

As with any other medical profession, practitioners of acupuncture and Oriental medicine are concerned with the standard categories of risk that pertain to all medical practitioners including, but not limited to, misdiagnosis, improper modality or medical systems used in treatment, and treatment given by unqualified individuals. Of major concern is the growing number of health-care professionals who are practicing acupuncture after completing only 100- to 200-hour education programs. The NCCAOM fears that such a minimalist approach to education cannot adequately equip a practitioner with the depth of knowledge necessary to effectively practice acupuncture.

Similar concerns exist with respect to the current trend of consumers self-medicating with over-the-counter herbal preparations. The NCCAOM believes that such preparations should only be available through practitioners who have been trained and certified in herbal medicine. Furthermore, uniform quality control standards and regulatory oversight of the preparation of herbal products by manufacturers are also indicated.

The NCCAOM certification process effectively evaluates a practitioner's knowledge of safe and competent care. The acupuncture and Oriental medicine professions have a record of quick response when new health risks surface. For example, the NCCAOM modified its eligibility criteria to include passage of a "Clean Needle Technique" (CNT) course when concerns arose regarding disease transmission via needles. Thus, through appropriate education, certification, licensure, and continuing education requirements, the public welfare will be well protected.

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?

The NCCAOM agrees that it is appropriate to address consumers' concerns regarding professional competence and conduct in CAM. In acupuncture and Oriental medicine, these concerns are addressed at the state level by licensing boards and at the national level by NCCAOM's certification standards, its Code of Ethics, and its clearly defined disciplinary action procedures. These procedures were developed by the NCCAOM to provide an avenue for individuals, including consumers, to express concerns and file complaints about NCCAOM Diplomates. When a complaint is received about an NCCAOM Diplomat, the complaint is investigated. A decision is made by our Review and Disciplinary Committee (RDC), composed of both practitioners and public member(s). Opportunities for appeals and further reviews are always provided. Sanctions may include reprimands, censures, suspensions, and revocation of certification. The NCCAOM believes that the disciplinary action procedures that it has developed for the acupuncture and Oriental medicine fields can be used as a model for other CAM fields.

To our knowledge, there are no formal programs that address consumer concerns or complaints about CAM products. Because patient safety is our primary concern, we are interested in participating in the development of and/or reviewing recommendations for development of such programs.

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?

The NCCAOM believes that patients would be best served by appropriate and timely communication between their CAM practitioner and their conventional provider. Data regarding history, diagnosis, medications including herbs, current treatment strategies, blood disorders, implanted devices, and known treatment outcomes represent the minimum information categories that should be transmitted between practitioners so that each can assess the effectiveness of the respective systems of treatment for a given condition.

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

The NCCAOM makes the following recommendations to assure the quality of CAM practices and products for the benefit of consumers:

1. CAM practitioners should graduate from accredited schools and demonstrate competency as measured by national certification standards.
2. Federal and private sector funding should be increased to improve the number and quality of surveys, outcomes research, randomized clinical trials, and laboratory investigations pertaining to CAM.
3. Only certified or licensed practitioners should dispense CAM products such as herbs.
4. Medical school curricula should be standardized to include alternative medicine theory, practice, safety, and efficacy.
5. Continuing education courses should be developed and designed to provide allopathic physicians with sufficient knowledge and management skills to responsibly advise patients who use or request CAM.
6. Cross-residency training opportunities should be created for allopathic physicians and students to study under CAM practitioners and likewise for CAM practitioners and students to study in allopathic hospitals and clinics.
7. Federal funding should be appropriated for the development of public awareness campaigns about CAM. For example, public service announcements could urge consumers to seek care from certified CAM practitioners and increase consumer awareness of the need to disclose to their health care provider all CAM self-care products in use.
8. Consistent national standards need to be developed for CAM credentialing, malpractice insurance, and scope of practice.
9. Standardized CAM curricula should be developed pertaining to effective research methodology.
10. A full-text database should be created for peer-reviewed studies, systematic reviews, meta-analyses, and selected texts involving CAM therapies.
11. A comprehensive toxicology index should be created for herbs, vitamins and supplements commonly available over-the-counter.
12. Expand the student loan repayment plan to include CAM students for work in underprivileged settings and chemical dependency centers.
13. Include acupuncture and Oriental Medicine coverage in federal health insurance programs.
14. Development of an Office of Herbal Products within the FDA.

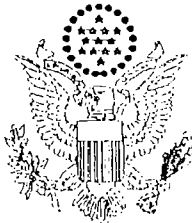
Thank you for taking the time to consider the information presented in this letter. Please continue to consider the NCCAOM as a resource for current information about the standards of

competency and practice within the field of acupuncture and Oriental Medicine. Contact me by email at cherlihy@nccaom.org or by telephone at 703-548-9004 ext. 3250 if I can offer further information on any of these topics.

Christina S. Herlihy, M.A., Ph.D.
Chief Executive Officer

cc: NCCAOM Board of Commissioners

Tab 28



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 2, 2001

Donald L. Weaver, MD, Director, National Health Service Corps
Health Resources and Services Administration
Bureau of Primary Health Care-Room 8-10A
4350 East-West Highway
Bethesda, MD 20184

Dear Dr. Weaver:

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 scholarship and/or loan repayment programs available for students of CAM or emerging professions particularly for those who wish to provide services for underserved populations? If not, why not?
2. If these programs do not exist, how can such scholarship and loan repayment programs be established?

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

Chair

James Gordon, MD

Commissioners

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David Bresler, PhD, LAc, OMT

Thomas Chappell

Eric Clay, PhD, RN, DplA

George DeVries, III

William Fair, MD

Joseph Faus, MD, FACP

Veronica Gutierrez, DC

Wayne Jonas, MD

Luannea Larson, LCSW, LMFT

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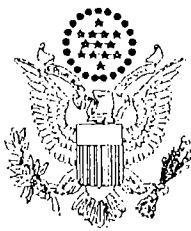
Consultant Staff

Kenneth Fisher, PhD

Maurice Miller, MPH

James Swyers, MA

Tab 29



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 3, 2001

Executive Director
National Qigong Association
P.O. Box 540
Ely, MN 55731

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 Qigong undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than Qigong?
2. Should there be national standards or certification to provide CAM practices and products? If so, how and by whom should national standards or certification be established, to whom should they apply, and how should they be implemented?
3. Should the numerous Qigong and other energy healer organizations come together to form "a community?" If so, how and by whom should that "community" be formed?
4. Should there be condition-specific or modality-specific practice guidelines and why or why not? If so, how and by whom should these guidelines be developed, to whom should they apply, and how should they be implemented?
5. Are your members concerned about malpractice liability associated with providing CAM practices and products?
6. Are there any risks associated with CAM that may be of concern to your members? If so, can you suggest ways to minimize those risks?
7. Should there be a mechanism to address consumer concerns or grievances about the quality of CAM practices or products? If so, what should that mechanism be?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr., MD

David Bresler, PhD, LAc, OME

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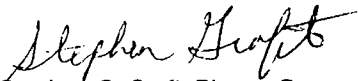
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9. What policy recommendations would you like to make to assure the quality of CAM practices and products whether they are provided by a practitioner or used as self-care?

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,

A handwritten signature in black ink, reading "Stephen Groft". The signature is fluid and cursive, with a horizontal line extending from the end of the name.

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

Please find enclosed the following answers to the questions developed by the Commission. Please keep in mind the relatively short time frame given to this organization to respond.

Question # 1

There are no National Educational Standards for Qigong in undergraduate, postgraduate , and continuing education in place at this time. The National Qigong (Chi Kung) Association has professional membership requirements for instructors, Qigong healers and medical Qigong practitioners. We are in a National dialogue about standards with the National Certification Commission for Acupuncture and Oriental Medicine, the American Qigong Association, The World Academic Society of Medical Qigong, the American Association of Oriental Medicine and the European Federation of Taiji and Qigong.

Question # 2

Yes, By national certification or accreditation boards and other professional organizations.

Question # 3

The National Qigong (Chi Kung) Association USA has continued dialogue with numerous National and International Qigong organizations. In terms of forming a community with other energy healers we have no opinion at this point in time because we have not had the opportunity to discuss this issue. Formation of a community would naturally be Modality Specific.

Question # 4

Currently Under discussion, no answer available at this time.

Question # 5

Currently Under discussion, no answer available at this time.

Question # 6

Currently Under discussion, no answer available at this time.

Question # 7

Currently Under discussion, no answer available at this time.

Question # 8

Currently Under discussion, no answer available at this time.

Question # 9

Currently Under discussion, no answer available at this time.

THE QIGONG RESEARCH AND PRACTICE CENTER
www.qigonghealing.com

EXECUTIVE DIRECTOR:
KENNETH S. COHEN, M.A., M.S.T.H.

February 14, 2001

Dear Colleagues,

I hope that the White House Commission on CAM will consider the following.

Personal Introduction

I am the author of *The Way of Qigong* (Random House) and more than 150 journal articles. I am a senior qigong practitioner, educator, and scholar (33 years experience) and one of the few North American practitioners who speaks Chinese and reads both modern and classical Chinese. In 1994 I was a keynote speaker at the World Congress on Energy Healing in Basel, Switzerland. I was chosen among practitioners world-wide (including China) as the sole representative of Chinese medicine. My work has been accredited for CMEs at many conferences, including the American Academy of Medical Acupuncture and the National Institute for the Clinical Application of Behavioral Medicine. I was one of 9 "exceptional healer research subjects" studied by the Menninger Institute in their 12 year project "Physical Fields and States of Consciousness." I am aware of the religious issues involved in qigong because I studied Taoism in graduate school (UC Berkeley), apprenticed to a Taoist Abbot from South China (Huang Gengshi), and am an ordained interfaith minister (2 year program at the New Seminary in NYC).

In North America I

- created the very first qigong practitioners' code of ethics
- created the first Qigong School (Montreal 1976) and teacher training program (Boulder, Colorado 1981)
- was probably the first qigong practitioner to use qigong as CAM to treat physician- and pain-clinic referred clients.

P.O. BOX 1727, NEDERLAND, COLORADO 80466, U.S.A.
Fax/Phone (303) 258-0971

THE QIGONG RESEARCH AND PRACTICE CENTER

www.qigonghealing.com

EXECUTIVE DIRECTOR:

KENNETH S. COHEN, M.A., M.S.TH.

Re: national standards or certification

I have already addressed these issues in the following articles in *Qi: The Journal of Traditional Eastern Health and Fitness*

- "Why Are Most Published Works On Qigong So Poor?" Spring 98
- "I'll Drag My Tail Through the Mud: Why Qigong Should Remain An Unlicensed Profession" 8:3 Autumn 98
- "The Highest Standard is Free of Rules! More Thoughts on Licensing Qigong" 9:1 Spring 99
- "Is Qigong Political? A New Look At Falun Gong" 10:2, Summer 2000

Qigong, both as a personal health and wellness discipline and as a treatment modality (External Qi Healing-- "Chinese Therapeutic Touch"), is rooted in religious literature. Virtually all source material is found among the 1200 volumes of the Taoist Canon. Since at least the fourth century BC Taoist recluses practiced qigong as a way of *xing ming shuang xiu*-- cultivating body and mind in balance, achieving longevity, and unifying with the mystical Tao, the Way of Nature. Although some Chinese medicine practitioners practiced or prescribed qigong, they were clearly borrowing from a spiritual discipline. Similarly, some physicians might feel compelled to pray for their patients, but this does not mean that ministers must apply for medical licensure. The classification of qigong as an exclusively medical discipline did not begin until 1934, with the publication in China of a book on qigong for tuberculosis.

There are political reasons why many people today assume that qigong is primarily a branch of Chinese medicine. In 1951 the Chair of the Chinese Communist Party, Chen Duxiu branded Taoists as *fan dong dao shi* "counter-revolutionary". Temples were destroyed, priests were forced back into lay life, and qigong was frowned upon. Qigong became officially illegal during the Cultural Revolution, 1966-76 and for six years thereafter. The prohibition was lifted in 1982 when the Chair of the Chinese Academy of Science, Qian Xuesen, issued a public endorsement of qigong as a valid way to improve health. Qigong was artificially extracted from its religious context and placed under the dominion of the state approved medical industry. "Medical Qigong" was created. Naturally, under Chinese censorship laws, all books and articles alluded to the authenticity of this discipline.

The political dimension of qigong is well highlighted by the recent persecution and torture of practitioners of spiritual qigong, including Falun Gong, and the current prohibitions against all qigong schools. The official voice of the Chinese

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EXECUTIVE DIRECTOR:

KENNETH S. COHEN, M.A., M.S.TH.

Communist party-- Xin Hua News Agency, considers spiritual qigong "a threat to the stability of Chinese society." I submit that what Communism is really objecting to is the fact that HEALING, as opposed to medicine, is highly individualistic and beyond both standardization and state control.

With nearly 100,000 Chinese practicing religious qigong -- Falun Gong, Zhong Gong, and others-- and more than 7,000 styles of qigong, many of which include conditioning exercises for the martial arts, it is obviously impossible for any group to set a uniform standard. Shall the White House Commission design tests in Taoist liturgy or rare martial arts to make sure that practitioners are correctly representing their sect?

Re: Condition-specific guidelines

Qigong takes a systemic and wellness approach to disease. Although modern Chinese medical practitioners may appear to be tailoring the qigong technique to the disease, a careful investigation will show that this is not really the case. For example, the so-called medical qigong textbooks, several of which have been translated into English, often prescribe the same qigong technique for conditions as diverse as rheumatoid arthritis, cancer, and migraine.

Re: Risks

The only risks result from not following common sense and are thus beyond the purview of regulation. For example a patient with advanced arthritis of the hips should not attempt to climb a mountain or practice a qigong posture from a low stance. As with any physical or spiritual discipline, a person can become ill from simply doing too much. Of course, qigong practitioners should make it clear to their clients or students that they should never use qigong as a substitute for necessary medical intervention.

Respectfully,

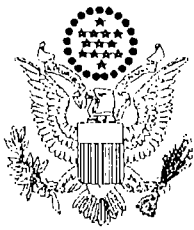


Kenneth S. Cohen

P.O. BOX 1727, NEDERLAND, COLORADO 80466, U.S.A.

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Tab 30



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

Chair

James Gordon, MD

Commissioners

George Bernier, Jr, MD
David Bresler, PhD, LAc, OME
Thomas Chappell
Effic Chow, PhD, RN, DiplAc
George DeVries, III
William Fair, MD
Joseph Fins, MD, FACP
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Joseph Kaczmarczyk, DO, MPH
Doris Kingsbury
Geraldine Pollen, MA

Consultant Staff

Kenneth Fisher, PhD
Maureen Miller, MPH
Frances Sowers, MA

Rebecca Good, RN,C, ACRN, LPC
Executive Director
Nurse Healers-Professional Associates International
3760 South Highland Drive-Suite 429
Salt Lake City, UT 84106

Dear Ms. Good:

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 Therapeutic Touch undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to CAM other than Therapeutic Touch?
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

Chang, Michele (NCCAM)**Subject:** FW: CommissionresponseFeb2001.doc

3760 South Highland Drive Suite 429 Salt Lake City, Utah 84106
Phone: (801)-273-3399 Fax: (801)-273-3352

Thank you for including Nurse Healers-Professional Associates International, the official organization of Therapeutic Touch, to participate in this worthwhile endeavor. For those members off the commission that are not familiar with Therapeutic Touch (TT) I will give a very brief history. Therapeutic Touch was developed in the early 1970's by Dr Dolores Krieger, then a professor of nursing at New York University, and Dora Van Gelder Kunz, a natural healer. Nurse Healers-Professional Associates International (NH-PAI) was formed in 1976 by the Dr Krieger and a group of professionals who felt there was a need to have an organized body to share information and to develop standards of practice and policy and procedure for this well researched and effective healing therapy. Dr Dolores Krieger, presently Professor Emerita, taught the first class in any college or University on a complementary therapy at New York University back in the late 1970's. This class was on Therapeutic Touch and is still being taught there today. In addition, TT is taught in numerous colleges and universities throughout the United States and in over 80 countries throughout the world. TT has the strongest research base of any other CAM therapy, including multiple doctoral and master thesis predominately in nursing. Therapeutic Touch is a nursing diagnosis according to the North American Nursing Diagnosis Association (NANDA.) Although primarily nurses practice TT, Dr Krieger and Dora Kunz realized that healing is a natural potential and other healthcare professionals as well as lay people can learn and use TT to help others.

I will address the interesting and in some cases challenging questions that were developed to guide the Commission's deliberations.

1. Are there national educational standards for Therapeutic Touch undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to CAM other than Therapeutic Touch?

Yes, there are national educational standards for Therapeutic Touch education which are set by Nurse Healers-Professional Associates International, the official organization for Therapeutic Touch. There are courses taught at the undergraduate, post graduate and continuing education level

While NH-PAI does not set standards for other CAM therapies, it supports and includes other CAM therapies in its conferences. Although many of our practitioners practice other CAM therapies and have taken classes from a person qualified to teach such therapy, they do not teach other CAM therapies in a TT class. Students in a TT class often ask questions while they are trying to compare TT with other modalities. TT teachers need to be familiar with a variety CAM therapy, but it is unrealistic for anyone to be current with all of the alternatives. Further, it is not the function of a TT class to go into depth on any other modality than TT. It would be confusing to the student to intermingle therapies. TT is only one option among many; this would

be the perspective of any teacher or practitioner.

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?

Yes, there should be national standards of for CAM practices and products. Standards, certification and/or credentialing would be done by the official organization that has a full understanding of the CAM therapy. National Standards and certification should apply to all individuals who practice or teach the modality, especially in a hospital, healthcare facility, and private practice or for compensation.

The application would be directed to and credentialing implemented by the appropriate organization for each CAM therapy.

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

No, the energy healer organizations should not form a "community". You can not lump different energy modalities together. Each is separate and distinct. IT MUST BE UNDERSTOOD THAT ALL ENERGY HEALING IS NOT ALIKE. You begin to muddy the waters for the consumer and in educating the health care professionals and the general public if this is done. Each form of energy healing needs to stand on its own research and not on already proven and established healing modalities that are not even related in their approach, program or process. In addition, there is already sharing through professional journals and the many conferences held throughout the United States.

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?

There should be modality specific guidelines and standards of practice set by the professional organizations of each modality. The modality specific organization is best equipped to do so. They are the experts in the modality history, education, practice and research with it. As for condition specific guidelines, one can not do that with TT as it is based on and individualized assessment. While two people may have the same "condition", energetically their treatments might look differently. It takes away from being client focused. Healing is about treating the whole person and we are each different and unique. As one practices TT for a period of time and attends the advanced workshops, information is shared on what different practitioners have found helpful in certain clinical situations, but it may not be the primary focus each client needs.

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

Each modality has to be considered individually. This is a difficult question for NH-PAI as TT is a non-invasive technique. The TT Therapist works mostly in the client/patient's energy field and sometimes does gentle hands on work. There have been no problems with TT in the almost 30 years it has been in existence. However, some of our members feel the need for malpractice insurance in this litigious society and others do not. There is a double-edged sword to malpractice insurance for CAM therapies. If there is no insurance, then there is no money to be sought after. If malpractice insurance comes to be, then it is feeding into the possibility of dramatically increased lawsuits which has occurred in the past 20 years in conventional/western

medicine. Question 6 will continue NH-PAI's response to this question.

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?

As stated above, TT has little, if any risk when it TT is the only CAM therapy used and the individual is well educated in using the intervention.

There are possible risks to CAM. There is a lack of credentialing in many modalities and the proliferation of practitioners who say they practice a modality, but are not qualified to do so.

In particular, energy modalities have lumped together, and this is a particular problem because the practice of one often violates the conceptual basis of another and the rights of the uninformed client/patient 's are not receiving what they think they are.

There is need for more research and increased funding. Each CAM must be clearly defined with its own research. For example, several modalities have cited TT research as their own. Each of these modalities has a different conceptual basis, which are not compatible. When this is done, it misleads the uninformed, which is often the medical community. IT IS ESSENTIAL FOR EACH CAM TO HAVE INTEGRITY REGARDING THE RESEARCH OF THEIR OWN WORK/THERAPY.

Another risk is that the CAM practitioner demonstrates a negative attitude toward allopathic medicine. It is important that the CAM practitioner is part of the medical team. The patient is empowered to use Dr Krieger's "optional medicine" approach in which they choose from among the options of treatment.

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

CAM practices or products? If so, what should that mechanism be?

Yes. The mechanism would be the same as that for allopathic medicine. This has not been addressed by healing organizations yet, but is an area, which deserves exploration and clarification.

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?

Full disclosure with the consent of the client/patient is most helpful and appropriate on both practitioner's parts.

A common problem lies in the fact that the patients/clients do not tell their conventional medicine provider that they are seeing or seeking a CAM provider out of fear that their doctor may react negatively.

The conventional medicine practitioner should communicate the same information that they would to a conventional medicine practitioner. BOTH are professionals in their area of expertise and all information relevant to the patient/client's wellbeing should be shared. The problem lies in the lack of respect some allopathic practitioners have for CAM. There needs to be massive education and appropriate CAM awareness should begin at the college, nursing and medical school levels.

Clients/patients need to be part of the team and not feel they need to discontinue one over the other.

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?

Only CAM practitioners who meet the credentialing criteria of the official organization or accrediting body practice in healthcare facilities, hospitals, and private practice or for numeration.

There is Policy and procedure for the practice of each CAM where it is practiced. The practitioners credentialing information should be available for the client. Products should have proper labeling. Better education of the healthcare providers and public about CAM. More cooperation and referrals by allopathic practitioners to CAM practitioners they have checked out. Many CAM practitioners will give them a free consult to experience the technique or process. More research in CAM.

Increased access to CAM therapies by reimbursement from insurance companies, Medicaid and Medicare. Governments increased role in educating the public in the advantages, of self-responsibility, alternative/complementary modalities and choice.

Thank you again for inviting NH-PAI to participate in these hearings.

Feel free to contact me with any questions you may have. We will inform you via your web site registration if we will be able to have a representative from NH-PAI attend. Please keep us apprised of any other meetings and Commission activities

Rebecca Good, MA, RNC, LPC
Coordinator Nurse Healers-Professional Associates International, Inc
3760 South Highland Drive #429
Salt Lake City, Utah 84106
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Tab 31



White House Commission on Complementary and Alternative Medicine Policy

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

February 5, 2001

Mr. Ed Tso
Program Director,
Office of Dine Culture, Language, and Community Services
Division of Dine Education
Box 670
Window Rock, AZ 86515

Dear Mr. Tso:

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 from 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?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr., MD

David Bresler, PhD, LAc, OME

Thomas Clappell

Ellie Chow, PhD, RN, DiplAC

George DeVries, III

William Fair, MD

Joseph Fins, MD, FACP

Veronica Gutierrez, DC

Wayne Jonas, MD

Linnica Larson, LCSW, LMFT

Tieraona Low Dog, MD, AHG

Charlotte Kerr, RSM

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Joseph Kaczmarek, PhD, MPH

Doris Kingsbury

Ceralline Pollen, MA

Consultant Staff

Kenneth Fisher, PhD

Maureen Miller, MPH

James Myers, MA

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,

A handwritten signature in cursive script that reads "Stephen C. Groft".

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

Below follows in its entirety the two-part information on Traditional Healing received from the Dine [Navajo] Medicine Man Society.

Please note that the word "Dine" is the how the Navajo people refer to themselves. So to facilitate reading these two documents, substitute "Navajo" for "Dine."

=====

February 08, 2001

Dear Dr. Kazmarczyk,

I was contacted Mr. Ed Tso, Program Director of the Office of Dine Culture, Language, and Community Services of the Navajo Tribal Government. He furnished my staff with the communications you had with him dated February 5, 2001. He felt it was important to have the actual representatives of the Dine Medicine Practitioners too participate. DMAI is a non profit entity out side of the structure of Navajo Formal Government and have most recently asserted its authority based on traditional laws practiced by the Traditionalists. The formal Navajo Government uses the DMAI as the Formal Advisory Group on issues of traditions and culture. We have deliberately positioned ourselves as such and it was an up hill battle. You must be aware that our government, which uses culture and traditions, has been underground for a variety of reasons as related through the attached paper. We feel it is important to point this out at this juncture.

We are providing the following paper as the position of our organization. We feel strongly about this position and wish to help in the formation of a policy that will be inclusive of true traditionalist and culturalists. We are suggesting that we have a delegation of about three individuals to participate in a meeting of the same nature to be held on Feb. 22-23, 2001 in Washington. DC or to attend that meeting.

We do not have a central office; we all work out of our homes and it is difficult to contact us some times as were also are practitioners called on for healing. I find that it is convenient for us all to have a point of contact. In my case, all written communications is at the above address with a CC to Mr. Bluehouse, an extra copy to Mr. Bluehouse to be delivered to Mr. Slivers, DMAI Vice President. Email communications are best for expediency. DMAI Secretary's personal email is pbluchouse@yahoo.com may be used, please communicate through there. He has also offered the phone # (520) 729-5404 to be the contact for DMAI business. If you cannot contact him and it is urgent, call me at (520) 871-3254.

Sincerely,
Thomas Morris, Jr. DMAI-President

DMAI - Official Response

02-08-01

The DMAI (Dine Medicine Association, Inc.) is in a position to represent the grass roots Dine (Navajo) traditional medicine practitioners who are members of the Association. And by custom,

for those who wish not to be in an association membership, but who are in practice using the aboriginal healing laws and strategies of the Dine. We respect them, their use of that aboriginal law of the Holy Realm. We assert the laws of the original and aboriginal healing practice as our law of preference and as a foundational human right to heal one another. This representation is possible because the Association (DMAI) use the same aboriginal laws to prescribe the strategies to heal and to practice traditional strategies of medicine outside the function of the DMAI entity. As an entity, DMAI couples itself to the principles of the Dine philosophy of life and uses modern management protocol to progress as an entity and to benefit the practitioners through a voice of unity of their effort and purpose. The entity of DMAI further presents its function as the non-profit business function and interface with other entities and organizations in the effort of preserving, protecting, perpetuating and promoting the aboriginal strategies of medicine.

DMAI have associated to prevent erosion, misuse, improper commercialization and general destruction of our healing strategies. In addition to protecting, perpetuating, preserving and promoting traditional medicine, we are associated to be recognized as an entity to conduct ordinary business on behalf of DMAI. DMAI, as an entity, recognizes every practitioner and that each practitioner is acting independently whilst in concert and cloaked with, the aboriginal laws during and outside the actual ceremonial practice of Dine medicine. With this clear, as to the entity relationship of the association, and to its membership and non-members, we are requesting to be invited to the hearings to represent Dine Medicine Practitioners.

At the grass roots and to our people, the Dine traditional medicine practitioner is the "primary health provider" and is not considered an alternative. Today, western medicine is the "compliment" and the "alternative" to our traditional practice. This must be understood and respected so that dialog and clarity of intent and purpose is not compromised between professionals in the sciences of healing. Additionally, our thoughts and language are considered as sacred as the Creator's thought and voice. We feel, because of that fact, that our "Holy Way" is sacred. The Creator is the force and effect of the healing, the thought, the voice, the actions; the ceremonial system of healing is sacred. The system of words and ceremony are equivalent to the scientific language and process as that of western medicine.

We appreciate the CAM policy developers in its efforts to include cultural and traditionally correct practitioner strategies to be considered for study and for consideration for other possible mutual benefits. However, it is not clear who will benefit. History and our experience dictate to us to be openly cautious and suspicious as to motives and methodologies of the research of our medicine and products. This position is an attempt to create clarity and deep and meaningful trusted and respectful dialog between the western and traditional practitioners of medicine and to instruct researchers to give due credit and honor to indigenous people. Historically, there are many of those who have taken credit for knowledge they simply discover. They have taken information that is originally known and practiced by the indigenous practitioners. These unscrupulous individuals have subsequently become the "experts" and have elevated their social and economic position in life while leaving the original users in shambles and without respect. This practice of not giving credit where it is rightfully due must stop.

We, the Dine, are a distinct culture and we understand that there is diversity in the dominant culture and we have experienced events that created miss-trust between us. Even then, we

coexist and it is possible to respect each cultural ways. Together, all of us, as a people, both western and traditional practitioners, we share common intent and finality of purpose, we both endeavor to heal. On the other hand, the traditional practice of medicine, as an applied sciences, is as varied and diversified as there are many western doctors and medicine people. Each practitioner, with their methods and techniques applied only by their hands and with the knowledge gained from a source revered and respected, is the standard. The standard is extracted from the area we call the "Holy Level" of knowledge. To harness a single standard to represent "Indian Traditional Medicine" is going to be impossible; this must be understood and accepted by the commission. An analogy to create clarity is offered as follows. Mr. Philmer Bluehouse, the current Secretary of the Dine Medicine Association, Incorporated (DMAI), calls it the "Puzzle Effect". The puzzle effect is described, "each individual part of a puzzle has a uniqueness, and may not be exactly the same size and shape as any other part of the puzzle. Each part has a gift and uniqueness, each part contributes its ability and limitation to the whole, it all fits in some where. When each part is placed properly, we then get to see the whole picture and understand the complexity, the individuality and the commonality of the whole. Like a puzzle, each of us holds a part of the mystery of healing. This is the best picture."

The reliance on this source is information from the holy level may not be totally acknowledged or understood by western ways. In the way of the Dine practitioner, there is total emersion into the Holy Way strategy. We understand that there is a central theme of healing and that we emphasize and respect the diversity of our medicine even among ourselves. That central theme is best described in the above analogy. We are also aware of a Pan - Indian Movement where there is a mass wholesale and commercialization of what is labeled as "Indian Medicine or Indianess" we caution against this because of the sacredness, the delicateness and the dangers involved in improper and disrespectful practice of Indian Ways and Medicine. This is an absolute belief and value of our people. To violate these laws of nature is not a benefit to humanity but of its destruction. Much of these strategies and values are revealed through the Dine Narrative, "Journey to Father Sun".

Generally, there were twin boys created to reestablish peace on the earth surface. These warriors of peace were sanctioned to journey into the Universe to Father Sun to collect information and strategies to be used, on the earth, to rid the earth of monsters and problems. These monsters and problems were of our own creation, consummated, and created during journey where some beings violated the Natural Laws of the Holy Beings. These violations then manifested as the problems of life and of our own doing, and we are responsible for their creation, destruction or healing. The Narrative is describing a systematic progression of using Holy Knowledge, turning it into practical knowledge to sustain us. It contains information of strategy, planning, problem solving, commitment, actualization and the maintenance of self and culture.

We emphasize the importance of aboriginal practice and strategies specific to the Dine. We do not exclude our purpose to employ these Dine strategies on any persons that desire healing. We do, however, assert and exclusively maintain the right to heal using the aboriginal strategies and science.

We are aware of the movement to capture and legislate traditional and cultural people's traditional medicine values and traditions or even to regulate their affairs from a central

powerful governmental force. We must remind those who attempt to legislate and regulate from a powerful source that they become the death of our freedom to regulate self, to take self responsibility and to employ properness in the efforts of healing while ever conscious of the standards of the "Holy Level" mentioned above. The other possibility is to drive the practice further underground for it's own salvation. Caution is advised to the commission about this. The power of the source, which regulates us in traditional medicine, is very real to us, we respect, honor and employ it. That original law regulates us, we are therefore, are self regulated and certified in a different way other than of western mans principles or understanding. DMAI does not want to be regulated by out side powerful forces other than by the unwritten laws, our own, that regulate us; we want to regulate self and to be responsible for self while naturally regulated by the aboriginal laws and strategies of healing. Those laws may eventually form the future written DMAI Policies, Procedures, Rules and regulations that support the practitioners and the DMAI's purpose and function.

We do not disagree that "conventional healthcare practitioners" need to be educated. Training about traditional medicine, training must be designed to provide working knowledge, not actual knowledge, to understand, respect and accept the ability of traditional practitioners. Western practitioners must not abridge the knowledge and procedures of traditional practitioners and they must allow traditional practitioners to employ what they have learned by traditional apprenticeship and through study under Dine medicine people. The Office of Dine Culture, Language, and Community Services has done a good job but has also been limited in manpower and financing to meaningfully cover all aspects of Dine Medicine. I hear that they have very little money to continue the "Apprenticeship Project". Among our people, we have an unwritten infrastructure through which dissemination of practitioners, their specialties are readily accessible to the masses. It is not necessary to create glitzy PR protocols.

Western practitioners do not necessarily understand the research methods we use. It is a process innate to and of the ceremonies, process and procedures of our traditional protocols, written or unwritten, oral or silent. The research is an on going process and does not necessarily fit the paradigm of western research. On the other hand, Mr. Philmer Bluehouse, has understood how, like the western research approach, the Dine protocols can be quantified and qualitative to form hypothesis and form fact where it may be proven what works and doesn't. Mr. Bluehouse has stated that the systems of Chants, Prayers, Ritual Object preparation and use, and the Dine Narratives contain all of the mile markers and information to conduct research that can be precise. He has understood the problem to have informants to participate. Bluehouse points out; "It is the trust and respect that has been lost between researchers and practitioners all because of the style of anthropology and research conducted in the past. If there is participation, it is usually an ego or financial arrangement and is consummated out side the protocols of traditional limitations or of those policies of DMAI which are written or unwritten". He also appreciates the efforts by those researchers who made an effort to document information of the practitioners of the recent past because there is value in the information. On the other hand, he expresses his sadness that those informants died poor while the recorders became "experts" and advanced them selves socially and economically.

In terms of research, as suggested in the immediate paragraph above, the area of research as to the reliance and reasons for reliance on traditional Dine medicine, as the "Primary Care" model by Dine, is of great importance to the young Dine. This is because the elders have

advocated the resurgence of true traditional practice and we are now seeing that the young see a figure out of curiosity and to research it. Earlier there is mention of a standard prescribed by the Holy Level, Bluehouse has said, "it is possible to research the visible and audible to understand the Holy Level, its content and access the knowledge". He, however, cautions that, "it is to be approached with respect, honor, responsibly, and with deliberate intent and purpose to heal. If it is for pure research, it is possible to cause a disturbance of the order of things and to invoke or cause an imbalance in the law." The standard is based on the reliance of original law, tried and tested strategies obtained from the "Holy Level" discussed earlier. Additionally, medicine people had a traditional style of "Refresher Courses, or in-service". Here are the open discussions and comparisons of technique, agreement and disagreement in the formation of consensus to deliver healing strategies.

In answer to the posed questions designed to guide the Commission, we offer the following answers to the questions as follows:

Q1.

For our people, "Traditional Healers" are those individuals who have apprenticed under a well known, accomplished, proven, and respected practitioner. The practitioner is the guide to the apprentice. Guidance is provided by the ability for the practitioner to reveal the standards provided by the "Holy Beings" in the "Holy Level". The apprentice, through repetition, recitation and demonstration, provides the "Guide" with the appropriate information and moves on to other opportunities of knowledge. The actual process of learning is done through teaching ceremonies and through participation in actual ceremonies. The actual experience of information for transformation and for retention, by the apprentice, is a matter of individual capacity or limitations. You and I may not have the same experience of the apprentice. There are many methods and techniques of course.

Q2.

In the Dine way, an individual may decide to follow the path of healing by making a conscious choice to do so and may approach a practitioner who meets the standard in Q1 and who will accept to teach the apprentice. Another way is to recognize a natural gift given by the Holy Beings, to acknowledge the presence, to accept the gift and to officially sanction the ability through ceremonial acknowledgement. This is part of the traditional licensure process. This process is unwritten, but the standard is prescribed in the ceremonial system. Currently, DMAI considers this tradition and issues a written and recorded Certificate recognizing the individual to be a practitioner. We also have several categories of Certification that acknowledges all levels of traditional practice. This is truly an internal practice. We have incorporated the Peacemaking strategies into the system to insure compliance to duty and responsibility. Peacemaking is a process that does not use sanctions but uses healing to deal with the problems of medicine people. If the matter of problem is so great, the individual no longer enjoys the respect once held. This is the demise and condition, which evolves on its own as a control mechanism. It is the Holy Level working. So, why would one decide to perpetrate improper conduct and compromise their position and ability?

Q3.

For the Dine practice, licensure is to be kept as a matter of local choice and decision through self-regulation. We must be exempt from a central government intrusion by regulation

of matters which they have no knowledge of practice and process. We do ask financial assistance to document and to the development these indigenous systems to meet our requirement using the original laws.

Q4.

For the Dine, we have an unwritten protocol in gift giving, offerings and the exchange of money and goods for Traditional Medicine performance. For us, this promotes a formation of community, responsibility and ownership to the strategies for healing. This, again, should not be regulated from the outside, however; third party billing issues must be discussed with the western practitioners, of that technique, to determine use and respect for traditional medicine. Again, the Dine is self-regulated in this effort using traditional law. The stoppage of third party billing is because of western medicine using only their standards and therefor excluding traditional medicine. On the other hand, there are those practitioners who see abuse of that system where individual patients will not realize, responsibility and become conditioned for "another Government Handout". It also promotes individuality and no unity of effort and destruction of community. It does this by some one powerful entity to promote, "I'll pay for you", and thereby destroying the spirit of including relatives, extended clan relatives to participate in healing. There is the formation of exclusion and selection of patients and giving the traditional practitioner to be "in for just the money" and the appearance of arrogance as if "he acts if he has no relatives". These are the cautions given by wise medicine people. Some have said, "We may be creating our own monster again if we are not careful".

Q5.

Dine must perform Dine Traditional Medicine and healing. Much of the practice should be separate and complimentary. We do not wish to perform western medicine procedures out of respect, we ask for the same respect in return. It is possible to work side by side in any event and to trust and respect the other. We realize this may be difficult.

Q6.

In the case of Dine traditional healing process, it would be best augmented with financial support in an effort of repatriation to fix the attempted destruction of our culture and ways. We point out that DMAI is a financially poor entity but is rich in culture and in the practice and promotion of traditional Medicine. DMAI is postured to negotiate these matters. We have our policy of protecting and preserving our healing protocols.

Q7.

Traditional healing is to be maintained and further developed by the Dine in our case. We should be encouraged to teach one another. The strategies for teaching are already in place through common law (traditional law) and protocol. The practice of ceremonial teaching and process are already in place but not as in the western sense. Our challenge is to correctly capture the process and procedures for our own use. We need financial help in this way.

Q8.

The strategies of complete confidentiality are not a value in traditional Dine ways. If you were sick or a hooligan, in the community, it is community business to help you to heal. Confidentiality was not an option. I'm not sure if this question infers that traditional medicine practitioners are not to be trusted with information of a critical nature to help in healing of a

patient. In our way, all information is useful to understand the total picture of the puzzle and must be used to those ends. The caution from us is how western society use information to punish, shame and sanction rather than to heal and to include. We wonder where the beast comes from.

Q9.

DMAI wants to participate fully to represent Dine traditionalists. It will be, however, difficult for us to travel, as our coffers do not have the monies to support travel, per diem and expenses. Much of our progress was dependent on out of pocket expense based simply on the desire to see that our ways do not die. To make one policy statement and not knowing the future makes it difficult to be stagnant. On going and perpetual inclusion of our way will help us to continue to grow and heal. We think of this commission and process as a living being, please honor these few words of humility and humbleness which is based on our strong desire to maintain ourselves as a culture with what cannot be taken from us. But, for us to revive our ways and to participate, perpetuate promote and protect these ways with your help but not through government intrusion. 'Axheeh'e, doo Hagooninaa'.

© 020801 "DMAI" T morris, s/P bluehouse. Dine medicine people at large.

Tab A



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 3, 2001

Chair

James Gordon, MD

Commissioners

George Bernier, Jr, MD

David Bresler, PhD, LAc, OMB

Thomas Chappell

Effie Chow, PhD, RN, DnLA

George DeVries, III

William Fair, MD

Joseph Fins, MD, FACP

Veronica Gutierrez, DC

Wayne Jonas, MD

Linnea Larson, LCSW, LMFT

Pieraona Low Dog, MD, AHG

Charlotte Kerr, RSM

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Joseph E. Pizzorno, Jr, ND

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Julia Scott

Xiaoming Tian, MD, LAc

Donald Warren, DDS

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Michelle Chang, CMT, MPH

Executive Secretary

Jean Albrecht

Corinne Axelrod, MPH

Joseph Kaczmarezyk, DO, MPH

Doris Kingsbury

Geraldine Pollen, MA

Consultant Staff

Kenneth Fisher, PhD

Maureen Miller, MPH

James Swyers, MA

Executive Director
Omega Institute for Holistic Studies
150 Lake Drive
Rhinebeck, NY 12572

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.

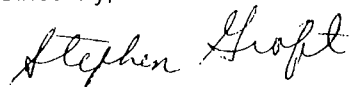
1. Are there national educational standards for meditation and other mind-body undergraduate, postgraduate, and continuing education? Should those national educational standards include exposure to conventional or western medicine as well as CAM other than mind-body approaches?
2. Should there be national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

A handwritten signature in cursive script that reads "Stephen Groft".

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

Tab B



White House Commission on Complementary and Alternative Medicine Policy

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

February 1, 2001

Hardy Spoehr
Executive Director
Papa Ola Lokahi
222 Merchant Street
2nd Floor
Honolulu, HI 96813

Dear Mr. Spoehr:

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 from 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?

Chair

James Gordon, MD

Commissioners

George Bernier, Jr, MD

David Broder, PhD, LAc, OME

Thomas Chappell

Ellie Glor, PhD, RN, DmlA

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Tieraona Low Dog, MD, AHG

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Consultant Staff

Kenneth Fisher, PhD

Maureen Miller, MPH

James Swartz, MA

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

January 9, 2001

Joseph M. Kaczmarczyk, DO, MPH
Senior Medical Advisor
White House Commission on Complementary
and Alternative Medicine Policy
6701 Rockledge Drive
Suite 1010, MSC 7707
Bethesda, MD 20817

Dear Dr. Joe:

Aloha! Enclosed you will find my response to the seven questions that you asked me to reply to in regards to traditional healers: also enclosed are the following:

- 1) Hawaii State House resolution 196 which names me as a protégé of Emma Defries, a recognized Kahuna Nui and descendant of Hewahewa Nui the Kahuna Nui to Kamehameha I.
- 2) Support letters from Malia Craver (Kupuna & Hawaiian Spiritual and Cultural Consultant of Queen Liliu'okalani Children's Center), Kawena Johnson (Emeritus Professor of Hawaiian, University of Hawaii-Manoa). They are knowledgeable elders in the Hawaiian community affirming my positions as Kahuna/traditional healer.
- 3) Support letter from Dr. Paul Pearsall (Ph.D. in clinical and educational psychology) affirming my work with him and affirming my position as Kahuna/traditional healer.

I hope that you will find all the information enclosed satisfactory to your request and helpful in your quest for setting policies for traditional healers.

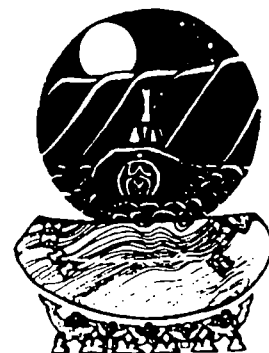
Kūnou au ma mua ou, "With Respect To You,"



Kawaikapuokalani K. Hewett
Cultural Health Director

Waimanalo Health Center

Ph. (808) 259-7948 Fax: (808) 259-6449



**41-1347 Kalanianaʻole Hwy.
Waimanalo, Hawaii 96795**

(7) Questions Pertaining to Traditional Healers

Question 1: Who should be designated as traditional healers?

Question 2: How and by whom should the individuals be selected and credentialed?

Question 3: Should these healers be licensed or exempt from licensure?

Question 4: Should traditional healers be allowed to charge for their services? And, how should this be accomplished?

Question 5: Should there be a sliding fee scale?

Question 6: Should traditional healing be integrated with conventional medicine or should it be kept separate?

Question 7: How should traditional healing be perpetuated and how should it be taught?

Question 1

“Who should be designated as traditional healers?”

The great Hawaiian scholar and author Samuel Kamakau wrote that healers are characterized by three distinct qualities.

1. *Ma‘ema‘e o waho*, the outward purity of the healer. That in appearance, manner, and practice, the healer emulated purity that was visible and understood by the people who looked at him or her.
2. *Ma‘ema‘e o loko*, the inner purity of the traditional healer. The inner purity was understood in all that the healer said and was present in the healing that was done through his or her work and the continual success of the healer.
3. *Haipule*, the healer’s piety. The healer had a direct relationship with *Akua* or God. This, the aura, was the greatest quality of the healer.

Traditional healers have other qualifiers, which we must include, that pertain to their specific healing abilities.

4. *Mo‘okūauhau*, the genealogy. An ancient ‘*Ōlelo noeau* or proverb states, “*Ko ke Akua ha‘i āmio*,” or the Gods speak through narrow channels. Our ancient Gods established the tradition of the *kahuna* or healers in our ancient past. The Gods chose the lineages of the *kahuna*; therefore, the genealogies from the ancient past of our people to the present, reflective of the lineage of the *kahuna*, must always be taken into account when referring to “traditional healers.”

The word “tradition” or *ka ‘ike a me ka noe‘au o nā kūpuna* imparts the meaning that at some place and time in our ancient history, this art/skill was begun by someone and handed down from generation to generation. It is perpetuated today.

That a healer can verify his or her lineage from an established lineage of healers is not only of great importance but also sacrosanct, and he or she is the embodiment of the *mana* or authority and the *mana* or power of that lineage. He or she is the *iwi*, the bones, the *i‘o*, the flesh,

and the *koko*, the blood, of their ancestors. They are the embodiment of a legacy from ancient time until today.

5. *Mo'o Kahuna*, the succession of the lineage of the *kahuna*. Although the healer may not be of the bones, the flesh, or the blood of a particular lineage, he or she may have been taught by someone of that lineage. Through the teachings, he or she becomes a part of that lineage and has a responsibility to perpetuate that lineage.

6. *Ulu pono*, the success rate of the healer.

7. *Hana mau ana*, the years of commitment to healing.

Although I do not want to discount contemporary healers and healing styles, I feel they must be distinguished from traditional healers and traditional healing styles as established by the fourth and fifth qualifiers listed above for traditional healers. I also feel that the first three qualifiers as well as the sixth and seventh do apply to all healers and should be used as "the standards."

These people may not have the lineage or genealogy by being a descendant or by being taught by a particular lineage but may have a unique gift of healing.

Also included with contemporary healers are people who are genuine in their intention and have taken the time to learn, to study, to practice, and to take workshops, all with the intention of healing.

Question 2

"How and by whom should the individuals be selected and credentialed?"

The qualifiers of question one are the same in application to the credentialing. To be a *kahuna*, the individual must have the following qualifiers:

1. *Mo'okūauhau*, genealogy, that a *kahuna* descends from an established lineage of healers or descends from the teaching of that lineage. And that he or she has been trained through a lineage and tradition of a *kahuna*.

2. *Ho'okahuna*, training, that a person becomes a *kahuna* through his genealogy and training.
And that a person can only become a *kahuna* if he or she is selected to be one by another *kahuna*.
3. *Ma'ema'e o waho/ma'ema' o loko*, that the healers reflect an outward and inward purity that imbues all that they do in their healing.
4. *Haipule*, piety, that their relationship with God is seen in their holiness and ability to heal.

Question 3

“Should these healers be licensed or exempt from licensure?”

The traditional healer or *kahuna* already meets all the qualifications of question one; therefore, he or she by traditional standards is more than licensed.

By western standards, the *kahuna* is not licensed, but if being licensed is a means to obtain health insurance benefits for working in a clinic situation much like the one I work in, then he or she should merit the recognition and honor that come with the work.

Question 4

“Should traditional healers be allowed to charge for their services? And how should this be accomplished?”

We refer to fee for service with the tradition of *ho'okupu* or gift giving. In studying the historical writings of Kamakau, he makes mention of a *kahuna* receiving gifts for his or her services. The wealthier the person, the greater the gifts that were given. The chiefs, because of their wealth, gave vast amounts of gifts. The *maka'ainana* or the common people gave lesser gifts. However, **everyone** gave gifts or *ho'okupu*. It remains to be our responsibility and tradition.

Ho'okupu was given to the people that gathered the herbs for preparation into medicine by the *kahuna*. Gifts were always given because the gift giving is seen as part of the healing process for that person who is seeking the healing.

Two existing services that we may be able to align with “fee for services” are:

1. *Lomilomi*, massage
2. *La'au*, herbal medicines, teas, and tonics.

I say this because health insurance already covers the cost or part of the cost for these services through a prescription for medicine or if a referral for therapeutic massage is made by a medical doctor.

A possible third service would be *ho'oponopono* or counseling. This tradition could be aligned with psychiatry or possibly social work and should be charged for services through health insurance accordingly.

Question 5

“Should there be a sliding scale?”

The sliding fee scale much like the *ho'okupu* or gift giving for services is most appropriate for the traditional healers and the contemporary healers as well as in regards to *lomilomi* or massage, *la'au* or medicines, teas and tonics, and for *ho'oponopono* or counseling. For other healing traditions such as, *pule hō'ola* or prayer for healing, *la'au kāhea* or distance prayer and praying for guidance for healing, *inoa* or the tradition of giving a name, and *ho'omaika'i* or the tradition of blessing, *ho'okupu* should remain in perpetuity.

Question 6

“Should traditional healing be integrated with conventional medicine or should it be kept separate?”

Although I do believe that we can work together to access success in the healing and the wellness of our patients, conventional medicine and traditional healing practices should remain separate yet respectful of each other's traditions and skills. The foundation of the practice of the traditional healer is *pule* or prayer. *Pule* plays an important role in every aspect of the work of the traditional healer. Diagnosing is done through prayer. The gathering and preparation of herbal medicines is done with prayer. Administering of herbal medicines is done with prayer. This is because the deity is attached to every aspect of healing and is manifest in all living things.

If conventional medicine were the same, doctors would be no different and would be called "traditional healers."

However, there is a difference and it is reflected in our beliefs, in the ways we are schooled, the ways that we practice, and in the ways that we promote our work and ourselves.

There may be a time when we will be able to integrate our traditions/services in healing particular clients and particular illnesses. The success of these collaborations is dependent on the respect of each other's traditions.

The designation of traditional healer must be distinguished from contemporary healers and professionals practicing conventional medicine who have taken specialized courses that now enable them to advertise these traditional specialties and charge unrealistic set fees for them. Again, I cannot emphasize more the importance of the criteria of a traditional healer than I have already detailed in answer to question one

Question 7

"How should traditional healing be perpetuated and how should it be taught?"

I come from a genealogy of healers and from a legacy of healing traditions. I have letters of support from family members and specialists who can validate that I was chosen and trained by *kahuna* and come from an ancient genealogy of *kahuna*. I am of the bones, the flesh, and the blood of my ancestors. In my mind, the healing tradition should be perpetuated in the exact same way that was done to me. That, like my teachers decided, I decide how and to whom that legacy is imparted to.

I may not have gone to conventional medical school nor graduated and received my diploma and my license to practice, but I have fulfilled every one of the qualifiers of a *kahuna* from question one. I trained under the strict tutelage of my last teacher, Emma Defries, a recognized *kahuna* in the state of Hāwai'i from 1972 until her death in 1982 and have been practicing since then.

I hope that these words have been of some help to you in putting the work together that you are doing. This legacy and these genealogies are of utmost importance, and we must work together to uplift them for they come from an ancient source and an ancient beginning, and their traditions are being perpetuated today through the traditional healers.

We must honor the traditional healers and give them the due respect that their station, practice, and commitment call for. The traditional healers should be at the forefront of all decision-making processes that pertain to traditional healing and traditional healing practices.

I hope that my answers are of help to you and your work as the Senior Advisor to the White House Commission on Alternative Medicine. On a personal note, I ask you with the information in this letter to please uplift the status of the "traditional healer."

Hawaii State House Resolution196

Speaker
HENRY HAALILIO PETERS
Vice Speaker
DANIEL J. KIHANO
Majority Leader
DENNIS R. YAMADA
Majority Floor Leader
KATHLEEN STANLEY

HOUSE OF REPRESENTATIVES THE ELEVENTH LEGISLATURE

STATE OF HAWAII
STATE CAPITOL
HONOLULU, HAWAII 96813



February 10, 1981

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HERBERT A. SEGAWA
Third District
YOSHITO TAKAMINE
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Minority Leader
Minority Floor Leader

Mr. Frank Kawaikapuokalani Hewett

Dear Mr. Hewett:

I transmit herewith a certificate and a
copy of House Resolution No. 196, which
was adopted by the House of Representatives of the
Eleventh Legislature of the State of Hawaii, Regular
Session of 1981.

Very respectfully,

George M. Takane

George M. Takane
Clerk, House of Representatives

(To be made one and ten copies)

HOUSE OF REPRESENTATIVES
ELEVENTH LEGISLATURE, 1981
STATE OF HAWAII

H.R. NO. 196

HOUSE RESOLUTION

HONORING THE MEMORY, THE SPIRITUAL LEADERSHIP, AND THE CULTURAL CONTRIBUTIONS OF THE LATE "AUNTIE" EMMA DE FRIES.

WHEREAS, "Auntie" Emma de Fries, passed away on December 8, 1980 at the age of 76; and

WHEREAS, Auntie Emma, a born mystic and a kahuna nui was highly respected and loved among Hawaiians as a spiritual leader in tune with nature; and

WHEREAS, she devoted much of her life to the perpetuation of the Hawaiian culture by giving talks about old Hawaii and teaching the Hawaiian language, hula, and ancient chants; and

WHEREAS, she was a descendant of Hewahewa, the Kahuna nui to Kamehameha the Great and was the granddaughter of Henry Kaaunuiamahi de Fries, son of John Howard de Fries, who brought some of the first Chinese families to Hawaii; and

WHEREAS, she was a member and spiritual adviser of the Protect Kahoolawe Ohana and made trips to the target island to conduct ancient Hawaiian religious services; and

WHEREAS, in 1979, she was one of nine persons honored by the Honpa Hongwanji Mission of Hawaii as a living treasure of Hawaii; and

WHEREAS, as an example of her dedication to Hawaiian activities and despite the development of a heart condition during the summer of 1980, she chanted at a four-hour rally at Iolani Palace for those participating in the election for the Office of Hawaiian Affairs; and

WHEREAS, she was a member of the Daughters of Hawaii and numerous other Hawaiian civic organizations and for many years served as curator of the Queen Emma Summer Palace; and

WHEREAS, her selfless devotion to the perpetuation of the Hawaiian culture will be deeply missed for she touched many people with her respected authority; now, therefore,

BE IT RESOLVED by the House of Representatives of the Eleventh Legislature of the State of Hawaii, Regular Session of 1981, that this body honors the memory of Emma de Fries and extends its condolences and heartfelt sympathy to her family; and

BE IT FURTHER RESOLVED that certified copies of this Resolution be transmitted to her hanai children, Olga Kahihiimaikalani Mitchell, Pua Wong, and protege Frank Kawaikapuokalani Hewett; sisters, Mrs. Esther K. Smythe, Mrs. Marion Espinal, Mrs. Lani Kalama, Mrs. Violet Anakalea, Ms. Heanu de Fries, and Mrs. Pomaiulu Sham; brothers, Henry H., Danny, and Victor de Fries; family matriarch, Mrs. Marion Peters; and nephew, John Alexander Liholiho de Fries III.

Richard M. Mahum
Russell J. Abraham
Robert J. Hanks
Marshall K. Ry

Daniel M. Nakamoto

Henry H. Nakamoto
Herbert Segawa
Walter H. Hanks

Robert M. Hanks
Richard M. Hanks
Walter H. Hanks
John H. Hanks

Charles H. Hanks
Kiy T. Kumura

James Aki
H. H. Hanks

OFFERED BY:

J. H. Hanks

Kenneth Boyd Kamalier

Eloise Yamashita Tungpala

Daniel M. Hanks

Ann C. Hanks

Anthony Hanks

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John Hanks

John Hanks

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Calvin K. Hanks

Ben J. Vignoli
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William W. Throckmorton
Wilbur J. And
Frederick W. Hollings

Support Letter

Malia Craver
Queen Liliuokalani Children's Center
Kupuna/Hawaiian Spiritual and Cultural Consultant



QUEEN LILI'UOKALANI CHILDREN'S CENTER LILI'UOKALANI TRUST

16 November 2000

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PHONE 245-1873
FAX 245-2167

Waimanalo Health Center

Board of Directors

41-1347 A Kalaniana'ole Highway

Waimanalo, Hawaii 96795

Aloha Kākou

My name is Aunty Malia Craver and I write this letter to support Kawaikapuokalani Hewett as Waimanalo Health Center's Cultural Practitioner/Kahuna.

Kawaikapuokalani is a humble man, knowledgeable in the Hawaiian cultural traditions and customs of our ancestors. With this knowledge and the gifts given to him by his kūpuna, he is able to maintain the culture and traditions of the past and incorporate them into today's ever-changing world.

Kawaikapuokalani's genealogical history traces thirty generations from Pa'ao to Hewahewa Nui, the last high priest. The thirty generations also represents the migrations of Pa'ao from approximately 936 A.D. In Hawaii's history, there were two dynasties. The religious rule from Pa'ao to Hewahewa Nui, 870 years and the secular rule from Pili to Lili'uokalani, 929 years. Kawaikapuokalani's kūpuna are the 26th generation of Huanuikalāla'ila'i, before Hewahewa Nui.

If I can be of further assistance, please do not hesitate to contact me. Mahalo.

O' wau nō me ka ha'aha'a

Mary M. Craver

Mary Malia Craver
Kupuna/Hawaiian Spiritual and
Cultural Consultant

cc: Kawaikapuokalani Hewett

Support Letter

**Kawena Johnson
Emeritus Professor of Hawaiian
University of Hawaii-Manoa**

Rubellite Kawena Johnson
1019 Maunaihi Place #102
Honolulu, HI 96822
October 3, 2000

Waimanalo Health Center
Board of Directors
41-1347 A Kalaniana'ole Hwy.
Waimanalo, HI 96795

To whom it may concern:

I had hoped to have this letter of recommendation and support for Frank Kawaikapuokalani K. Hewett in the mail before September 29th past, but I am late with it. I trust, however, that you will have it in your hearts to overlook this tardiness on my part and that it will not deter you from giving him your wholehearted support in what is dearest to all of our hearts and interests now and in the future. I say this because never before has it become so important to put our best people into those areas of Hawaiian leadership which will help to see Native Hawaiians secure those most talented and most qualified to serve.

I refer to Kawaikapuokalani, whom I have known since the days he was matriculating in the hula with Auntie Edith Kanaka'ole in Hilo. He was then a very young man pursuing a rounded education with specific attention to the dance, especially the kahiko. I had not met him then, but I had heard numerous marvelous reports on his ability, both from Auntie Edith herself and other instructors at the University of Hawaii-Hilo, such as Fred Kalani Meinecke (now Director of the Hawaiian Language Program at Windward Community College) while I was teaching at University of Hawaii- Manoa campus.

Later, he came to Manoa to learn more, and I was fortunate to have him in a special class reserved by the Department of Indo-Pacific Languages. It was a tutorial class in which the student may select someone to study with, and he enrolled with me in advanced Hawaiian language translation. For this tutorial Frank himself selected the materials which we would work on together, and most of them were items from his own family records--chants, especially, of the most difficult kind, because they were the *mele inoa* and *koihorua* of so many of the prominent chiefs of old. All of them were originals which had never been translated. We wrestled with them throughout the time for which he was enrolled, and he was punctual, did his work, and showed a sincere interest to searching for answers to those difficult passages that refuse to be translated. I attest to his willingness to probe and to reserve judgment until the most trustworthy decision is made on a difficult usage in the text, to which he brought the distinct advantage of knowing the *hula kahiko*.

I found, as he once said to an audience on the island of Hawaii, where he was one of the principal speakers, that he was descended from one of the most famous of the district chiefs of Kona, Ke'eaumoku-papaiahehe, father of Ka'ahumanu, wife of Kamehameha I. It is not so much that he is a descendant of that great person, for all Hawaiians connect to great ones such as Ke'eaumoku, but it was the appeal that he made to the audience so that we could overcome the tabu on speaking about one's genealogy in public, that he would have to break with that tabu. Ordinarily, afterward, you may hear some folks grumbling, especially among the elders, but no one was left put out by his remarks. Quite the opposite happened. He opened a door which until then had a big lock on it.

I remember then being impressed with his public delivery and how his approach to that audience showed his sensitivity to Hawaiian feelings about certain tabu things. Ever since he has demonstrated that quality and capability. He is one of the few Hawaiian talents with serious intent about representing Hawaiian society and culture with art and dignity.

Therefore, I recommend that he be recognized as a Native Hawaiian practitioner of Hawaiian arts and sciences, particularly of those aspects of Hawaiian medical practices and the healing arts, the *ho'oponopono*, *la'au kahea*, *kapa inoa*, *ho'omaika'i i ke akua*, *la'au lapa'au* methods which he knows from his in-family practices and from specialists with whom he had been faithfully trained from boyhood into manhood.

He has also developed his own management style and self-support through his own initiative, and there is ample evidence in his public work and performances that he has supplied a whole new generation the standards of former generations as to have, therefore, sincerely earned the public trust.

I urge that you give him every favorable consideration.

Very sincerely yours,

A handwritten signature in cursive script that reads "Rubellite Kawena Johnson". The signature is written in dark ink and is positioned above the printed name.

Rubellite Kawena Johnson
Emeritus Professor of Hawaiian,
University of Hawaii-Manoa

Support Letter

**Paul Ka'ikena Pearsall, Ph.D.
President and CEO, Ho'ala Hou**

PAUL PEARSALL, Ph.D.

President and CEO, Ho'ala Hou (To Revitalize)

December 1, 2000

Waimanalo Health Center
Board of Directors
41-1347 A Kalaniana'ole Highway
Waimanalo, Hawaii 96795

Aloha Kakaou:

I am writing in support of Kawaikapuokalani Hewett as Waimanalo Health Center's Cultural Practitioner/Kahuna. Kawaikapuokalani's genealogical history, deep and broad knowledge of Hawaiian cultural customs, traditions, and rituals, fluency in the Hawaiian language, its derivatives and meanings, and 'Olelo no eua, and his long and creative contributions to hula can be attested to by kupuna throughout the islands. In addition to these most profound and appropriate credentials that make him a most unique and valuable Hawaiian healer in every sense of that word, I humbly offer my view of his credentials from my perspective as a psychoneuroimmunologist, clinician, researcher, and former director and chief of behavioral medicine at Beaumont Hospital and Sinai Hospital. In these roles, I hope the board will consider my perspective on Kawaikapu's skills as a Hawaiian cultural perpetuator, practitioner, and kahuna.

Kawaikapu is unique in his ability to incorporate the most recent findings from modern medicine into his strong cultural background. I have known Kawaikapu for more than 20 years. During that time, I have had the honor of speaking on the same program with him at many major medical programs, including the Harvard and Stanford Schools of Medicine and many other programs involving international audiences of healers and health care workers from around the world. He immediately earns the respect of Western scientists while being able to teach them about the powerful and sacred concepts of the Hawaiian healing arts. He has been able to impress the most careful and respected physicians while honoring and never compromising the Hawaiian healing traditions and their historic spiritual base. He illustrates the relationship of the various Hawaiian healing arts and concepts to modern medicine's increasing awareness of the wisdom of ancient ways to well-being. He is able to go beyond the various systems of Hawaiian medicine to teach the central and established concepts upon which these systems are historically based. He always begins from the point of respect and honoring of fundamental Hawaiian

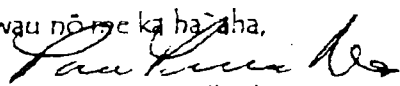
principles and guards against their corruption, simplification, or misuse by those who would yet again take from the Hawaiian culture without honoring its historic wisdom or understanding its spiritual roots.

Kawaikapu has also written a highly esteemed forward to one of my recent books regarding the power of prayer and distant intent. Many physicians, scientists, and researchers around the world have complemented his forward and its gentle blend of ancient Hawaiian concepts of healing with the most recent research on the impact on living systems by distant intentionality. I have witnessed Kawaikapu doing this same thing in my role as a member of the clinical advisory board for the 'Ai Kupele Cultural Healing Program at the Waimanalo Health Center.

The Latin root meaning of the word "doctor" is "to teach." Kawaikapu is one of Hawaii's most revered, effective, and influential teachers. The Latin meaning of the word "heal" is "to make whole." Kawaikapu's knowledge of the Hawaiian language and its sacred meanings, his life-long respect for the Hawaiian culture, his creativity in seeing how these cultural lessons can be dynamic and powerful guides in healthy modern life, and particularly his skills at cautious, humble, careful, inclusive patient assessment of health and healing issues make him uniquely qualified to help patients become "whole" again.

Kawaikapu has a modern mind, Hawaiian heart, healer's spirit, and indigenous soul. He will be a most valuable resource for the Waimanalo Health Center and to those who seek its help and guidance.

O wau nō me ka ha'aha,



Paul Ka'ikena Pearsall, Ph. D.

President and CEO, Ho'ala Hou

Clinical Professor, University of Hawaii at Manoa

Heart Transplant Study Team and Human Energy Laboratory, University of Arizona

School of Medicine

Board of Directors, Hawaii State Consortium on Integrative Health Care

cc: Kawaikapuokalani Hewett

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February 1, 2002

Stephen C. Groft, Pharm.D, Executive Director
White House Commission on Complementary and Alternative Medicine
Policy
6701 Rockledge Drive
Rockledge II, Room 1010, Mail Stop 7707
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Dear Dr. Groft,

Thank you for your letter of February 1, 2001, requesting our responses to specific questions for the Commission.

First, let me say I am not a traditional healer. My responses are those of an administrator of a health advocacy and health facilitating agency focusing on issues surrounding Native Hawaiian health and wellbeing and the health and wellbeing of other native peoples both on the continental United States and in the Pacific.

With that proviso in mind, let me respond to your questions. A forethought....if the Commission is truly serious about its fact-finding in the area of traditional healing practices among the native peoples of what now is the United States, ie. American Indians, Alaska Natives, and Native Hawaiians, it must go to them and seek guidance. Long-distance communication via letter, e-mail, etc. is not culturally appropriate for discussion of such subjects which at their core have a strong spiritual base. There are important protocols, some of which directly relate to your questions, which simply can not be grasped or translated without personal face to face communication. Native cultures are oral cultures and as such personal relationships form the basis of trust and, ultimately, information sharing.

First some background....Native Hawaiian healing practices reflect traditions which extend back two thousand years and before. Prior to western contact, a whole multitude of practices were known and used by traditional healers to keep the population well and healthy. The physical practices have been outlined in Handy, E.S.C., M.K. Pukui, and K. Livermore. Outline of Hawaiian Physical Therapeutics, Bishop Museum

Bulletin 126, 1934 (reprint 1985) while the mental practices and values associated with Native Hawaiian culture are discussed in Pukui, M.K., E.W. Haertig, and C.A. Lee. Nana I Ke Kumu, vol. 1 and vol. 2, Queen Lili'uokalani Childrens Center, Honolulu, 1972.

Today, there are four major practices which continue and are practiced within the Native Hawaiian family structure, the Native Hawaiian community, and/or the community at large. All are based on a strong spiritual foundation and include bits and pieces of each other. These practices are:

- o La`au Lapa`au - The practices associated with the healing qualities of plants and herbs in association with purifying the body.
- o Lomilomi - The practices associated with body massage and manipulation.
- o La`au Kahea - The practices associated with calling upon divine intervention in association with healing natural products.
- o Ho`oponopono - The practices associated with setting right relationships among people.

There are a number of resource materials which have been published on these practices and these are noted in the attached Reference List (See Traditional Healing).

Your specific questions:

- (1) Who should be allowed to use the 'Traditional Healer' designation?

The Native Hawaiian Health Care Improvement Act (P.L. 100-579/reauthorized in P.L. 102-396/and currently in Congress for reauthorization as S. 87) defines a *Traditional Native Hawaiian Healer* as follows:

Traditional Native Hawaiian Healer.-The term "traditional Native Hawaiian healer" means a practitioner-

- (A) who-
 - (i) is of Hawaiian ancestry, and
 - (ii) has the knowledge, skills, and experience in direct personal health care of individuals, and
- (B) whose knowledge, skills, and experience are based on demonstrated learning of Native Hawaiian healing practices

acquired by-

- (i) direct practical association with Native Hawaiian elders, and*
- (ii) oral traditions transmitted from generation to generation.*

We continue to abide by and respect this definition. In 1998, Papa Ola Lokahi was asked to convene a state-wide group of elder Native Hawaiian practitioners by the State Legislature for the purpose of making recommendations on licensure requirements. The group in its deliberations acknowledged this definition but, at the same time, some elders did not feel that one needed to be of Hawaiian ancestry to practice traditional Native Hawaiian healing practices.

(2) How and by whom should Traditional Healers be selected and credentialed?

In terms of selection, generally, the selection process is 'self-selecting'...i.e, the community knows who to go to and for what. In early days, healers were family-based and family members know who in their family was trained to do what. Today, this is not the case. Some traditional healers are practicing within larger institutions or organizations such as the Waimanalo Health Center, the Waikiki Health Center, and the Wai`anae Coast Comprehensive Health Center. In Wai`anae, the practitioners are 'judged' to be valid and competent practitioners by an advisory group of Native Hawaiian elders from the community. The Waikiki Health Center teams one of its nurse practitioners with a traditional healer when services are provided. Other traditional healers practice as sole proprietors. In the self-selecting process, those healers who are not all that they say they are, are quickly identified by the community.

The credential question has been an on-going one in Hawai`i. Under King Kalakaua in the 1880s, a credentialing committee was established for practitioners. It was never able to control who accessed whom for service, however, because many healers simply continued to do what they always did within their respective families. And family members continued to seek help from their respective family healers. Any credentialing authority today would not succeed as there is simply not a consensus for such among the healers themselves and the Native Hawaiian community generally. As the elder group convened by Papa Ola Lokahi in 1998 stated....Native Hawaiian healers are 'credentialed' by Ke Akua (God)....not by politicians or state agencies.

(3) Should Traditional Healers be licensed or exempt from licensure?

In Hawai`i, traditional Native Hawaiian healers are exempt from licensure by state law (See Hawaii Revised Statute 453-2). Papa Ola Lokahi has been active in this effort. Without exemption, Native Hawaiian

practitioners would be in violation of Hawai'i State law as it relates to the practice of medicine.

(4) Should traditional Healers be allowed to charge for their services?

This is an on-going discussion in the Native Hawaiian community. It is best discussed and defined by the practitioners themselves. In olden times, the traditional healing practices were provided with no set "fee schedule" in mind. Individuals could make donations and contributions in the form of produce or whatever they valued for services provided.

(5) Should traditional healing be integrated with conventional medicine?

In Hawai'i, traditional healing has already been integrated with conventional medicine in a number of instances. As noted above, three of the primary health care centers have already done so (Waimanalo Health Center, Waikiki Health Center, and Wai'anae Health Center). At the federal level, the US Department of Veterans Affairs in Hawai'i is currently developing an integrated approach for those desiring traditional Native Hawaiian healing services. This is based on the Navajo experience.

At the same time, there are some practitioners who do not want to be integrated or practice within the confines of a health center or public program. Much depends upon the individual perspective of the traditional Native Hawaiian healer. This is another question best responded to by traditional healers themselves.

(6) How should traditional healing be preserved and perpetuated?

This is something the culture must do...not government. Government can assist in the process by creating a climate for its continuation, i.e. employment and training funds for individuals in training, etc., but because the process of preserving and/or perpetuating traditional healing practices is part of a cultural process with specific protocols and personal dedication and choices of lifestyle, it does not lend itself to direct government intervention. This question can again best be answered by the traditional practitioners themselves.

(7) To whom and how should traditional healing be taught?

Traditionally, the healer would make the determination as to whom he or she would teach. Because such practices are culturally based and reflect to knowledge of generations as per the healer, that knowledge remains the property and responsibility of the healer to pass on....and, indeed, it is his or her choice not to pass on as well. Teaching venues, again, are the purview of the traditional healers themselves...not something

that can be standardized or necessarily institutionalized.

(8) Should there be communication between conventional health care providers and traditional healers when both are involved?

It is Papa Ola Lokahi's hope that there would certainly be some interaction when clients seek services from both types of providers. This occurs in most cases now. Some traditional practitioners will not treat clients if they are undergoing certain procedures or are on certain medicines. In the practice of la'au, there are certain plant substances which are not appropriate when taken in conjunction with certain pharmaceuticals. It is important that clients and health providers be aware.

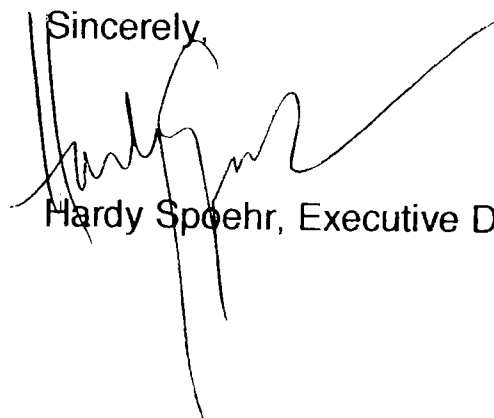
(9) What policy recommendations would we make to the Commission?

In the Native Hawaiian Health Care Improvement Act, we have tried to enable and encourage traditional Native Hawaiian healing practices for those so desiring these services (See S. 87, 107th Congress).

Our basic policy recommendation is more of a procedural one. You need to reach out to the traditional practitioners in the country....go to them...to Navajo, to Lakota, to Seneca, to Passamaquoddy/Penobscot, to Hawai'i, to Samoa, and to ask them directly and personally how and what is needed to enable them to carry on their traditional practices and the other questions noted above.

Thank you for the opportunity to reply.

Sincerely,

A handwritten signature in black ink, appearing to read 'Hardy Spehr', with a long, sweeping horizontal stroke extending to the right.

Hardy Spehr, Executive Director

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NATIVE HAWAIIAN REFERENCE LIST

The following list of references is not a comprehensive list. It attempts to identify a sampling of studies and reports on the subject of Native Hawaiian health. References are listed in alphabetical order by topic. Publications may appear in more than one category. Kanaka Maoli Authors' names are in boldface type.

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