkrais Method* is not medically or therapeutically oriented. The *Feldenkrais* practitioner does not make any medical claims, does not diagnose or purport to cure; and does not prescribe medications.

*For a complete scope of practice for the *Feldenkrais Method*, see the Standards of Practice for the *Feldenkrais Method*.

Tab 19

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. Shirley Norwood
President
Hellerwork International
3435 M Street
Eureka, CA 95503

Dear Ms. Norwood:

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 hellerwork undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than hellerwork?
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

I am answering the following questions as a representative of Hellerwork Practitioners, and specifically in regard to Hellerwork Practitioners, not as a consumer of CAM services at large.

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

YES

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

OUR STUDENTS OFTEN HAVE SOME BACKGROUND ALREADY, AND OUR TRAINING INCLUDES ANATOMY, PHYSIOLOGY AND PATHOLOGY

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

THAT WOULD BE ACCEPTABLE, AND EVEN HELPFUL, TO US

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

WE ARE ALREADY IN THE PROCESS OF INVESTIGATING THE POSSIBILITY OF JOINING WITH OTHER "STRUCTURAL INTEGRATION BODYWORKERS (specifically the Rolf Institute and the Guild of Structural Integration) REGARDING THE CREATION OF A NATIONAL CERTIFICATION EXAMINATION (based on the model of the current exam for Massage Therapists) THAT WOULD BE SPECIFIC TO OUR MODALITY.

3. Should the numerous bodywork organizations come together to form "a community?"

WE WOULD WELCOME SUCH A MOVE

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

VOLUNTARY, RATHER THAN GOVERNMENT SPONSORED, AND IT SHOULD INCLUDE THE PRESIDENT OR EXECUTIVE DIRECTOR OR SOME OTHER HEAD OF EACH NATIONAL ORGANIZATION OR PRACTITIONER ASSOCIATION. If the WHC on CAM had all the names and addresses, perhaps they could provide the initial mailing list and call to convene, then let it go on organically from there. THE PURPOSE SHOULD BE COOPERATION FOR MUTUAL GOOD, NOT ONE OR MORE GROUPS SEEKING TO DICTATE OR HAVE POWER OVER THE OTHERS.

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

AS STATED BEFORE, THESE WOULD BE WELCOME IF WE IN THE STRUCTURAL INTEGRATION COMMUNITY CREATED THEM OURSELVES, SO THAT THEY APPLIED TO US.

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

SEE ABOVE. THEY SHOULD APPLY TO ALL PRACTITIONERS OF STRUCTURAL INTEGRATION, AND THEY COULD BE IMPLEMENTED (see Question 2 above) with a National Certification Exam, THEN WRITTEN INTO OUR RESPECTIVE PRACTITIONER AGREEMENTS AND REQUIREMENTS FOR CERTIFICATION.

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

ALL HELLERWORK PRACTITIONERS CARRY PROFESSIONAL LIABILITY INSURANCE, AT A VERY REASONABLE COST, SINCE NOT ONE OF US HAS EVER BEEN 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?

NOT THAT WE ARE AWARE OF

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

YES

If so, what should that mechanism be?

WE ALREADY HAVE SUCH A MECHANISM IN OUR "PROCEDURE FOR MEDIATION AND RESOLUTION". If you would like a copy, please eMail me and I will send it to you.

8. What information should a conventional health care provider communicate to a CAM practitioner?

THE DIAGNOSIS (we don't diagnose), THE NUMBER OF SESSIONS PRESCRIBED, AND ANY MEASURABLE OUTCOME THEY MIGHT BE SEEKING.

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?

ASSESSMENT OF INITIAL MOBILITY AND FUNCTIONALITY, SESSION NOTES THAT DESCRIBE AREAS WORKED ON AND RESULTS ACHIEVED AND ENDING ASSESSMENT.

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?

THAT THE PUBLIC LOOK TO SEE IF A HELLERWORK PRACTITIONER IS "CERTIFIED" (meaning that they are a member of their professional association, follow the Code of Ethics and Procedure for Mediation and Resolution, do 36 hours of continuining education every two years, have professional liability insurance, and have any other licensure that might be required by their locale - a business license, a massage license, etc.

Ms. Shirley Norwood
President
Hellerwork International

Tab 20

White House Commission on Complementary and Alternative Medicine Policy

6701 Rockledge Drive, Suite 1010, MS-7707, Bethesda, Maryland 20817 tel: 301-435-7592 fax: 301-480-169
E-mail: whccamp@mail.nih.gov Website: www.whccamp.hhs.gov

February 3, 2001

Executive Director
Institute of Noetic Sciences
101 San Antonio Road
Petaluma, CA 94952

Dear Executive Director:

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 mind-body undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than mind-body approaches?

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 mind-body 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?

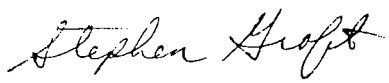
5. Are your members concerned about malpractice liability associated with providing CAM practices and products?

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

Tab 21

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 29, 2001

Mr. Ronald M. Hendrickson
Executive Director
International Chiropractic Association
1110 North Glebe Road-Suite 1000
Arlington, VA 22201

Dear Mr. Hendrickson:

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 chiropractic undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM?
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 chiropractic 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?
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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

CHIROPRACTIC SCIENCE AND PRACTICE IN THE UNITED STATES:

A REPORT TO THE WHITE HOUSE COMMISSION ON COMPLIMENTARY AND ALTERNATIVE MEDICINE POLICY

ON BEHALF OF

THE INTERNATIONAL CHIROPRACTORS ASSOCIATION

BY RONALD M. HENDRICKSON
EXECUTIVE DIRECTOR

February 14, 2001

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Appendix A: A Summary of Studies on Benefits from Chiropractic Care

PREFACE

The International Chiropractors Association (ICA) welcomes this important opportunity to offer comment and information on the status of the chiropractic profession in the dynamic, complex and increasingly competitive health care marketplace in the United States. Chiropractic has had more than a century to explore the potential as well as the limitations of its science and to find its place in the educational, regulatory, and health care delivery, administration and funding systems in the United States and in many other nations around the world. The experience of the chiropractic profession holds important lessons and experiences which other approaches to health and healing might benefit.

The International Chiropractors Association is grateful to the White House Commission on Complimentary and Alternative Medicine for providing this opportunity to share information and perspectives on emerging alternatives in the health care system. We hope this dialogue will be expanded and extended in every possible direction, all to better serve the consumer and to foster an environment of objective exploration and research on emerging health care procedures.

The material contained in this initial paper attempts to summarize some of the basic components of chiropractic science and practice. It focuses on the unique nature of chiropractic as a profession because of the need to fully understand the separate and distinct nature of chiropractic science and practice. A wealth of literature exists to support and amplify every aspect of this initial discussion. ICA looks forward to a positive and serious exploration of the ways and means to fully integrate the widest possible range of health care choices into the fabric of our nation's public and private health care options.

We believe that the contents of this paper address in a systematic and well-referenced manner the questions set forth by the Commission to guide the discussion on this important series of public policy issues. One important question, however, will be the subject of debate and discussion for the next century. That question, as posed by the Commission in its call for information, states:

> *What policy recommendations would you like to make to assure the quality of CAM (complimentary and alternative medicine) practices and products whether they are provided by a practitioner or used as self care?*

The International Chiropractors Association (ICA) would, on the basis of the experience of the chiropractic profession, offer the following points:

A. The research and exploration of alternative and complimentary procedures, at appropriate objective standards, must be a priority for all emerging approaches to health care. The funding of such research should, however, be a high public policy priority. Traditional, entrenched interests have, in the case of chiropractic, argued against the inclusion of chiropractic care in public health programs because of insufficient research data. At the same time, for anti-competitive reasons, those same interests lobbied aggressively to prevent public funding for chiropractic research. Other sciences and health procedures should have the benefit of objective, timely and publicly funded research to explore their full potential and to identify their limitations.

B. Every consumer is entitled to full and honest information about any new health procedure. Clarity and accuracy in describing new technologies and health procedures is essential for the protection of the public and the honest evaluation of such procedures in the outcomes process. Public guidelines regarding disclosure and the making of health care effectiveness claims should be a high priority, especially in cases where practitioners of emerging procedures may not be certified or licensed in the civil regulatory process.

C. Public information agencies at the federal and state level should be mobilized to serve as responsible, objective information resources for consumers of health care choices. The utilization of the Internet and other public health information and outreach systems for purposes of informing citizens on new health research findings, choices and concerns would certainly be in the best interests of all parties, provider and consumer alike.

D. Standard trial and pilot study procedures should be developed to study and, if results are positive, integrate new technologies and procedures into federal health care programs such as Medicare, Medicaid, Federal Employee Health Benefits Programs, veterans care and other health care funding and delivery programs.

E. Guidelines for the incorporation of emerging health procedures and technologies into private health insurance should be developed on a national level.

These key points would help to provide a climate of objective and timely evaluation of health procedures to the maximum benefit of the consumer and those public and private systems of health care funding and administration that are and will continue to be under severe financial pressure to provide the highest quality care at the lowest possible price. The present system is heavily weighted towards hospital and institutional based, orthodox medical care, anchored in surgery and drug therapy, and increasingly radical, end-stage interventions. This system must be altered to remove the inertia and, too often, sheer prejudice and medical bias that has obstructed the exploration of alternatives. The ultimate issue is quality of life. In the decisions that consumers may make, the widest possible range of choices is the best guarantee of optimal care.

CHIROPRACTIC SCIENCE AND PRACTICE: AUTHORITIES AND DEFINITIONS

OVERVIEW

Chiropractic is a very specific health care science applied by doctors of chiropractic who practice under an extensive body of authorities. These authorities have evolved over more than a century of legislative and judicial development, educational growth, practical experience and professional consensus. Like other first professional degree holders, the doctor of chiropractic is a carefully regulated professional who must qualify on a number of levels to obtain the right to practice. This overview outlines the exact nature of the authorities under which contemporary doctors of chiropractic practice and sets out those basic definitions that explain and delineate the essential elements of the science and its practice.

Chiropractic science is an approach to human health that was developed through extensive anatomical study in which the elements of the human system, particularly the spine and nervous system continue to be examined in an effort to understand the relationship between the state of those anatomical elements and optimal human health. The basic premise of chiropractic science is that abnormalities and misalignments of the spine, defined as subluxation(s) in chiropractic science, can and do distort and interrupt the normal function of the nervous system and may create serious negative health consequences. The correction and/or reduction of subluxation(s) through the adjustment of spinal structures can remove nervous system interference and restore the optimal function of the body. Essential to basic chiropractic theory is the concept of the inherent ability of the human body to effectively maintain optimal health, comprehend the environment and function in a normal manner. This concept is important since chiropractic perceives spinal subluxation(s) as barriers to normal function and obstacles to the body's innate intelligence.

Chiropractic science is largely based on anatomical study and human systems functions. Chiropractic scientific observations are compatible with and support the chiropractic

philosophy. Chiropractic philosophy represents the unique chiropractic approach to health and healing.

Chiropractic has enjoyed over a century of lively and serious scientific and conceptual debate. The chiropractic profession has benefited enormously from this on-going, self-examination and reality testing based on the scientific and research record. The outcome of those years of critical evaluation and debate, which remain on-going, has been a strong consensus regarding the nature of chiropractic science and practice and the key definitions that set chiropractic apart as a distinct, unique health care science and practice. This consensus is best depicted by the unanimous adoption of a paradigm statement by the Association of Chiropractic Colleges, International Chiropractors Association, American Chiropractic Association, Federation of Chiropractic Licensing Boards, Council on Chiropractic Education, the National Board of Chiropractic Examiners and the Congress of Chiropractic State Associations. This paradigm statement reads as follows:

Chiropractic is a health care discipline which emphasizes the inherent recuperative power of the body to heal itself without the use of drugs or surgery.

> *The practice of chiropractic focuses on the relationship between the structure (primarily the spine) and function (as coordinated by the nervous system) and how that relationship affects the preservation and restoration of health. In addition, Doctors of Chiropractic recognize the value and responsibility of working in cooperation with other health care practitioners when in the best interest of the patient.*

THE CHIROPRACTIC PARADIGM

Purpose

The purpose of chiropractic is to optimize health.

Principle

The body's innate recuperative power is affected by and integrated through the nervous system.

Practice

The practice of chiropractic includes:

- establishing a diagnosis;
- Facilitating neurological and biomechanical integrity through appropriate chiropractic case management; and
- promoting health.

Foundation

The foundation of chiropractic includes philosophy, science, art, knowledge, and clinical experience.

Impacts

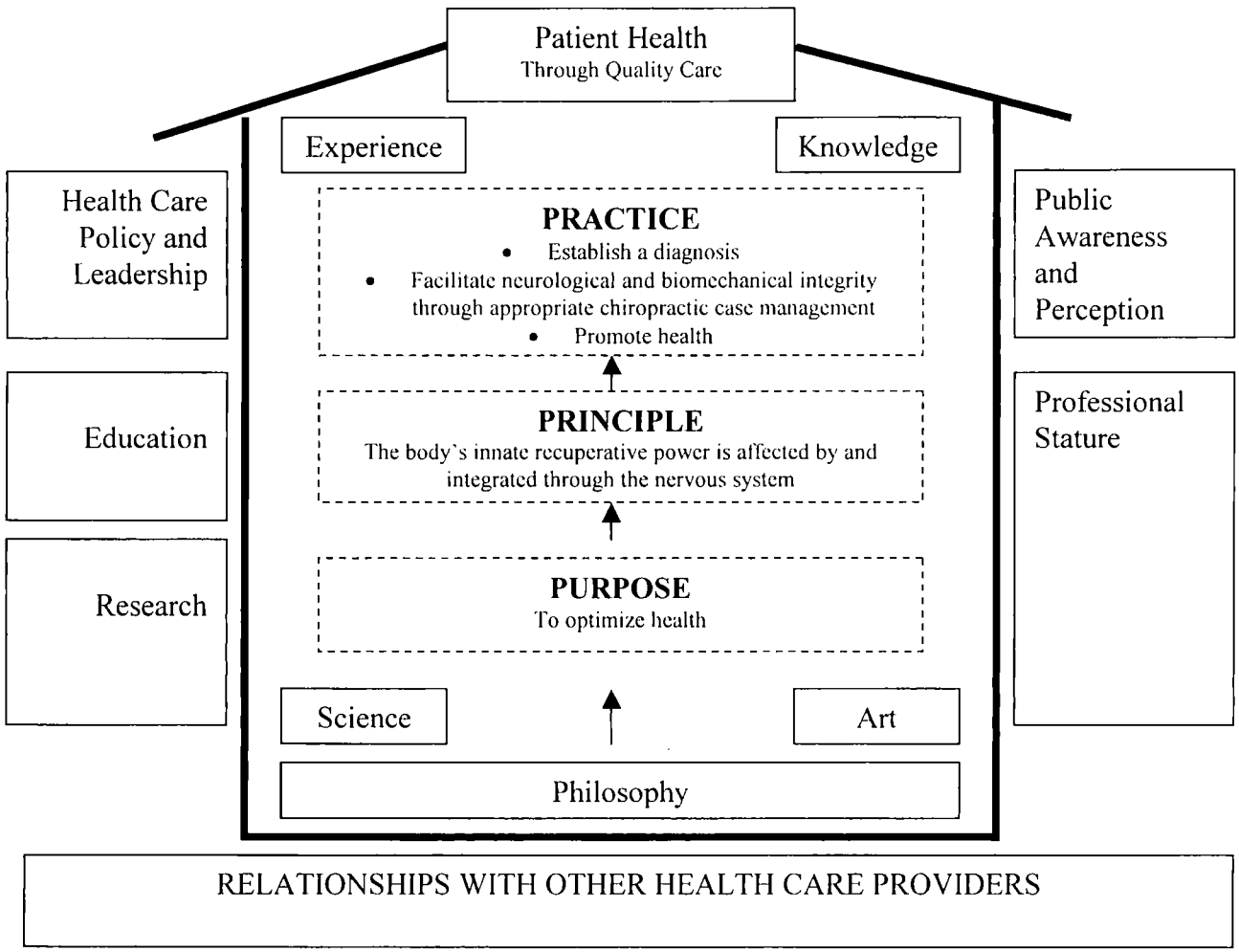
The chiropractic paradigm directly influences the following:

- education;
- research;
- health care policy and leadership;
- relationships with other health care providers;
- professional stature;
- public awareness and perceptions; and
- patient health through quality care.

The Subluxation

Chiropractic is concerned with the preservation and restoration of health, and focuses particular attention on the subluxation.

The ACC Chiropractic Paradigm



A subluxation is a complex of functional and/or structural and/or pathological articular changes that compromise neural integrity and may influence organ system function and general health.

A subluxation is evaluated, diagnosed, and managed through the use of chiropractic procedures based on the best available rational and empirical evidence.

CHIROPRACTIC EDUCATION

To obtain a license to practice chiropractic in any of the 50 states requires the degree of doctor of chiropractic from an accredited chiropractic educational institution or program. Chiropractic educational standards are strict and demanding, requiring study in the basic sciences comparable to medical, dental and osteopathic curricula. This education consists of four or more years of full-time, in-residence study is required in human anatomy, physiology, biomechanics, chiropractic diagnosis/analysis, adjustive techniques, public health issues and chiropractic philosophy.

Chiropractic college students must complete a rigorous and uniquely specialized program of classroom and practical training that includes more than 2,000 hours of study of the anatomy, dynamics and biomechanics of the human spine and the nature and components of the spinal subluxation complex. No other health care professional devotes this level of serious scientific study to the human spine. A detailed examination of the curricula offered by federally accredited chiropractic institutions illustrates the uniqueness of chiropractic and the highly specialized nature of chiropractic professional education.

Chiropractic students are thoroughly trained in the appropriate use of sophisticated diagnostic technology including imaging procedures such as x-ray, thermography, video-fluoroscopy, magnetic resonance imaging and other state-of-the-art investigative technologies and procedures. The capacity to evaluate the health care needs of the chiropractic patient, including appropriate referrals to other health professionals when necessary, is an important objective of chiropractic education.

Chiropractic education is designed not only to impart scientific knowledge, but to develop clinical skills and proficiencies that "represent those minimal skills a candidate should demonstrate when presenting for licensure after completing the educational program." These areas of clinical competency include the taking of patient histories, physical examinations, imaging studies, chiropractic analysis/diagnosis or clinical impressions, referral, care plans, spinal adjusting, case follow-up, record keeping and others.

Nearly 14,000 students attend the 16 chiropractic colleges accredited by the Commission on Accreditation of the Council on Chiropractic Education (CCE), according to 1999 data.

The Commission on Accreditation is recognized by the U.S. Department of Education. The standards adopted by the Council on Chiropractic Education, "indicate the minimum education expected to be received in the accredited institutions that train students as chiropractic primary health care providers." CCE standards were developed as a measure of the quality of programs offered by chiropractic institutions.

CCE standards were developed to reflect the needs of chiropractic professional education and the broad consensus that has evolved regarding chiropractic professional instruction. Chiropractic education, even prior to the existence of the CCE, offered professional instruction sufficient to meet the requirements for licensure in the various states. The forward to the "Standards for Chiropractic Institutions" of the CCE defines the role of a doctor of chiropractic and his/her professional education as follows:

> *"A Doctor of Chiropractic is a physician whose purpose is to help meet the health needs of the public as a member of the healing arts. He/she gives particular attention to the relationship of the structural and neurological aspects of the body and is educated in the basic and clinical sciences as well as in related health subjects. Chiropractic science concerns itself with the relationship between structure (primarily the spine), and function (primarily coordinated by the nervous system), of the human body as that relationship may affect the restoration and preservation of health."*
>
> *"The purpose of his/her professional education is to prepare the doctor of chiropractic as a primary health care provider; to provide the students with a base of knowledge sufficient for the performance of his or her professional obligations as a doctor of chiropractic. As a portal of entry to the health delivery system, the doctor of chiropractic must be well educated to diagnose for chiropractic care, to provide chiropractic care, and to consult with, or refer to, other health care providers as indicated."*

Most CCE accredited chiropractic colleges have sought to further demonstrate their academic strength by qualifying for recognition and accreditation by regional accrediting agencies. For example, Life University in Marietta, Georgia, is accredited by the Southern Association of Colleges and Schools; and Palmer College of Chiropractic in Davenport, Iowa, is accredited also by the North Central Association of Colleges and Schools.

THE LEGAL ESTABLISHMENT OF CHIROPRACTIC

The practice of chiropractic is a privilege authorized by the legislatures of the various states under the authorities reserved to the states in the U.S. Constitution. The realities of chiropractic practice flow from this legal establishment, and, ultimately, in every instance, the doctor of chiropractic will be held accountable to such provisions, statutes and regulations as have been established by state law. Any attempt to encode professional practice guidelines for the chiropractic profession must begin with a thorough, objective examination of this legal establishment and reflect the realities, authorities and limitations contained therein.

The legal development of chiropractic began shortly after the initial articulation of chiropractic principles and, by the 1920s, chiropractic was well on the way to formal legal recognition and regulation through licensure in numerous states. The first law passed by a state legislature authorizing and regulating the practice of chiropractic as a separate and distinct health care profession was in Kansas on March 20, 1913. This action was followed in quick succession by the legislature of North Dakota in that same year, and by Arkansas, Oregon, Nebraska and Colorado, by 1915. This represented the beginning of a recognition process that was not completed until 1974 when Louisiana finally adopted a chiropractic licensure law.

The statutes governing the practice of chiropractic are worded similarly in every state. All states statutes have recognized chiropractic as a primary contact health care profession applying its unique science and procedural approach to health care. Common to all state statutes is an emphasis on the spinal adjustment procedure and such diagnostic activities as are necessary to properly perform this function and to protect the public. A second common thread running through the legal mechanisms establishing chiropractic is the drugless and non-surgical nature of chiropractic science. Chiropractic like podiatry, dentistry, and optometry exist as a legal exception to the practice of medicine with its own area of application and clinical expertise care of the articulations of the human frame, particularly the spine, through the application of chiropractic adjustments, etc. as a science and art.

The status of the doctor of chiropractic, as established by statute, training and experience, includes the ability and authority to evaluate the general health status of an individual for certification purposes, in the context of a required physical for school, employment, sports and, as federally authorized, approval to operate heavy transportation machinery. The U.S. Department of Transportation authorizes DC's to perform physical examinations for long-distance truck drivers, etc.

Such physicals are a routine part of chiropractic practice. The clinical competence to perform such evaluations and through standard health status measures such as blood pressure, heart rate, etc. , make a statement about the general health of an individual does not necessarily include an obligation or authority to develop a full-body medical diagnosis or to perform procedures outside the recognized scope of chiropractic. In the presence of abnormal findings in the course of routine physical examinations for specific purposes, such as those cited above, the DC follows the standard chiropractic care pathways as described in chapter 2, making such care decisions (including referral) as are clinically indicated on an individual basis.

Doctors of chiropractic are also obligated to perform certain public health functions that are common to all primary contact, doctor level health care professionals. Many state laws obligate the doctor of chiropractic to report child abuse, spouse abuse, certain communicable diseases and other findings to public health authorities. Likewise, the doctor of chiropractic may have responsibilities under state laws and regulations to take action in the presence of substance abuse.

The process by which the several state legislatures developed statutory language and authority for the practice of chiropractic have been very specific in identifying chiropractic as a branch of the healing arts that is separate and distinct from all others. In particular, statutes tend to be especially clear and specific in identifying chiropractic as a practice apart from, distinct from and not the practice of medicine. The following citations from a number of current state statutes convey this distinct, "not medicine" element in chiropractic's legal establishment:

> **Idaho**: *Chiropractic practice, as herein defined is hereby declared not to be the practice of medicine...*(Idaho Code Title 54, Chapter 7: 54-704 Chiropractic practice, No. 3.)
>
> **Kentucky:** *The practice of chiropractic shall not include the practice of medicine or osteopathy...* (Kentucky Revised Statutes Annotated Title XXVI Chapter 312: 312.015 Definitions for Chapter, No. 5.)
>
> **Maine**: "*...and chiropractic is declared not to be the practice of medicine, surgery, dentistry or osteopathy."* (Maine Revised Statutes Annotated, Title 32 Chapter 9, Subchapter 1, 451.Definitions)
>
> **Maryland**: *Except as otherwise provided in this title, "practice chiropractic" does not include the use of drugs or surgery, or the practice of osteopathy, obstetrics, or any other branch of medicine.* (Annotated Code of Maryland Title 3, Subtitle 1 section 3-101.Definitions, (f)(3).

Minnesota: *The practice of chiropractic is not the practice of medicine, surgery, or osteopathy.* (Minnesota Statutes Annotated Health Chapter 148, Sec. 148.01.Chiropractic, No. 2.)

An enormous body of judicial decisions and opinions, reaching back nearly 100 years, likewise identifies chiropractic as a practice different from medicine. Such decisions reflect the strong positions outlined in statutory languages regarding the separateness of chiropractic. This statutory and judicial record has clarified the status of chiropractic beyond dispute and/or doubt, and has established chiropractic as a science, art, philosophy and practice distinct from and different from medicine.

The other common theme is the legislative guarantee to the chiropractic professional of access to appropriate diagnostic technology. All jurisdictions in the U.S. authorize x-ray applications and a list of other technologies is common in state statutes. Also, there are common limitations, such as the prohibition to the use of x-ray technology for therapeutic, as opposed to diagnostic purposes. Many states have demonstrated through legislation a commitment to arm the DC with diagnostic technologies appropriate to actual practice needs, and to protect the patient.

State laws have clearly established chiropractic as a separate professional endeavor and spell out in considerable detail the parameters of chiropractic practice. The specialized nature of chiropractic is particularly evident when one contrasts chiropractic scope and licensure to the practice of medicine in all its branches.

THE STATUTORY ESTABLISHMENT OF CHIROPRACTIC RESPONSIBILITY FOR CLINICAL ACTIVITY RELATED TO THE NERVOUS SYSTEM

The scopes of practice established by state legislatures are, in most instances, quite specific. Among the core concepts embodied in law is the relationship between the chiropractic adjustment and/or manipulation and the functions of the nervous system.

Most states have enacted statutes that contain specific references to the neurological responsibility of the doctor of chiropractic, relating nerve interference to human dysfunction. This nerve interference is recognized by statute to have human health consequences and constitutes the primary chiropractic diagnosis. No state statute requires a patient to present conditions or symptoms other than the finding of such nerve interference to fall within the realm of chiropractic professional competence.

Examples of state statutes that identify caring for the nervous system as a primary responsibility of the doctor of chiropractic include:

> ***Alabama**: The term "chiropractic," when used in this article, is hereby defined as the science and art of locating and removing without the use of drugs or surgery any interference with the transmission and expression of nerve energy in the human body. (Code of Alabama 1975 Title 34, Chapter 24, Article 4, Division 1 Section 34-24-120 (a)*
>
> **Colorado**: *"Chiropractic" means that branch of the healing arts which is based on the premise that disease is attributable to the abnormal functioning of the human nervous system. It includes the diagnosing and analyzing of human ailments and seeks the elimination of the abnormal functioning of the human nervous system by the adjustment or manipulation, by hand, of the articulations and adjacent tissue of the human body, particularly the spinal column.* (Colorado Revised Statutes Annotated Title 12, Article 33 Part 1 Section 12-33-102(1)
>
> **Florida**: *"Practice of chiropractic" means a noncombative principle and practice consisting of the science, philosophy, and art of the adjustment, manipulation, and treatment of the human body in which vertebral subluxations and other malpositioned articulations and structures that are interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells of the body, thereby causing disease, are adjusted, manipulated, or treated, thus restoring the normal flow of nerve impulse which , produces normal function and consequent health by chiropractic physicians using specific chiropractic adjustment or manipulation techniques"*(West's Florida Statutes Annotated, Title XXXII, Chapter 460, 8a).
>
> **Indiana**: *"Chiropractic" means the diagnosis and analysis of any interference with normal nerve transmission and expression, the procedure preparatory to and complementary to the correction thereof by an adjustment of the articulations of the vertebral column, its immediate articulation, and includes other incidental means of adjustments of the spinal column and the practice of drugless therapeutics.* (West's Annotated Indiana Code Title 25, Article 10 Chapter 1, 25-10-1-1, Sec 1 (1)
>
> **Maryland**: *"Practice chiropractic" means to use a drugless system of health care based on the principle that interference with the*

transmission of nerve impulses may cause disease.

"Practice chiropractic" includes the diagnosing and locating of misaligned or displaced vertebrae and, through the manual manipulation and adjustment of the spine and other skeletal structures, treating disorders of the human body. (Annotated Code of Maryland Title 3 Subtitle 1 Section 3-101 (f)(1)(2)

Tennessee: *"Chiropractic" means a system of healing based on the premise that the relationship between the structural integrity of the spinal column and function in the human body is a significant health factor and the normal transmission of nerve energy is essential to the restoration and maintenance of health.*

The practice and procedures used by the doctor of chiropractic shall include the procedures of palpation, examination of the spine and chiropractic clinical findings accepted by the board of chiropractic examiners as a basis for the adjustment of the spinal column and adjacent tissues for the correction of nerve interference and articular dysfunction. (Tennessee Code Annotated, Title 63 Chapter 4, 63-4-101(a)(b)

THE LEGISLATIVE ESTABLISHMENT OF SUBLUXATION AS AN ELEMENT IN CHIROPRACTIC PRACTICE

The concept of the subluxation has previously been defined via the consensus paradigm statement quoted above. This clinical element of chiropractic is recognized not only in chiropractic education, literature, philosophy and practice, it is strongly established in both state and federal legislation as a primary element of chiropractic clinical responsibility. These laws also identify the adjustment of the subluxation to restore normal nerve function as a unique service not provided by medicine, osteopathy or any other health care discipline.

Many states specifically identify the concept of subluxation in their chiropractic practice statutes. Most states imply an understanding of the subluxation complex by specifying the responsibility of the doctor of chiropractic for adjusting the spine and adjacent tissues for the elimination of nerve interference.

Examples of state statutes that expressly identify the detection of and caring for subluxation(s) as the core of chiropractic practice include:

Arizona: *A doctor of chiropractic is a portal of entry health care provider who engages in the practice of health care that includes:*

- *the diagnosis and correction of subluxations, functional vertebral or articular dysarthrosis or neuromuscular skeletal disorders for the restoration and maintenance of health.*
- *Treatment by adjustment of the spine or bodily articulations and those procedures preparatory and complementary to the adjustment including physiotherapy related to the correction of subluxations. (*Arizona Revised Statutes Annotated, Title 32, Chapter 8, Article 2 32-925(a), No. 1, 3)

Connecticut: *The practice of chiropractic means the practice of that branch of the healing arts consisting of the science of adjustment, manipulation and treatment of the human body in which vertebral subluxations and other malpositioned articulations and structures that may interfere with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells of the body, which may be a cause of disease, are adjusted, manipulated or treated.* (Connecticut General Statutes Annotated Title 20, Chapter 372, Section 20-24, (1)

District of Columbia: *"Practice of Chiropractic" means the detecting and correcting of subluxations that cause vertebral, neuromuscular, or skeletal disorder, by adjustment of the spine or manipulation of bodily articulations for the restoration and maintenance of health.* (District of Columbia Code 1981, Part 1, Title 2, Chapter 33, Subchapter I . 2-3301.2(3)(A)

Delaware: *The practice of chiropractic includes, but is not limited to, the diagnosing and locating of misaligned or displaced vertebrae subluxation complex.* (Delaware Code Annotated, Title 24, Chapter 7, . 701 b.)

Florida: *"Practice of chiropractic" means a noncombative principle and practice consisting of the science, philosophy, and art of the adjustment, manipulation, and treatment of the human body in which vertebral subluxations and other malpositioned articulations and structures that are interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells of the body, thereby causing disease, are*

adjusted, manipulated, or treated, thus restoring the normal flow of nerve impulse which produces normal function and consequent health by chiropractic physicians using specific chiropractic adjustment or manipulation techniques...(Florida Statutes Annotated Title XXXII, Chapter 460, Section 460.403 (8)(a)

Idaho: *"Adjustment" means the application of a precisely controlled force applied by hand or by mechanical device to a specific focal point on the anatomy for the express purpose of creating a desired angular movement in skeletal joint structures in order to eliminate or decrease interference with neural transmission and correct or attempt to correct subluxation complex.* (Idaho Code, Title 54 Chapter 7, 54-704 (1)(a.)

Maine: *Chiropractic. "Chiropractic" means the art and science of identification and Correction of subluxation and the accompanying physiological or mechanical abnormalities. The term subluxation, as utilized within the chiropractic health care system, means a structural or functional impairment of an intact articular unit. Chiropractic recognizes the inherent recuperative capability of the human body as it relates to the spinal column, musculo-skeletal and nervous system.* (Maine Revised Statutes Annotated, Title 32, Chapter 9, Subchapter 1 section 451 (1).

Massachusetts: *"Chiropractic", the science of locating, and removing interference with the transmission or expression of nerve force in the human body, by the correction of misalignments or subluxations of the bony articulation and adjacent structures, more especially those of the vertebra column and pelvis, for the purpose of restoring and maintaining health.* (Massachusetts General Laws Annotated Part I, Title XVI, Chapter 112, Section 89)

New York: *The practice of the profession of* ***chiropractic*** *is defined as detecting and correcting by manual or mechanical means structural imbalance, distortion, or subluxations in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.* (Consolidated Laws of New York, Chapter 16 Title VIII, Article 132, Section 6551 (1.)

Other state statutes that define and identify the subluxation specifically include Kentucky, Nevada, New Jersey, Texas, Utah, Vermont, and Washington. These statutes are