

Information Summary and Recommendations

Physical Therapy Dry Needling

Sunrise Review

December 2016



Publication Number 631-063

For more information or additional
copies of this report contact:

Health Systems Quality Assurance
Office of the Assistant Secretary
PO Box 47850
Olympia, WA 98504-7850
360-236-4612

John Wiesman, DrPH, MPH
Secretary of Health

This page intentionally left blank.

Contents

Page

- 1 The Sunrise Review Process
- 3 Executive Summary
- 7 Summary of Information
- 23 Review of Evidence of Efficacy
- 27 Review of Proposal Using Sunrise Criteria
- 29 Detailed Recommendations
- 31 Summary of Rebuttals to Draft Recommendations

Appendix A: Request from Legislature and Draft Bill

Appendix B: Applicant Report and Follow Up

Appendix C: Public Hearing Summary

Appendix D: Written Comments

Appendix E: Other States

Appendix F: Rebuttals to Draft Recommendations

This page intentionally left blank.

THE SUNRISE REVIEW PROCESS

A sunrise review is an evaluation of a proposal to change the laws regulating health professions in Washington. The Washington State Legislature's intent, as stated in chapter 18.120 RCW, is to permit all qualified people to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession. Changes to the scope of practice should benefit the public.

The Sunrise Act (RCW 18.120.010) says a health care profession should be regulated or scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

If the legislature identifies a need and finds it necessary to regulate a health profession not previously regulated, it should select the least restrictive alternative method of regulation, consistent with the public interest. Five types of regulation may be considered as set forth in RCW 18.120.010(3):

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions, and criminal prohibitions are not sufficient to eradicate existing harm.
2. *Inspection requirements.* A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business, when a service being performed for people involves a hazard to the public health, safety or welfare.
3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practices and, if required, a description of the service provided. A registered person is subject to the Uniform Disciplinary Act (chapter 18.130 RCW).
4. *Certification.* A voluntary process by which the state grants recognition to a person who has met certain qualifications. Non-certified people may perform the same tasks, but may not use "certified" in the title.¹ A certified person is subject to the Uniform Disciplinary Act.
5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to people who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensed person is subject to the Uniform Disciplinary Act.

¹ Although the law defines certification as voluntary, many health care professions have a mandatory certification requirement such as nursing assistants-certified, home care aides, and pharmacy technicians.

This page intentionally left blank.

EXECUTIVE SUMMARY

Background and Proposal

In March of 2016, Senator Randi Becker, Chair of the Senate Health Care Committee requested the Department of Health (department) conduct a sunrise review of a proposal to add dry needling to the physical therapist scope of practice. The Physical Therapy Association of Washington (PTWA) (applicant) provided an applicant report addressing how the proposal meets the sunrise criteria in chapter 18.120 RCW. PTWA provided a 2015 dry needling practice analysis prepared by the Human Resources Research Organization (HumRRO) as the basis for the proposal. Additionally, Senator Becker asked the department to “review the evidence on the efficacy of dry needling.”

Senate Bill (SB) 6374, included with the request, would create an endorsement on the physical therapy license. This endorsement would be available to physical therapists that have completed one year of full time physical therapy practice and 54 hours of education and training in dry needling. Dry needling is defined in the bill as “a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments. Dry needling does not include the stimulation or treatment of acupuncture points and meridians. ‘Dry needling’ is also known as intramuscular manual therapy or trigger point manual therapy.”

There has been a nationwide debate about whether physical therapists should be practicing dry needling. The issues being considered include whether dry needling is acupuncture, whether it is in the physical therapy scope of practice, and whether physical therapists have sufficient training to safely add it to their statutory scope of practice. This debate has been contentious and has been resolved in many different ways across the states. (See pages 20-21 for details on how other states approach the issue of dry needling by physical therapists.)

Recommendations

The department does not support the applicant’s proposal as submitted to add dry needling to the physical therapy scope of practice. It does not meet the sunrise criteria for increasing a profession’s scope of practice.

Rationale:

- The applicant did not demonstrate that 54 hours of training is sufficient to ensure professional ability of physical therapists to perform dry needling, which is an invasive procedure with potential serious risks of patient injury. The HumRRO analysis did not address a minimum level of training or assess current training programs for adequacy.
- There is no supervised clinical experience requirement. Physical therapists have vast training, including supervised clinical experience, in anatomy and physiology. However, physical therapist training does not include use of needles in treatment.
- The applicant report states that the majority of education necessary to perform dry needling is taught in entry-level physical therapy doctoral education. However, not all physical therapists practicing in Washington have completed doctoral level training and a doctorate is not required for licensure.

In addition, there are other challenges to implementing the proposed bill, SB 6374:

- The definition of dry needling in the bill is problematic, specifically the statement “Dry needling does not include the stimulation or treatment of acupuncture points and meridians.” The physical location of myofascial trigger points, muscular, and connective tissue often correspond with acupuncture points and meridians.
- Section two does not limit the dry needling endorsement to physical therapists who have received their Doctor of Physical Therapy (DPT) degree, even though the applicant report uses doctoral level training as the basis for its assessment of physical therapists’ substantial training in anatomy and physiology. The current physical therapy statute and rules allow full licensure with a baccalaureate physical therapy degree, or a baccalaureate degree plus an advanced physical therapy degree or certificate.

The applicants have, however, demonstrated the following:

- With adequate training that includes a clinical component, dry needling may fit within the physical therapist’s scope of practice in treating neuromusculoskeletal pain and movement impairments.
- Evidence provided in this review demonstrates a low rate of serious adverse events from physical therapists performing dry needling in other states, the United States military, and Canada.

The legislature may wish to consider adding dry needling to the physical therapist scope of practice through proposed legislation that includes additional safety requirements such as:

- Requirements for dry needling-specific education:
 - Inclusion of specific topics to include, at a minimum, the 16 specialized knowledge areas identified in the HumRRO analysis for competency in dry needling;
 - Specific training on needling high-risk areas and avoidance of serious adverse events;
 - Passage of a written and practical examination; and
 - Approval of training programs by the board of physical therapy;
- Authority for the Board of Physical Therapy to evaluate military training in dry needling to determine whether it meets the requirements above;
- Requirement for a supervised clinical practice experience to be defined in rule; including minimum hours and qualifications of supervisors. Recommend looking to other states for potential language, for example, Utah requires 250 supervised treatments;
- Requirement for physical therapists to obtain written informed consent from the patient on a form that clearly identifies the risks and benefits of dry needling and information on the physical therapist’s dry needling training. Recommend looking to Colorado for potential language;
- Clear authorization for physical therapists to use acupuncture needles in the practice of dry needling subject to the limitations in statute;

- Clear limitation that the use of acupuncture needles is only authorized within the physical therapist's management of neuromusculoskeletal pain and movement impairments, and require referral to an authorized practitioner of acupuncture for use of acupuncture needles for any other purpose; and
- Amend the definition of dry needling to remove the statement "Dry needling does not include the stimulation or treatment of acupuncture points and meridians."

Regulations developed by other states may be helpful in drafting proposed legislation.

This page intentionally left blank.

SUMMARY OF INFORMATION

Proposal and Bill Draft

In March of 2016, Senator Randi Becker, Chair of the Senate Health Care Committee, requested the department conduct a sunrise review of a proposal to add dry needling to the physical therapist scope of practice. The request included SB 6374 for consideration. PTWA provided an applicant report addressing how the proposal meets the sunrise criteria in chapter 18.120 RCW. Additionally, Senator Becker asked the department to “review the evidence on the efficacy of dry needling.”

SB 6374 would create an endorsement on the physical therapy license, available to physical therapists that have completed one year of full time physical therapy practice and 54 hours of education and training in dry needling. Dry needling is defined in the bill as “a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments. Dry needling does not include the stimulation or treatment of acupuncture points and meridians. ‘Dry needling’ is also known as intramuscular manual therapy or trigger point manual therapy.”

Background

There has been a nationwide debate about whether physical therapists should be practicing dry needling. The issues being discussed include whether dry needling is acupuncture, whether it is in the physical therapy scope of practice, and whether physical therapists have sufficient training to safely add it to their legislative scope of practice. This debate has been contentious and has been resolved in many different ways across the states. (See pages 20-21 for details on how other states approach the issue of dry needling by physical therapists.)

Recent activity in Washington regarding dry needling includes:

- On October 10, 2014, the King County Superior Court issued an order for partial summary judgement against Kinetacore, et al., enjoining them from inserting acupuncture needles or any similar needles for the purpose of dry needling in Washington. The judgement stated that a person that penetrates the tissues of human beings with acupuncture needles is practicing medicine.
- In December of 2014, the Board of Physical Therapy passed a motion that it would not address the issue of dry needling until the legislature provides further direction.
- On April 15, 2016, the Washington State Attorney General issued a formal opinion² on whether the practice of dry needling is within a licensed physical therapist’s scope of practice as defined in chapter 18.74 RCW. This was done at the request of Representative Eileen Cody. The attorney general opinion was that the current physical therapy scope of practice does not encompass dry needling, but noted that the legislature could expand the scope by amending the physical therapy statute.

The applicant group states that dry needling is used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, diminish persistent peripheral nociceptive (pain) inputs, and reduce

²AGO 2016 No. 3, <http://www.atg.wa.gov/ago-opinions/scope-practice-physical-therapy>, accessed August 16, 2016.

or restore impairments of body structure and function leading to improved movement and function.³ The applicant further states that physical therapists' practice of dry needling has the potential to reduce the cost of more expensive medical procedures or treatments such as imaging, surgery, and opioid pain medication. The applicant asserts that physical therapists have the proper education in the biomedical sciences, are already treating neuro-musculoskeletal injuries and conditions associated with trigger point myofascial pain, and are the ideal practitioners to provide dry needling.

There appear to be multiple schools of thought on dry needling. The Travell and Simons trigger point manual includes trigger point injection in the form of dry needling or injection of local anesthetic. Integrative Dry Needling (IDN) is based on Dr. Yun-tao Ma's systemic concepts that allow practitioners to view and treat the human body as an inter-related organism, yet allows the clinical freedom to adapt the treatment for each patient.⁴ Gunn Intramuscular Stimulation (IMS) uses acupuncture needles to treat myofascial pain syndrome (MFPS). It is part of a program of treatment for MFPS that may also include massage, physical therapy, and stretching.⁵

Many East Asian Medicine Practitioners (EAMP) and associations representing them oppose the proposal to add dry needling to the physical therapy scope of practice and state that dry needling is a subset of acupuncture. They add that acupuncture is more than traditional Chinese medicine and includes many styles, several of which were developed in the 20th century. Many trigger points correlate with traditional acupuncture points and meridians. Acupuncturists and EAMPs also use needling techniques to treat "Ashi" points, which they state are the same as trigger points. They describe Ashi points as tender points that react to local pressure and create either local or radiating pain and may or may not correspond to a channel-based acupuncture point.

Applicant Explanation of Why the Change in Regulation is Necessary

The applicant report states that allowing physical therapists to perform dry needling benefits Washington patients and that it is a safe, effective and appropriate tool for physical therapists to use in treating musculoskeletal impairments. The endorsement approach in SB 6374 will ensure safe practice by defining educational requirements to perform the technique. The applicant further states that the risk of adverse effects when physical therapists have performed dry needling and all reported adverse events were considered mild, such as bruising and pain while being needled.

The applicant report asserts that no one health care profession owns a skill or modality and professions can share modalities if they have the appropriate education, training, and legal authority. A profession is not defined by one modality. It states that the Attorney General Opinion⁶ supports the idea of overlapping scopes of practice, stating "...nothing in the statutes governing East Asian medicine show legislative intent to make it the only health care practice that uses inserted solid needles."

³ Applicant report (Appendix B, p. 68) American Physical Therapy Association. Description of Dry Needling in Clinical Practice: An Educational Resource Paper. Produced by the APTA Public Policy, Practice, and Professional Affairs Unit. February 2013.

⁴ <https://integrativedryneedling.com/>, accessed August 16, 2016.

⁵ As described by UW Medical Center

⁶ AGO 2016 No. 3

The applicant also asserts that adding dry needling to the physical therapist scope of practice would be cost-effective. Access to dry needling treatment improves outcomes and facilitates patient participation when used in concert with other physical therapy techniques like manual therapy and active exercise. The applicant report states that patients who are already receiving physical therapy prefer to receive treatment within Western medical models, and other practitioners that perform dry needling, like orthopedic doctors and naturopaths, are usually more expensive. It adds that patients who are not able to receive this treatment may require many more sessions of physical therapy to treat their condition.

Physical Therapy Education and Training

As of January 1, 2016, the APTA has designated a DPT as the standard for all entry-level physical therapist education programs nationally. However, this has been an evolution over many years that started with a baccalaureate degree program as the required degree prior to 1979. APTA passed a resolution to begin shifting to a post-baccalaureate degree requirement by 1990, and this requirement has evolved to the current DPT entry-level standard. As of August 2010, over 96 percent of accredited physical therapy programs offered the DPT.⁷

Washington's physical therapy law accepts a baccalaureate degree in physical therapy, or baccalaureate degree plus an advanced degree or certification in physical therapy, as the minimum education for physical therapist licensure. Depending on when a currently licensed physical therapist was credentialed, he or she could hold a bachelor's, master's, or doctoral degree. The University of Washington's Doctor of Physical Therapy Program requires 162 credits, 4,860 hours of class and lab time, and 1,500 hours of supervised clinical education. This training includes:

- 218 hours of gross and musculoskeletal anatomy;
- 83 hours of physiology; and
- 60 hours of neuroscience.⁸

The applicant report states that the overwhelming majority of education necessary for physical therapists to practice dry needling, including anatomical, physiological, and biomechanical knowledge, is taught in the entry-level physical therapy doctoral education.⁹ It states that specific dry needling skills are supplemental to doctoral-level education. The applicant report also cites two studies suggesting physical therapists have knowledge, training and skills necessary to clinically diagnose and manage musculoskeletal injuries beyond most non-orthopedic physicians.¹⁰

The applicant report relies on a 2015 practice analysis on dry needling from the nonprofit organization, Human Resources Research Organization (HumRRO) as the basis of its proposal, including the educational requirements in the proposed bill. HumRRO was commissioned by the Federation of State Boards of Physical Therapy (FSBPT) to organize this practice analysis to

⁷ American Physical Therapy Association, *Today's Physical Therapist: A Comprehensive Review of a 21st-Century Health Care Profession*.

⁸ Applicant report, Appendix B, pp. 75-76.

⁹ Per applicant report, this is demonstrated by the HumRRO analysis. See applicant report, Appendix B, p. 73.

¹⁰ Applicant report, Appendix B, p. 76.

determine the knowledge required to be competent in dry needling. This analysis states that the overwhelming majority of education necessary for physical therapists to perform dry needling is taught in entry-level physical therapy education. The report lists 16 specialized knowledge requirements that require advanced, specialized training for dry needling. These include emergency preparedness tasks, secondary effects or complications associated with dry needling on other systems such as the cardiovascular system, contraindications, palpation techniques, needle insertion, needle manipulation techniques, and physiological responses to dry needling.

HumRRO concludes that 14 percent of the knowledge related to competency in dry needling must be acquired through post-graduate or specialized training. The only skills determined not to be in entry-level physical therapy education are the handling of the needle and psychomotor skills.

The applicant report states that the proposed legislation is based on the HumRRO practice analysis. However, there are inconsistencies between the applicant report and the HumRRO analysis on which it relies. These include:

- HumRRO does not identify training requirements. It identifies knowledge areas, tasks, and skills that require advanced or specialized training for physical therapists to perform dry needling.
- HumRRO acknowledges that there does not appear to be widespread agreement regarding the minimum number of practice hours necessary to perform dry needling, and that the acquisition of knowledge and skills is dependent on more than just the number of hours of deliberate practice.¹¹
- The applicant report assumes a DPT as the entry-level training in the proposal, but it is not clear whether the HumRRO analysis makes this same assumption. The HumRRO task force members were not all DPTs and this analysis was done at the national level.

In addition, the department identified some challenges with the HumRRO analysis, which include:

- HumRRO and FSBPT convened a task force with experts in dry needling to consolidate information and construct a final list of competencies. However, the task force only included representation of physical therapists. It did not include representation from other health care providers like EAMPs, medical doctors, or nurses, who could have offered their expertise in topics like needle technique, physiological responses, and contraindications to assist with development of minimum training to ensure safe needle technique.
- HumRRO states that 86 percent of the knowledge needed to safely perform dry needling is acquired during physical therapy entry-level education. This analysis is problematic because:
 - The HumRRO analysis identifies the entry-level physical therapy knowledge and skills required at the time of licensure. Licensure requirements and scopes of practice vary considerably from state-to-state.

¹¹ HumRRO Analysis footnote, Appendix B, p. 118.

- Entry-level education for Washington licensure only requires a baccalaureate physical therapy degree.
- The HumRRO analysis did not consider information specific to Washington, the task force members are not Washington-licensed physical therapists, and it appears that the physical therapists surveyed in this process represented a sample from across the country.

Dry Needling Training

PTWA's applicant report lists a number of dry needling courses currently being offered, including:¹²

- Kinetacore:
 - 54 contact hours (Level I and Level II, each level is 27 contact hours over three days) to earn the certificate. Approximately 40 of these hours are on needle handling.
 - Requires one year of physical therapy practice before registering for the course.
 - There is an additional course, Functional Therapeutics that is also 27 contact hours.
 - To qualify for the Level II course, you must have completed Level I and logged 200 dry needling treatments or have completed Level I and Functional Therapeutics and logged 100 dry needling treatments. Each level requires passing theoretical and practical exams to gain certificate and move to the next level.
- Integrative Dry Needling:
 - 54 contact hours (foundation and advanced courses, each 27 contact hours over three days). Approximately 39 of these hours are needle handling.
 - Foundation course is the prerequisite to take the advanced course.
- Institute of Advanced Musculoskeletal Treatments (IAMT):
 - 54 contact hours (Level I and Level II, each level is 27 contact hours).¹³ Approximately 49 of these hours are needle handling.
 - There is a level III course that does not specify the length of the course, but is described as combining manual therapy interventions with dry needling techniques and functional retraining to restore biomechanics and normalize function in patients.
- Myopain Seminars:
 - 81 contact hours (DN-1, DN-2, and DN-3 advanced course, each level is 27 contact hours over three days). Approximately 70 percent is needle handling.

¹² The applicant provided three different tables of information on these courses and the department has attempted to synthesize the information from those tables, Appendix B, pp. 91-93, pp. 164-179, and pp. 192-194.

¹³ The department received conflicting information on whether these courses are 20 or 27 contact hours.

- Each course must be taken in order and requires passing practical and theoretical exams to gain certificate.
- Spinal Manipulative Institute:
 - 54 hours of hands-on dry needling education (DN-1 and DN-2, each 27 hours over three days).¹⁴ Approximately 70 percent of each course is hands-on practical application (needle handling).
 - Students receive a comprehensive lecture on safe/clean dry needling technique, major and minor adverse events and relative/absolute contraindications. They then begin immediately handling needles and continue to do so during the practical components of the DN-1 and DN-2 courses.

These individual training companies determine course content and how to determine competency at the end of the program. The courses vary in length and content.

We received comments from the applicant and others that included additional dry needling training examples such as:

- IMS Dry Needling as taught by Steven Goodman, MD. “IMS is an elaborated technique of trigger point dry needling that is based on a comprehensive model of diagnosis and treatment of neuropathic-myofascial pain syndromes. This model was developed from the clinically recognized work of C.C. Gunn, M.D.”¹⁵ This is a 27-hour course designed to provide intensive instruction in the identification of appropriate patients for, and the safe practice of, IMS. Contains lectures, demonstrations and practical sessions where students act as models for the instructor or fellow participants.¹⁶
- Military training. All branches of the United States military allow physical therapists to perform dry needling, with varying requirements between branches. The United States Army requires evidence of appropriate dry needling education in either entry-level or postgraduate education, with supervision required for the first 25 cases before practicing independently. The requirements are similar for the air force. The U.S. Navy allows non-physician privileged physical therapists to perform dry needling after providing written evidence of completion of a certification course or training in a residency program.¹⁷

Acupuncture training

Acupuncture programs include masters’ degrees in Acupuncture or Acupuncture and Oriental Medicine, and also corresponding doctorate degree options. Washington state licensure as an EAMP requires successful completion of a course of didactic training in basic sciences and East Asian medicine, including acupuncture, over a minimum period of two academic years. It also includes completion of a minimum of 500 hours of supervised clinical training in East Asian medicine, including acupuncture. The department notes that Washington’s education and examination requirements in chapter 18.06 RCW are for the “system of medicine to maintain and

¹⁴ The department received conflicting information on whether these courses are 24 or 27 contact hours.

¹⁵ LearnIMS website, <http://www.learnims.com/>, accessed August 30, 2016.

¹⁶ <http://www.learnims.com/#!course-session-outline/c1v3j>, accessed August 30, 2016.

¹⁷ Applicant report (Appendix B, pp. 83-84).

promote wellness and to prevent, diagnose, and treat disease drawing upon the experience, learning, and traditions originating in East Asia, which include more than acupuncture alone.”

Bastyr University’s (Kenmore, Washington) acupuncture program features an integrated approach to acupuncture education that includes Western pathology and biomedicine clinical skills in its training.¹⁸ This training includes multiple credits devoted to traditional Chinese medicine diagnosis, pathology, and techniques; meridians and points; and acupuncture therapeutics based on East Asian medicine diagnostic and treatment procedures. Courses in treatments like tai chi and qi gong are also included in this degree program.¹⁹ It is unclear how much of the training is devoted to needle techniques and safety.

The department is also including information on Tri-State College of Acupuncture (New York, New York) because it offers unique training that includes classical and modern acupuncture theories to integrate East-West perspectives. Its programs teach three styles of acupuncture: traditional Chinese medicine (TCM), Japanese acupuncture, and Acupuncture Physical Medicine (APM). APM uses hands-on assessment by palpation to identify myofascial imbalances and trigger points, and teaches trigger point needling that is integrated throughout the three-year program.

Extensive trigger point needling training begins in the first year of the program with a hands-on course in structural and functional anatomy, 100 hours of supervised clinical practice which includes acupuncture point location and basic needling skill, and progresses in the second and third years of the acupuncture program. There are 100 hours of supervised clinical training in APM in the second year, 78 hours of supervised clinic rotations in APM after the second year, 250 hours of an acupuncture clinical internship which includes APM, TCM and Japanese acupuncture, and a 25-hour advanced techniques class during the third year.

Tri State College also offers an Acupuncture Integrative Medicine (AIM) Program for physicians and dentists. This 300-hour program provides core foundational training in acupuncture medicine with a strong emphasis on acupuncture trigger point needling. Of the 300-hour course, 150 hours are clinical and 150 are didactic training.²⁰

Dry Needling Compared to Acupuncture

According to the Applicant

The applicant report states that dry needling is a technique that originates in Western medicine. It uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues to treat musculoskeletal dysfunctions, diminish persistent peripheral nociceptive (pain) inputs, and reduce or restore impairments of body structure and function. Trigger points are described as taut bands of muscle fibers and the

¹⁸ According to comments received from Skye Sturgeon, DAOM, L.Ac., Department Chair of Bastyr University’s Acupuncture & East Asian Medicine program.

¹⁹ Bastyr University 2015-2016 academic calendar, <http://bastyr.smartcatalogiq.com/en/2015-2016/2015-2016-Academic-Catalog/School-of-Traditional-World-Medicines/Masters-Program/Master-of-Science-in-Acupuncture>, accessed October 17, 2016.

²⁰ <http://www.tsca.edu/site/prospective/doctors/>, accessed September 7, 2016, and per phone conversation and written follow up with Peter Dubitsky, Director of Clinical Training at Tri-State College of Acupuncture.

applicant attributes the work of Janet Travell, M.D. and David Simons, M.D. with the theoretical origin of dry needling and mapping of myofascial trigger points.

The applicants assert that dry needle practice originally involved injection of taut bands of muscle with medication or saline, but it was discovered later that it was the needle piercing the skin that caused the change in the muscle rather than what was injected. Practitioners have adopted variations on the original approach to include superficial and deep needling techniques. There are also variations in the needling technique used by physical therapists, with some referring to the thrusting technique and others leaving the needle in the muscle for a specified amount of time.

The applicant report argues dry needling is not acupuncture because it differs in historical, philosophical, indicative and practical context and is based on Western neuroanatomy and modern scientific study of the musculoskeletal and nervous systems. It states dry needling does not rely on traditional Eastern medicine theories where acupuncture is used to stimulate acupuncture points and meridians to restore energy flow (also known as qi) within the body. It adds that acupuncture points are predetermined points mapped out on the body based on thousands of years of empirical study in Chinese medicine. In response to EAMPs' assertion that dry needling is the same as Ashi point needling, the applicant group states that although Ashi points more closely correlate with trigger points, Ashi points are treated in the context of the whole treatment, not just a stand-alone treatment.

According to the Washington East Asian Medicine Association (WEAMA)

WEAMA and many EAMPs state that Ashi acupuncture and dry needling are indistinguishable from one another from a regulatory and legislative standpoint. They state that the procedure and tools are the same; the targets of the procedure are the same; the manipulation techniques are the same; and the response to the needling is the same. They add that acupuncture has measurable effects on autonomic regulation, neuroendocrine mechanisms, the cardiovascular system, etc., so for the applicants to say that acupuncture only works "to restore energy flow" is a gross misrepresentation. They add further that physical therapists use acupuncture studies to support dry needling, so they must understand that the same therapeutic phenomena are occurring in the body.

Department Analysis

The department finds that the discussion on whether or not dry needling is acupuncture is relevant in order to evaluate whether the proposal includes adequate training and oversight for the proposed dry needling endorsement or whether physical therapists should be required to meet the same standards for licensure as an EAMP before performing this treatment. The department does not consider the history of dry needling versus acupuncture relevant to the sunrise review.

- RCW 18.06.010(1) defines:
 - East Asian medicine as "a health care service utilizing East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders and includes... (acupuncture is one of the 15 categories of treatments listed);
 - (1)(a) "Acupuncture, including the use of acupuncture needles or lancets to directly and indirectly stimulate acupuncture points and meridians."

- RCW 18.06.020(2) states “A person may not practice East Asian medicine or acupuncture unless licensed as provided for in this chapter;”
- RCW 18.06.045 states “Nothing in this chapter shall be construed to prohibit or restrict: (1) The practice by an individual credentialed under the laws of this state and performing services within such individual’s authorized scope of practice...”

The April 15, 2016, Washington State Attorney General Opinion stated that dry needling falls outside the practice of physical therapy as defined in RCW 18.74.010(10). The conclusion was “RCW 18.74, as currently written and implemented, does not encompass dry needling in the practice of physical therapy.” This opinion goes on to note that the legislature could add dry needling by amending the physical therapy statute. The opinion also included a statement that nothing in the East Asian medicine statute shows legislative intent to make it the only health care practice that uses inserted solid needles.²¹

It does not appear that one could separate the definition of dry needling in SB 6374 from the definition of acupuncture in RCW 18.06.010. Stimulating underlying myofascial trigger points, muscular, and connective tissues will certainly indirectly, and in some cases directly, stimulate acupuncture points and meridians. However, dry needling can be distinguished from the statutory definition of East Asian medicine. It can be differentiated from the practice of acupuncture when used in physical therapy practice that is based on movement science as opposed to East Asian diagnosis and treatment.

The EAMP scope of practice and training includes much more than acupuncture, and acupuncture treatment and training include much more than inserting needles. Acupuncture training includes traditional Chinese medicine diagnosis, pathology, and techniques; meridians and points; acupuncture therapeutics based on East Asian medicine diagnostic and treatment procedures, and many other topics.

Physical therapists treat myofascial pain, functional impairments, and disabilities using a variety of physical therapy techniques that include stretching, manual therapy, massage, ultrasound, etc. Where authorized by state regulation, attorney general opinion, or state board opinion, physical therapists have added the use of acupuncture needles in this treatment to disrupt pain sensory pathways and relax contracted fibers. They use their training and expertise in anatomy and physiology, which includes dissection of muscles, nerves and tissue on cadavers, as a foundation to learn to identify trigger points and to determine the limits on the depth of needle placement.

It appears that the overlapping skills/knowledge that are relevant in the comparison with acupuncture training include palpating trigger points, physiological responses, contraindications and precautions related to needling, emergency preparedness and responses, and clean needle technique.

Acupuncture Needles

Another debate brought to our attention during this review is whether physical therapists are authorized to purchase acupuncture needles, which are regulated by the Federal Food and Drug

²¹ <http://www.atg.wa.gov/ago-opinions/scope-practice-physical-therapy>, accessed August 16, 2016.

Administration (FDA). Lawyers representing the APTA and the National Center for Acupuncture Safety and Integrity (NCASI) interpret regulations of acupuncture needles differently.

APTA legal analysis

The APTA analysis interprets FDA regulations as meaning that acupuncture needles are for use by qualified practitioners as determined by the states. They believe the FDA was clearly signaling that it would not involve itself in determining who is a qualified practitioner to use acupuncture needles, leaving this decision to the states.

Legal counsel for NCASI

The NCASI analysis interprets the FDA regulations to mean that federal law restricts the devices to sale by or on the order of “qualified practitioners of acupuncture” as determined by the states. They cite the definition of acupuncture needle in 21 CFR 880.5580 as “intended to pierce the skin in the practice of acupuncture” to mean that sale of these needles for a purpose other than the practice of acupuncture is outside the scope of the FDA’s approval.

FDA regulations

FDA regulations for acupuncture needles are:

21 CFR 880.5580 Acupuncture needle.

(a) *Identification.* An acupuncture needle is a device intended to pierce the skin in the practice of acupuncture. The device consists of a solid, stainless steel needle. The device may have a handle attached to the needle to facilitate the delivery of acupuncture treatment.

(b) *Classification.* Class II (special controls). Acupuncture needles must comply with the following special controls:

(1) Labeling for single use only and conformance to the requirements for prescription devices set out in 21 CFR 801.109...

21 CFR 801.109 Prescription devices.

A device which, because of any potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use is not safe except under the supervision of a practitioner licensed by law to direct the use of such device, and hence for which “adequate directions for use” cannot be prepared, shall be exempt from section 502(f)(1) of the act if all the following conditions are met:

(a) The device is:

(1)(i) In the possession of a person, or his agents or employees, regularly and lawfully engaged in the manufacture, transportation, storage, or wholesale or retail distribution of such device; or

(ii) In the possession of a practitioner, such as physicians, dentists, and veterinarians, licensed by law to use or order the use of such device; and

(2) Is to be sold only to or on the prescription or other order of such practitioner for use in the course of his professional practice.

(b) The label of the device, other than surgical instruments, bears:

(1) The statement “Caution: Federal law restricts this device to sale by or on the order of a _____”, the blank to be filled with the word “physician”, “dentist”, “veterinarian”, or with the descriptive designation of any other practitioner licensed by the law of the State in which he practices to use or order the use of the device...

Further complicating this issue, the applicants do not acknowledge that physical therapists that perform dry needling use acupuncture needles. The HumRRO analysis makes the statement, “Needles of similar design are used by practitioners of Acupuncture and Oriental Medicine,”²² which is an inaccurate statement because the needles are not similar, but exactly the same. The applicants sometimes acknowledge they use the same needle as acupuncturists. At other times, they state the needles look the same but are made through a different process of heating that changes the molecular structure.²³ The relevance of this issue is whether physical therapists and other non-acupuncture health care providers are legally authorized to purchase and use acupuncture needles in their practice.

The department looked into the assertion by the applicants that there is an FDA-approved needle for use in dry needling. Please note that the needle the applicant appears to be referencing is classified as an acupuncture needle (classified under medical devices as “Needle, Acupuncture, Single Use”). There is no new classification for physiotherapy or dry needling needles. “Physiotherapy Needles” is listed as the proprietary name of the device, not the classification, on the FDA website.²⁴

Evidence of Harm

Evidence of Safe Dry Needling - Provided by Applicant:

The applicant report and follow up comments state that dry needling is safe when performed by appropriately trained physical therapists (see Appendix B). Major malpractice insurers of physical therapy have issued statements to support that dry needling does not pose an increased risk when performed by physical therapists. Studies supporting the safety of dry needling include:

- Journal of Manual and Manipulative Therapy reported risk from PTs performing dry needling is less than 0.04 percent;²⁵
- Study by Brady of 7,629 dry needling treatments showed no instances of pneumothorax (lung collapse);
- A 2012 request from APTA to CNA, the largest healthcare malpractice insurer of physical therapists to provide information on claims against PTs nationally

²² Analysis of Competencies for Dry Needling by Physical Therapists, HumRRO, p. 1, Appendix B, p. 106.

²³ Jan Dommerholt testimony at the public hearing. See hearing summary, Appendix C, p. 209.

²⁴ <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cf/l/ldetails.cfm?lid=447790>,
https://www.accessdata.fda.gov/cdrh_docs/pdf15/K150903.pdf, accessed August 16, 2016.

²⁵ Applicant Report (Appendix B, p. 77), Brady, S. Adverse events following trigger point dry needling: a prospective survey of chartered physiotherapists, Journal of Manual and Manipulative Therapy, 2013;00:1-7.

related to dry needling. CNA found no trends relative to dry needling in 5,800 claims and stated “CNA does not foresee the practice of dry needling by a licensed physical therapist as having an immediate claim or rate impact.”

- The FSBPT’s Disciplinary Database of disciplinary actions taken by physical therapy regulators across the country showed:
 - In 2013, a physical therapist in Maryland was disciplined for not documenting dry needling on a patient. This practitioner had not received dry needling training and was found to be working outside of his individual competency.
 - In 2014, discipline was taken against two Arizona physical therapists for performing dry needling through clothing. One of these physical therapists was also licensed in Ohio, and action was taken in that state in 2015 based on the Arizona action.

The applicant report adds that there are also risks from acupuncture, and comparisons of risk with dry needling by physical therapists must be taken in light of the inherent risk in inserting a needle into muscle tissue. It cites a prospective acupuncture study that showed 8.6% of 229,233 patients who received 2.2 million acupuncture treatments experience at least one adverse event. This represents a total of 24,377 adverse events reported (one event per 90 treatments).

It also includes a statement that although the risk of pneumothorax²⁶ is low in the practice of dry needling, there was a Canadian Olympic athlete who suffered a double pneumothorax after acupuncture was performed by a massage therapist. However the applicant notes that baseline physical therapy education is much more thorough and intensive than that of a massage therapist. They add that there was no legitimate evidence submitted during the sunrise process to show there is a trend of increased risk from physical therapists performing dry needling.

Evidence of Harm from Dry Needling - Provided by EAMPs and Others:²⁷

WEAMA and others also submitted information about adverse events and the risk involved with dry needling:

- In Colorado, a physical therapist punctured freeskier Torin Yater-Wallace’s right lung with an acupuncture needle, causing damage to the lung that led to pneumothorax. He required surgery to treat the pneumothorax and was hospitalized for five days.
- Letter from Emily Kuykendall (Maryland resident) was submitted, which stated she suffered a punctured nerve in her leg from a physical therapist performing dry needling, causing serious pain and suffering and which necessitated drug therapy.

²⁶ A leak in the space between the lung and chest wall that results in a collapsed lung.

²⁷ WEAMA comments (Appendix D, pp. 279-280, 563-564), Comments from John Moore (Appendix D, pp. 312-314), Society for Acupuncture Safety (SAS) comments, which included a document written by the National Center for Acupuncture Safety and Integrity (NCASI), *Top Two Facts You REALLY Need to Know about DRY NEEDLING* (Appendix F, pp. 676-677)

- Three physical therapists in Arizona performed dry needling through patients' clothing, resulting in findings by the Arizona Board of Physical Therapy of "engaging in the performance of substandard care by a physical therapist due to a deliberate or negligent act or failure to act regardless of whether actual injury to the patient is established."
- 2016 CNA report, Physical Therapy Professional Liability Exposure: 2016 Claim Report Update.
 - This report cites an example of a patient who underwent three dry needling procedures with a physical therapist to treat a calf injury and acquired a bacterial infection requiring intravenous therapy and two surgical procedures.
 - This report also provided examples of dry-needling claims related to improper insertion techniques, including three patients hospitalized for pneumothorax and one patient hospitalized and surgery performed due to a broken acupuncture needle lodged in her hip.

WEAMA also notes that not all dry needling resources are in agreement on the safety of dry needling during pregnancy, noting that Dr. Gunn of IMS Dry Needling considers dry needling to be contraindicated during pregnancy.

In addition, John Moore of SAS submitted videos of two different physical therapists performing dry needling (one appears to be in a Washington facility and the other in an Arizona facility) and requested the sunrise team view them. We believe these are intended to demonstrate instances of questionable dry needling regarding technique and safety.²⁸

Department Analysis

The department finds that dry needling is an invasive procedure with potential serious risks of patient injury and death. We add the following to WEAMA's discussion above regarding the 2016 CNA report:

This report identified dry needling as an emerging risk, but it also included guidelines to address these emerging exposures that include:

- Consulting with the patient's referring practitioner regarding precautions or contraindications;
- Performing a thorough examination of the skin;
- Applying a thorough and accurate informed consent process;
- Appropriate infection prevention techniques; and
- Implementing communication and emergency response measures.

The evidence outlined above demonstrates physical therapists have had a small number of cases of serious adverse events from dry needling. However, these events have been rare. There are inherent risks from any practitioner puncturing the skin with acupuncture needles and the

²⁸ Videos are available upon request.

department must ensure adequate training to safely perform these procedures while avoiding rare but serious adverse events.

Other States

Many states have looked at the issue of physical therapists performing dry needling and have come to a number of different conclusions. The department received information on other states from the applicant and others. However, since this is an ongoing debate nationally, information is constantly changing. The department conducted independent research on how other states have addressed this issue and is providing information collected as of August 30, 2016. (See Appendix E, pages 577-585 for a table of state regulations and decisions).

- Five states permit dry needling by statute:
 - Arizona, A.R.S. 32-2001(4). Rules require 24-hour course approved by one of five physical therapy organizations.
 - Delaware, 24 Delaware Code, Section 2602(6)(10). Rules require two years of active physical therapy practice and successful completion of a dry needling program of 54 hours.
 - Georgia, Georgia Code 43-33-3(7)(D). Does not appear to require additional dry needling training.
 - Tennessee, (House Bill No. 25, 4/9/15). Rules require 50 hours of instruction in musculoskeletal and neuromuscular systems; anatomical basis of pain mechanisms, chronic pain, and referred pain; trigger points; and universal precautions. Also require 24 hours of dry needling specific instruction.
 - Utah, Utah Code 58-24b-102(14). Rules require two years in active physical therapy practice and successful completion of a course in trigger point dry needling that includes 300 hours, with 54 hours of in-person instruction and 250 supervised patient treatment sessions.
- Four states and the District of Columbia permit dry needling by rule or have rules pending: Colorado, Louisiana, Montana (pending), and Wyoming,
- Nineteen states permit dry needling by AG opinion or licensing board opinion/determination: Alaska, Arkansas, Iowa, Kentucky, Maine, Maryland, Mississippi, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Rhode Island, Texas, Virginia, West Virginia, Wisconsin.

Of note, Maryland's 2010 AG opinion stated "...the physical therapy board may determine that dry needling is within the scope of practice of physical therapy if it conducts rulemaking...and adopts a regulation that relates dry needling to the statutory definition of physical therapy. Any such process should consider standards for education and training that presumable would be at least as strict as those set by the legislature for physicians who use acupuncture needles..." There are currently proposed Maryland rules to require 80 hours of instruction with 40 hours in dry needling-specific content and 40 hours of practical hands-on instruction in the application and technique of dry needling, but these do not appear to have been adopted.

- Some states, Illinois, Kansas, Massachusetts, and Oregon appear to be unresolved on the issue.

Of note in Oregon, a 2014 Court of Appeals Appellate Commissioner issued an opinion that dry needling is not within the scope of practice of chiropractic medicine. The Oregon Physical Therapist Licensing Board stated this opinion was not applicable to physical therapy. However, the board later stated that it holds to a previous board opinion that dry needling is likely within the physical therapy scope of practice, but is an advanced intervention requiring post graduate training. It further stated “in the interest of public safety, until a measure of evidence based training and education can be determined, the board strongly advises its licensee to not perform dry needling of trigger points.” The board and Oregon Physical Therapy Association continue to monitor national trends and legislation regarding this issue.

Public Participation and Hearing

The department received the request from the legislature to conduct this sunrise review in March of 2016 and received the applicant report on June 1, 2016. The department posted the proposal and all applicant materials to the sunrise webpage and notified interested parties of a public hearing scheduled for August 2, 2016. Written comments were accepted until the close of the public hearing, with an additional two-week comment period for follow up after the hearing.

The department received over two hundred written comments about the proposal, an online petition with over 1,200 signatures in opposition, a petition with 566 signatures in support, and 27 people testified at the hearing. Here is a brief summary of the comments received in writing and at the public hearing. See Appendix D for all comments.

- The department received comments from many physical therapists, physical therapy students, and physical therapy organizations supporting the proposal and stating that it provides for safe practice of dry needling by physical therapists.
- Many patients of physical therapists who have had dry needling performed for pain wrote in with testimonials in favor of the proposal. They wrote in with success stories, as well as stories of not having insurance coverage for acupuncture as arguments supporting the proposal.
- Physical therapists who teach dry needling courses wrote in support of the proposal, stating that evidence supports dry needling as safe and effective when provided by physical therapists. They wrote that they have practiced and taught dry needling safely without severe adverse events.
- The East Asian Medicine Advisory Committee sent a letter stating that there is no meaningful distinction between dry needling and acupuncture; 54 hours of clinical training is woefully inadequate and does not include supervised clinical hours; and WEAMA and PTWA need to collaborate on this issue.
- The Council of Colleges of Acupuncture and Oriental Medicine submitted comments in opposition to the inclusion of dry needling in the physical therapy scope of practice including:
 - Urging the department to review the council’s position paper and discussion concerning the historical origins of dry needling in the “Ashi” point theory of Chinese medicine. According to its *Position Paper on Dry Needling*, dry needling is an acupuncture technique.

- In 2016, the Federation of Chinese Medicine Societies issued a statement defining the myofascial trigger points as “actually channel points, extra points, and Ashi points” and concluding “dry needling is actually [the] ‘rediscovery’ of acupuncture.
- It further identifies what it considered problems with the HumRRO analysis. These include that the basic definition of dry needling adopted by the report is not restricted to trigger point therapy and is overly broad and vague, making it impossible to reliably identify all the needed knowledge and competencies; failure to identify the amount of clinical practice necessary for the insertion of 3-inch needles into the human body; only an estimated 32 percent of licensed physical therapists are trained at the doctoral level upon which the report is based; avoids the issue of a lack of educational standards in the field; and fails to set minimum hours for skills training.
- Many EAMPs and organizations representing EAMPs sent comments opposing the proposal. Many state that dual licensure is the route physical therapists should take if they wish to do dry needling, which they state is the practice of acupuncture.
- The American Society of Acupuncturists wrote that dry needling is an acupuncture technique performed regularly by acupuncturists and medical doctors. It states that physical therapists are not appropriately educated on deep anatomic structures and how to safely insert needles into the body, and are not educated on acupuncture theory, needle technique, western or Eastern acupuncture theory, or the full complement of indications and contraindications for needle therapy. It states there is no agreed upon or vetted curriculum, no outside certification, and no independent examination of competency for instructors.
- WEAMA sent a number of comments and reference documents to demonstrate its assertion that dry needling is acupuncture and that the proposal does not meet the sunrise criteria. These included that there are no independently vetted standards for dry needling education, physical therapists should meet the same competency requirements as EAMPs in order to provide dry needling and that adverse event rates are higher than data provided by the applicant report (detailed in the Evidence of Harm section). They state that the requirement of 54 hours of training is unsubstantiated with no data to quantify this is a sufficient amount of training. The application has not provided cost comparisons to other modalities or mentioned referral to EAMPs for dry needling as an option, in order to demonstrate that the proposal will provide the most cost-effective option to protect the public.
- WEAMA and other EAMPs wrote that the American Medical Association (AMA), American Academy of Physical Medicine and Rehabilitation, American Academy of Medical Acupuncture, and other organizations have policy or position statements in opposition to dry needling by physical therapists.
- American Association of Acupuncture & Oriental Medicine wrote that it strongly urges legislators, regulators, and others to carefully consider the impact of trends in scope of practice expansion issues.

REVIEW OF EVIDENCE OF EFFICACY

The legislature's sunrise request also asked the department to separately review the evidence on the efficacy of dry needling.

The department's efficacy review focused on peer-reviewed articles published in scientific and medical journals. Systematic reviews, meta-analysis of the literature, and dry needling trials involving the treatment of specific types of myofascial pain were all identified as appropriate sources of evidence of efficacy. During the sunrise review, the department received documentation from both the physical therapy and acupuncture communities regarding efficacy of dry needling. These documents were used in this review. Additionally, patients who have received dry needling provided anecdotal testimonials to the efficacy of dry needling in written and verbal testimony during the sunrise review process.

Using the definition of dry needling in SB 6374, the department's survey of evidence focused on literature reviews and trials to determine the efficacy of dry needling in treating neuromusculoskeletal pain and movement impairments. It also identified trends in data collection and trial methodology. The department found several major limitations in conducting this survey, namely:

1. Literature reviews show that studies of the efficacy of dry needling have only started to be published in the last 20 years, which does not provide a robust source of high-quality studies or studies which have been repeated.
2. Many of the studies conducted in the past 20 years have been rejected by the literature reviews because of small sample sizes and poor methodology that is not standardized or replicable.
3. Specifically, the lack of an appropriate placebo for use in dry needling studies has prevented studies from collecting robust and high-quality data.

Tough et al. performed a meta-analysis based on seven studies of dry needling efficacy and came to the conclusion that "the limited sample size and poor quality of these studies highlights and supports the need for large scale, good quality placebo controlled trials in this area [of dry needling research]." Only seven out of 1517 studies identified in the initial review process were considered robust enough to perform a meta-analysis.

Dunning et al. also performed a literature review of dry needling studies to determine their efficacy in a clinical setting. Their conclusion, published in the journal *Physical Therapy Reviews*, found that while "several studies have demonstrated immediate or short-term improvements in pain, ... to date, no high-quality, long-term trials supporting in-and-out needling techniques at exclusively muscular [trigger points] exists, and the practice should therefore be questioned."

Liu, Lin et al. and Kietrys et al. echoed this critique, showing that while there may be some evidence of short-term relief, there are not enough trials to determine the long-term efficacy of dry needling and that more studies are needed to make a recommendation for its use in treating pain.

Looking past these challenges, evidence of efficacy in trials has been variable. Because there are several different standards for dry needling, in addition to different intents of practice between acupuncture and physical therapy applications of dry needling, results in trials are difficult to compare. However, the trials examined as evidence of efficacy have similar challenges:

1. Trials used different methods of dry needling that are not typically used in a clinical setting for treatment of the specific myofascial pain (for example, leaving needles in the body for 10-30 minutes when the typical application is an in-and-out motion).
2. Dry needling could not be isolated as an effective treatment because of its use with other modalities for pain management. Trials that recommend dry needling as an effective treatment recommend it exclusively within a care plan that incorporates other modalities of pain treatment.
3. The type of needles used is not consistent across trials.
4. There are multiple methods of identifying trigger points, which are not consistent across trials.

After reviewing the evidence, the department has found that some studies may show temporary pain relief for patients who receive dry needling (Aridici et al., Calvo,-Lobo, Pacheco-da-Costa, Hita-Herranz, Casanueva et al., Kietrys et al., Tekin et al.). However, the consensus in the literature reviewed is that more studies are needed to determine effectiveness of dry needling.

The following is a list of literature reviewed:

Annaswamy, Thiru Mandyam, et al. "Emerging concepts in the treatment of myofascial pain: a review of medications, modalities, and needle-based interventions." *PM&R* 3.10 (2011): 940-961.

Aridici, Rifat, et al. "Comparison of the Efficacy of Dry Needling and High-Power Pain Threshold Ultrasound Therapy with Clinical Status and Sonoelastography in Myofascial Pain Syndrome." *American Journal of Physical Medicine & Rehabilitation* 95.10 (2016): e149-e158.

Calvo-Lobo, César, Soraya Pacheco-da-Costa, and Edgar Hita-Herranz. "Efficacy of Deep Dry Needling on Latent Myofascial Trigger Points in Older Adults With Nonspecific Shoulder Pain: A Randomized, Controlled Clinical Trial Pilot Study." *Journal of Geriatric Physical Therapy* (2016).

Casanueva, Benigno, et al. "Short-term improvement following dry needle stimulation of tender points in fibromyalgia." *Rheumatology international* 34.6 (2014): 861-866.

Couto, Cláudio, et al. "Paraspinal stimulation combined with trigger point needling and needle rotation for the treatment of myofascial pain: a randomized sham-controlled clinical trial." *The Clinical journal of pain* 30.3 (2014): 214-223.

Dunning, James, et al. "Dry needling: a literature review with implications for clinical practice guidelines." *Physical Therapy Reviews* 19.4 (2014): 252-265.

Fogelman, Yacov, and John Kent. "Efficacy of dry needling for treatment of myofascial pain syndrome." *Journal of Back and Musculoskeletal Rehabilitation* 28.1 (2015): 173-179.

Ga, Hyuk, et al. "Intramuscular and nerve root stimulation vs lidocaine injection of trigger points in myofascial pain syndrome." *Journal of Rehabilitation medicine* 39.5 (2007): 374-378.

Gerber et al. Dry Needling Alters Trigger Points in the Upper Trapezius Muscle and Reduces Pain in Subjects with Chronic Myofascial Pain. *PMR*. 2015;7:711720.

Hong, Chang-Zern. "LIDOCAINE INJECTION VERSUS DRY NEEDLING TO MYOFASCIAL TRIGGER POINT: The Importance of the Local Twitch Response." *American Journal of Physical Medicine & Rehabilitation* 73.4 (1994): 256-263.

Kietrys, David M., et al. "Effectiveness of dry needling for upper-quarter myofascial pain: a systematic review and meta-analysis." *Journal of Orthopaedic & Sports Physical Therapy* 43.9 (2013): 620-634.

Kim, Tae-Hun, et al. "Intramuscular stimulation therapy for healthcare: a systematic review of randomised controlled trials." *Acupuncture in Medicine* 30.4 (2012): 286-290.

Liu, Lin, et al. "Effectiveness of dry needling for myofascial trigger points associated with neck and shoulder pain: a systematic review and meta-analysis." *Archives of physical medicine and rehabilitation* 96.5 (2015): 944-955.

Mayoral, Orlando, et al. "Efficacy of myofascial trigger point dry needling in the prevention of pain after total knee arthroplasty: a randomized, double-blinded, placebo-controlled trial." *Evidence-Based Complementary and Alternative Medicine* 2013 (2013).

Salom-Moreno J, et al. Changes in spasticity, widespread pressure pain sensitivity, and baropodometry after the application of dry needling in patients who have had a stroke: a randomized controlled trial. *J Manipulative Physiol Ther*. 2014; 37:56979.

Tekin, Levent, et al. "The effect of dry needling in the treatment of myofascial pain syndrome: a randomized double-blinded placebo-controlled trial." *Clinical Rheumatology* 32.3 (2013): 309-315.

Tough, Elizabeth A., et al. "Acupuncture and dry needling in the management of myofascial trigger point pain: a systematic review and meta-analysis of randomised controlled trials." *European Journal of Pain* 13.1 (2009): 3-10.

Unverzagt, Casey, Kathy Berglund, and J. J. Thomas. "Dry Needling for Myofascial Trigger Point Pain: A Clinical Commentary." *International Journal of Sports Physical Therapy* 10.3 (2015): 402.

This page intentionally left blank.

REVIEW OF PROPOSAL USING SUNRISE CRITERIA

The Sunrise Act, in RCW 18.120.010, states that a health care profession should be regulated or the scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

First Criterion: Unregulated practice can clearly harm or endanger the health, safety, or welfare of the public.

The proposal does not meet this criterion. Physical therapists are currently a thoroughly regulated profession with substantial training in the treatment modalities under their current scope of practice that includes up to 1,500 hours of supervised clinical training. The proposal as written adds an invasive procedure with the potential for serious risks of patient injury without offering adequate protections to the public.

The definition of dry needling appears to fall under the EAMP scope of practice and EAMPs have extensive training in needling techniques and safety. However, that does not mean other providers shouldn't also use these needles if they have adequate training and statutory authority to do so. Overlaps between scopes of practice are sometimes appropriate if evidence of adequate training to protect the public is included. The department found during this review that although the proposal submitted does not meet the sunrise criteria, dry needling may fit within physical therapy treatment of myofascial pain and movement impairments with adequate training that includes a clinical component.

Second Criterion: The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.

The proposal does not meet this criterion. There are adequate laws and rules in place to assure the public of physical therapists' initial and continued professional ability to practice within their current scope of practice. The proposal does not contain similar assurances.

The applicant has not provided evidence that the proposal provides assurance of initial and continuing professional ability for physical therapists to perform dry needling safely. The HumRRO analysis did not analyze current dry needling training or identify minimum training requirements; there are no consistent standards for the existing training programs; not all Washington state-licensed physical therapists have been trained at the doctorate level; and there is no supervised clinical training included in the proposal.

Third Criterion: The public cannot be effectively protected by other, more cost-beneficial means.

The proposal does not meet this criterion. The proposal as written does not offer adequate public protection.

EAMPs and their representative organizations have asserted that because dry needling is within their scope of practice, an EAMP degree should be the minimum level of training to perform it. However, this does not appear to be the least burdensome alternative to the proposal.

Acupuncture training related to needle techniques and safety may be beneficial for performing dry needling, but completing a full EAMP training curriculum and clinical experience would not be necessary to safely perform this procedure in the scope of physical therapy practice.

Physical therapists are already treating myofascial pain and trigger points within their current scope of practice. In addition, the department received a large number of patient comments requesting they be allowed to continue to receive dry needling in conjunction with their physical therapy treatment. If the applicant group could provide evidence of adequate training that includes a clinical experience component, this may be a cost-effective option for patients. Adding dry needling to an existing physical therapy treatment plan when indicated may be more efficient and cost-effective than referring a patient to an acupuncturist or other health care professional for separate treatment.

DETAILED RECOMMENDATIONS TO THE LEGISLATURE

The department does not support the applicant’s proposal as submitted to add dry needling to the physical therapy scope of practice. It does not meet the sunrise criteria for increasing a profession’s scope of practice.

Rationale:

- The applicant did not demonstrate that 54 hours of training is sufficient to ensure professional ability of physical therapists to perform dry needling, which is an invasive procedure with potential serious risks of patient injury. The HumRRO analysis did not address a minimum level of training or assess current training programs for adequacy.
- There is no supervised clinical experience requirement. Physical therapists have vast training, including supervised clinical experience, in anatomy and physiology. However, physical therapist training does not include use of needles in treatment.
- The applicant report states that the majority of education necessary to perform dry needling is taught in entry-level physical therapy doctoral education. However, not all physical therapists practicing in Washington have completed doctoral level training and a doctorate is not required for licensure.

In addition, there are other challenges to implementing the proposed bill, SB 6374:

- The definition of dry needling in the bill is problematic, specifically the statement “Dry needling does not include the stimulation or treatment of acupuncture points and meridians.” The physical location of myofascial trigger points, muscular, and connective tissue often correspond with acupuncture points and meridians.
- Section two does not limit the dry needling endorsement to physical therapists who have received their DPT degree, even though the applicant report uses doctoral level training as the basis for its assessment of physical therapists’ substantial training in anatomy and physiology. The current physical therapy statute and rules allow full licensure with a baccalaureate physical therapy degree, or a baccalaureate degree plus an advanced physical therapy degree or certificate.

The applicants have, however, demonstrated the following:

- With adequate training that includes a clinical component; dry needling may fit within the physical therapist’s scope of practice in treating neuromusculoskeletal pain and movement impairments.
- Evidence provided in this review demonstrates a low rate of serious adverse events from physical therapists performing dry needling in other states, the United States military, and Canada.

The legislature may wish to consider adding dry needling to the physical therapist scope of practice through proposed legislation that includes additional safety requirements such as:

- Requirements for dry needling-specific education:

- Inclusion of specific topics to include, at a minimum, the 16 specialized knowledge areas identified in the HumRRO analysis for competency in dry needling;
- Specific training on needling high-risk areas and avoidance of serious adverse events;
- Passage of a written and practical examination; and
- Approval of programs by the board of physical therapy;
- Authority for the Board of Physical Therapy to evaluate military training in dry needling to determine whether it meets the requirements above;
- Requirement for a supervised clinical practice experience to be defined in rule; including minimum hours and qualifications of supervisors. Recommend looking to other states for potential language, for example, Utah requires 250 supervised treatments;
- Requirement for physical therapists to obtain written informed consent from the patient on a form that clearly identifies the risks and benefits of dry needling and information the physical therapist’s dry needling training. Recommend looking to Colorado for potential language;
- Clear authorization for physical therapists to use acupuncture needles in the practice of dry needling subject to the limitations in statute; and
- Clear limitation that the use of acupuncture needles is only authorized within the physical therapist’s management of neuromusculoskeletal pain and movement impairments, and require referral to an authorized practitioner of acupuncture for use of acupuncture needles for any other purpose.
- Amend the definition of dry needling to remove the statement “Dry needling does not include the stimulation or treatment of acupuncture points and meridians.”

Regulations developed by other states may be helpful in drafting proposed legislation.

SUMMARY OF REBUTTALS TO DRAFT RECOMMENDATIONS

The department shared a draft report with interested parties September 26, 2016 and invited rebuttal comments. We received 70 comments that are summarized below along with our responses to key comments.

Applicant Rebuttals

The applicant rebuttal stated PTWA has serious concerns with the draft report, including concerns that the draft report focused continually on the practice and training of acupuncturists and used acupuncture as the only standard for needle usage without reference to safety data of this profession. They stated that the draft report erroneously inferred that physical therapists trained in dry needling would pose an inherent public health risk without citing data that training received by EAMPs is safer, which is misleading. Their rebuttals are summarized by topic.

Changes were made to address these rebuttals:

1. **Comparison of dry needling to acupuncture:** The applicants state that instead of focusing on physical therapists and the merits of adding dry needling to their scope of practice, the draft report focused on whether dry needling is the same as acupuncture, which they said is not the question to be answered in the review. It should be whether physical therapists can safely perform dry needling under the proposed bill. They have demonstrated why dry needling is not acupuncture and stated that the fact that a majority of states and the military do not consider dry needling to be acupuncture should be considered. They refuted arguments made by EAMPs regarding the history of and similarities between acupuncture and dry needling, re-stating their earlier arguments which conclude that knowledge of acupuncture, acupuncture points, or Ashi points by physical therapists is not necessary to practice dry needling. In addition, they state EAMP entry level education should not be used to measure physical therapy post-graduate education in dry needling because these hours presumably include other aspects of EAMP practice such as acupressure, ultrasound, laser, point injection therapy, etc.

Department Response: The department finds that the discussion on whether or not dry needling is acupuncture is relevant in order to evaluate whether the proposal includes adequate training and oversight for the proposed dry needling endorsement or whether physical therapists should be required to meet the same standards for licensure as an EAMP before performing this treatment (as being recommended by WEAMA).

We find that physical therapists do not need to meet the same standards as EAMPs to perform dry needling. We have clarified the department's position on the relevance of comparing acupuncture to dry needling by adding a department analysis in the Dry Needling Compared to Acupuncture section, and in various points in the report.

2. **Evidence of harm:** The applicants state that it is generally accepted that under the sunrise criteria the applicant must provide evidence of sufficient education and training to safely practice the increased scope of practice. They state that the department's analysis should focus on data and research on this topic rather than anecdotal evidence. They agree there is a serious risk of harm with dry needling, but state they have shown it to be safe when performed by physical therapists by providing evidence from malpractice insurers that it doesn't pose an increased risk, and the Brady study showing the risk of

significant adverse events to be less than .04 percent. They state that the individual cases demonstrating adverse events that have been submitted do not indicate a trend.

Department Response: The department added clarifying language in the Evidence of Harm section regarding the applicant's evidence of safety and the lack of a trend in adverse events linked to dry needling in physical therapy. We also added that the 2016 CNA Report findings included guidelines to address emerging exposures to risk from dry needling.

- 3. Education and training:** The applicants also state they have demonstrated that entry-level physical therapy education along with the 54 hours of continuing education in the proposal are sufficient training. They disagree with the department's rationale that the hours of training were not based on the HumRRO analysis, stating that the purpose of the HumRRO analysis was to determine what the content of the training should be, not the number of hours that should be required. They add that the absence of common adverse events despite widespread practice of dry needling by physical therapists with 54 hours of training or less demonstrates this amount of training is adequate. They also state that the studies they provided in the applicant report (White et al. and MacPherson et al) are the only prospective studies on the safety of needle penetration techniques directly comparing physical therapists trained at the standard proposed in the applicant report with a standard comparable to EAMPs in Washington. They state that these studies show almost identical results regarding patient safety.

They add that if the department has concerns about the proposed educational standards, they suggest using model language from other states. For example, Arizona and Delaware require a written and practical examination, Colorado has course instructor standards, and Utah requires 250 supervised treatment sessions.

Department Response: The department's assessment was based on the applicant report's citation of the HumRRO report as evidence of the 54-hour training requirement, and it appears that the education requirement in the proposal was based on current training programs. The department has made changes in the report to reflect the safety evidence provided by the applicant, and also to add options regarding potential use of model language from other states.

- 4. Recommendation that the applicants collaborate with EAMPs and medical acupuncturists:** The applicants state that other endorsements on the physical therapy license, such as spinal manipulation, allow for experienced physical therapists to supervise the training. Including only EAMPs and medical acupuncturists as clinical supervisors would be problematic due to knowledge of integration of dry needling and in willingness to collaborate, and they request consideration of other providers like physical therapists with proficiency in dry needling to provide supervision. In addition, they state that they have attempted to collaborate with WEAMA, with no success because WEAMA will only discuss dual licensure. They have collaborated with physiatrist and dry needling educator, Dr. Steven Goodman on the proposed educational requirements.

Department Response: The draft report recommended collaboration to identify adequate educational and supervised clinical hours, not that EAMPs and medical acupuncturists provide the supervised clinical experience. However, the department has

removed the recommendation from the report in response to comments from both sides indicating that collaboration would be problematic regarding this issue.

5. **Use of needles:** The applicants disagree with the draft report's statements that there are differing legal opinions regarding physical therapist use of acupuncture needles. They repeated their earlier information about the legal analysis performed for APTA and state the FDA regulations do not designate acupuncture needles as restricted devices but as prescription devices with specific regulations.

Department Response: The draft report did not make a conclusion regarding this issue, but simply provided information on the analyses provided by both the applicant and WEAMA. However, the department added a statement that the relevance of this issue is whether physical therapists and other non-acupuncture health care providers are legally authorized to purchase and use acupuncture needles in their practice. We also added a recommendation to clearly include authorization for use of these needles if the legislature considers a different bill.

6. Requests for specific statements to be revised or removed from draft report:

- Statement "physical therapist training does not include invasive techniques..." should be removed because their training includes needle electromyography and sharp wound debridement.

Department Response: The department revised the statement in the report.

- Statement that the HumRRO analysis did not include representation from medical acupuncturists and EAMPs, "who have the most training and experience in filiform needle insertion techniques, needle manipulation techniques, physiological responses, and contraindications." is inaccurate because the majority of western medical literature on these issues is published by physical therapists, MDs, DOs, and PhDs. They requested the statement be removed or modified to include these other providers.

Department Response: The department has revised this statement in the report and has also removed the draft recommendation for collaboration in identifying minimum training and supervised experience.

- Finding "The applicant over-simplifies the practice of acupuncture in its arguments on why dry needling is not acupuncture, arguing that acupuncture is only based on the ancient rules of channels and meridians and movement of qi (energy flow)." The stated the applicant report did not attempt to describe the full practice of East Asian medicine and the finding does not bear relevance.

Department Response: The department has removed this statement from the report because it is not relevant.

- Statement regarding acupuncture nomenclature being sometimes used in dry needling training and that there are studies that show using traditional acupuncture points is more accurate than palpation in identifying trigger points. They state they have been refuted in public comments by dry needling educators and there were not specific references to support them.

Department Response: The department removed these statements after further review.

- Finding “Physical therapists refer to acupuncture needles as tools, just as a stethoscope is a tool. However acupuncture needles are, and have always been, one of the main tools used by EAMPs.”

Department Response: The department removed the findings section because the findings were already included within specific sections of the report.

- Statement “EAMP training includes use of needles and needling techniques throughout their curriculum and supervised clinical experience.”

Department Response: The department removed the findings section of the report after further review because the findings were already incorporated into specific sections of the report.

- Paragraph demonstrating a label on an acupuncture needle package. The stated it is inappropriate because it’s simply one company’s practice.

Department Response: The department removed this paragraph after further review.

7. **Requests for changes to the department’s draft recommendations:** The applicant suggests the final report be written in a way that suggests future bill language that ensures a pathway to endorsement and include:

- A suggested number of hours of training that would be adequate, and direction on what methods they should use to analyze adequate training standards;
- A proposed supervision requirement from the department, that could be based on other states;
- Removal of the statement “physical therapist training does not include invasive techniques” from the recommendations because their training includes electromyography and sharp debridement;
- A department recommendation of including the requirement of doctoral-level education or a certain number of years of post-entry level practice;
- Not limiting our recommendation for collaboration on training to EAMPs, but add other needle experts like physicians, ARNPs, and naturopaths; and
- The recommendation to use an alternative definition of dry needling be changed to the definition recommended by APTA.

Department Response: The department has revised the recommendations in the report to include some of these suggestions. The applicant has demonstrated addition of dry needling to the physical therapy scope of practice may be appropriate under a different legislative proposal.

Changes were not made in response to these rebuttals:

8. **Doctoral-level training:** The applicants state that the draft report concluded that because not all physical therapists practicing in Washington have completed doctoral level

training, dry needling should not be added to their scope of practice. They disagree with this assessment stating the following:

- Mark Guthrie, former chair of the University of Washington, Doctor of Physical Therapy Program has stated that there has been little change in the foundational science education in anatomy, physiology and biomechanics over the years, and that the changes in the current doctorate programs are additions of pharmacology, differential diagnosis, and a much greater emphasis on evidence-based practice.
- The FSBPT competency paper doesn't specifically discuss DPT education but rather entry level practice, which they stated a physical therapist holding a bachelor's or master's degree far surpass. Those physical therapists not holding a DPT, for the most part, have been practicing for at least 10 years and have further refined clinical knowledge through examination, palpation, and overall management of patients with musculoskeletal conditions.
- Though the draft report states that licensure requirements and scopes of practice differ from state to state, they state that physical therapy educational standards are set on a national level and entry level knowledge and skills do not differ greatly from state to state.

Department Response: The applicant report and physical therapist testimony in writing and at the public hearing continuously brought up doctoral-level training as the overwhelming reason to support the underlying training of physical therapists to safely perform dry needling. The department did not make changes to the report in response to these comments.

9. Requests for specific statements to be revised or removed from draft report:

- Discussion of a case related to a leg infection because it was due to failure to supervise or monitor and citing it in the applicant report as evidence of negligence in the technique is misleading.

Department Response: The department did not make any changes to the report in response to this comment. This case was included in a section clearly designated as information provided by WEAMA, and the citation indicated "failure to supervise or monitor."

Rebuttals from patients

We received 31 letters from patients relaying stories of physical therapists using dry needling to end their chronic pain they have suffered, in some cases for 25 years or more, and nothing else has worked for them. These patients state that they were disappointed in the draft recommendations and would like the department to support adding dry needling to the physical therapy scope of practice. They also state:

1. They have not found dry needling available from acupuncturists;
2. Some patients have tried to obtain dry needling from medical doctors and found their costs are much higher;
3. Some patients can't receive insurance coverage for acupuncture;

4. State-paid insurance doesn't cover alternative medicines like acupuncture, so why keep these tools limited to those professions? Since these treatments have been proven helpful in specific treatment like muscle therapy, we should prevent the public's access to them;
5. Dry needling has been safely performed by physical therapists;
6. Dry needling is the only thing that has alleviated their chronic pain; and
7. Physical therapists are experts in sports injury rehabilitation and adding dry needling is part of this rehabilitation.

Department Response: The department has revised its evaluation of the third sunrise criterion to reflect these comments.

Rebuttal from Aaron McLuen

Mr. McLuen was one of the patients who commented. His rebuttals were very specific so we are including them in addition to the points made above. Mr. McLuen states that in order to justify denying physical therapists the ability to include dry needling in their practice, the sunrise review should demonstrate there is significant evidence of risk or harm to the public. He states the draft report failed to indicate solid evidence of this need to protect the public. Additional points he makes are.

1. A principle weakness in the report is that it seems to accept, without detailed analysis, that acupuncture has an exclusive right to any treatment or technique involving needles. The opposition is trying to protect their corner of the healthcare market and compromises their ability to objectively view dry needling by physical therapists for its benefit to the public.

Department Response: This is now clarified this issue in the department analysis within the Dry Needling Compared to Acupuncture section, as well as in the assessment of sunrise criteria and recommendations.

2. The draft report fails to acknowledge the benefits to patients, which drastically outweigh any statistical evidence of potential harm. Dry needling by physical therapists should be allowed because it has immense benefits to patients with minimal, statistically insignificant risk.

Department Response: The department has addressed patient benefit in the assessment of sunrise criteria.

3. The risk from physical therapists performing dry needling is low enough that CNA, the largest malpractice insurer of physical therapists stated it found no trends relative to dry needling and does not foresee it as having an immediate claim or rate impact. The draft report does not show any data that suggests the public would be at higher risk as a result of dry needling.

Department Response: This rebuttal was very similar to the applicant's comment that was addressed in the response to applicant rebuttal number two.

4. The only comparison that is appropriate in this review is how each classroom course, supervised clinical experience requirement, supplemental training program prepare the physical therapist or acupuncturist for the specific act of dry needling as it pertains to

treating acute musculoskeletal inflammation or conditions, rather than needling for other conditions acupuncturists are qualified to use needles to treat.

Department Response: The department has clarified the relevance of comparing dry needling to acupuncture in the Acupuncture Training and Dry Needling Compared to Acupuncture sections, as well as in our assessment of the sunrise criteria.

5. The following are recommendations that Mr. McLuen states could be factually supported:
 - Modify the proposed legislation to require a doctoral degree;
 - Clarify the definition of dry needling and its intended purpose. This should include clarifying that acupuncturists do not have an exclusive right to using acupuncture needles and using more specific language to define trigger points and dry needling; and
 - Accept the proposed 54-hour training but add periodic reviews by the physical therapy board to determine whether adjustments may be necessary. He states it is reasonable to conclude this training is a sufficient starting point since it aligns with the requirements in other states and has not exposed a public safety risk.

Department Response: The department cannot change the proposed bill that was submitted. We can only make recommendations. We have made some of the suggested changes to the report, including recommendations, in response to these comments and the applicant's similar comments. See responses to applicant's comments for details.

Rebuttal from Susanne Michaud, Physical Therapist

Dr. Michaud's rebuttals included many comments that were similar to the applicant and Aaron McLuen. She provided the following additional rebuttal points:

1. The statement that the AMA does not support physical therapists doing dry needling should not hold weight because it is based on politics, a unilateral decision by one person on the board who is both a physician and an acupuncturist.

Department Response: After further review, the department has changed the reference to AMA and other organizations' opposition to the proposal in the Public Participation and Hearing section to clarify that WEAMA and other EAMPs submitted comments on these organizations' positions. We did not receive comments directly from these other organizations.

2. She questions the draft report pointing out that not all physical therapists have doctoral level training, stating that only doctoral programs currently exist and that we are saying that all of the work and continuing education and real life education of physical therapists trained prior means nothing.

Department Response: This issue was addressed in the department's response to applicant rebuttal number eight.

3. She states that the department's dismissal of the HumRRO report because acupuncturists and medical acupuncturists were not consulted is a failure to understand that what these professionals do is not the same as dry needling. She states a better argument could be

made that physiatrists and other physicians practice dry needling, and that the report shows a lack of impartiality and understanding by the department.

Department Response: The department has clarified our position on this issue in the training section and recommendations.

4. She closed by stating that the department is complicit in keeping a valuable service away from the public in this time of opioid addiction and chronic pain.

Department Response: The department has made changes to our assessment of the sunrise criteria and recommendations relating to patient access to dry needling.

Rebuttal from Zachary Skaggs, Physical Therapist

Dr. Skaggs states:

1. Physical therapists are movement specialists with a great understanding of nerve to muscle to bone interactions and their substantial training, which includes many hours in a lab dissecting cadavers to understand the placement of all structures in the human body and memorization of nerve levels and muscle innervation to better understand injuries and movement issues.

Department Response: The department has added information in the Physical Therapy training section to include more detail on dissecting nerves and muscle tissue on cadavers.

2. Physical therapists use acupuncture needles in a different way backed by evidence based practices in peer reviewed journals. They strictly treat movement disorders with no intention of encroaching on acupuncture's practices. Physical therapists' goals are to create physiological healing response and decrease areas of muscle tension with skilled placement guided by vast knowledge of human anatomy and interaction of all the bodily structures;

Department Response: The department has added analysis and clarification in the report on what distinguishes dry needling from acupuncture.

Rebuttal from Shane Koppenhaver, Physical Therapist and Physical Therapy Professor

Dr. Koppenhaver states the draft report made some excellent points but he disagrees with what is considered training in dry needling and what should be included in training on physical needle insertion practice. He teaches dry needling in the army in entry level DPT training and post-professionally and estimates that at least 95% of the knowledge and skills to practice dry needling are academic. He compares the training of medical doctors, nurses, and podiatrists where schools include robust academic instruction but relatively few hours of hands-on training with needles. He states that physical skills like dry needling, injections, and sharp debridement are important but require relatively few hours compared with the foundational knowledge requirements and 54 hours is sufficient in his opinion, and is substantiated by published studies of risk associated with dry needling performed by physical therapists.

Department Response: The department included in its alternative recommendations for the legislature's consideration authority for the board of physical therapy to evaluate military training to determine equivalency.

Rebuttal from Anne Coxon

She states that the draft report raised a serious discrepancy in logic, leading her to believe the department is not supportive of medical training provided by the military. She states the draft report implied the department has deemed military trained physical therapists are not qualified to perform dry needling in Washington. She states it also implied physical therapists with doctorate degrees are less capable than acupuncturists with far less education.

Department Response: The department added more information about current military training in the final report. We also added a recommendation to consider military training in any future bill.

Rebuttal from Joshua McDonald

Mr. McDonald states that the draft recommendations added restrictions to the practice of dry needling and he feels this is a mistake because:

1. The evidence of harm provided was only a small number of anecdotes. The sunrise criteria state the potential for harm is easily recognizable and not remote or dependent upon tenuous argument, which would require scientific inquiry over anecdotes.

Department Response: The department has added clarifying language regarding evidence of harm. See response to applicant rebuttal number two for details.

2. The draft recommendations will drive many patients who have relied on dry needling for pain to pain medication instead. Pain medications are far more dangerous than dry needling.

Department Response: The department has revised its evaluation of the third sunrise criterion to reflect these comments.

3. The more the department restricts the freedom of consenting adults from progressing by trying new things, the more knowledge will stagnate.

Department Response: The final report acknowledges patient support for the proposal and includes recommendations for the legislature that includes additional safety measures to consider regarding this proposal.

Jacqueline Berg, Physical Therapist and Dry Needling Patient

Dr. Berg states she understands how dry needling can be confused with acupuncture treatment and that it may be difficult to understand the benefit of dry needling if you've never felt the relief it provides from chronic, intolerable pain. Her comments include:

1. Her story of multiple surgeries and chronic pain and all of the treatments she tried from all types of health care providers to find relief. She stated that after all the years of trying to find relief from pain; she found instant relief when a Canadian physiotherapist performed one treatment of dry needling.
2. Stating she now has to go through expensive treatments to find the next best thing since physical therapists cannot perform dry needling in Washington. She provides her descriptions of the differences she has experienced between the treatment provided by acupuncturists and dry needling performed by physical therapists.

3. Reiterating arguments made by others that the risk is minimal and that physical therapists are qualified to dry needle because of their underlying training and daily use of palpation.
4. That she went to school to become a physical therapist after her experience with dry needling because she wanted to provide the treatment to help others.
5. That dry needling training is how to physically use the needle technique safely and she agrees that supervision should be incorporated into the endorsement but should be incorporated into the department's recommendation to support the proposal.

Department Response: The department has revised its evaluation of the third sunrise criterion to reflect these comments from Dr. Berg and other dry needling patients. The department believes the changes made in response to the applicant's rebuttals also address these comments.

Andrea Love, Physical Therapist

She asks the department to remember that physical therapists dissect tissue as part of their curriculum and labored for hours dissecting skeletal muscle. Their training included separating out blood vessels and nerve tissue, dissecting down to the tendon insertions of the muscles and keeping blood vessels and nerves intact. She states that she did research and acupuncturists don't get this in their education. Since physical therapists have seen the tissue they are treating and have seen how deep tissue goes, it's crazy to say they are under-qualified to treat this tissue and that dry needling just adds one more technique to treat this tissue.

Department Response: The department has revised the physical therapy education section in response to these and other similar comments.

Ben Larner, Physical Therapist

Dr. Larner reiterates the doctorate level training physical therapists receive including gross anatomy and said that the head professors at Harvard Medical School said that physical therapists learn more about the musculoskeletal system than MDs. He states that physical therapists go through much more rigorous and extensive training than acupuncturists. He reiterates the low complaint rate against physical therapists in general and that it is even lower regarding dry needling. He states that patient care and the ability to receive appropriate treatment should be the main issue, not whether acupuncturists will lose business under the proposal.

Department Response: The department has revised the physical therapy education section in response to these and other similar comments.

Paul Killoren, Physical Therapist

Dr. Killoren states that the draft recommendations were disappointing because of his personal beliefs and training, but also because he feels the substantial amount of relevant information submitted by physical therapists was dismissed for opinions, hearsay and blatant financial interests of another profession. His rebuttal comments include the following points:

1. The department should also recommend adequate supervised clinical training if we feel it is necessary for the proposal.

Department Response: The department has included recommendations for the legislature to consider regarding supervised clinical training.

2. Physical therapy education was not analyzed in the report, especially compared to acupuncture training, because even a Master's level physical therapy education involves a more anatomically and western medically-based curriculum than acupuncture.

Department Response: The department has added details to the physical therapy education section in response to this and other comments.

3. The applicants met with WEAMA twice to attempt to reach a mutual agreement on training requirements or a compromise on the issue, but WEAMA would only consider dual licensure as an acupuncturist as the only option.

Department Response: The department has removed the recommendation for collaboration with EAMPs from the report in response to comments from both sides indicating that collaboration would be problematic regarding this issue.

4. He also submitted an article in *Acupuncture in Medicine, Rare But Serious Complications of Acupuncture Traumatic Lesions*, that reviewed prospective studies on the frequency of adverse events from acupuncture, including pneumothorax. This article looked at case reports and extracted information on the application errors to attempt to increase the quality of acupuncture in education and therapy. The article stated that knowledge and application of anatomy was the primary contributor to reducing the risk of adverse events with acupuncture. One of the conclusions in the article was “all of the traumatic injuries described could have been avoided if practitioners had had better anatomical knowledge, applied existing anatomical knowledge better, or both.”

Department Response: The department believes this comment has been addressed through clarification of the evidence of adverse events in the report. See the department's response to applicant rebuttal number two for details.

Eric Moen, Physical Therapist

Dr. Moen makes some of the same points as earlier comments, and adds that he questions whether the acupuncturists are really worried about safety. His rebuttal comments include that:

1. Comparisons of safety data of both groups that were provided in the review demonstrate that physical therapists have better safety rates with dry needling and that acupuncturists perform higher risk procedures with needles.

Department Response: The department has addressed this comment through clarification of the evidence of adverse events in the report. See the department's response to applicant rebuttal number two for details.

2. He questions how acupuncturists can claim safety as the issue when the KOMO 4 news story showed an acupuncturist demonstrating dry needling without gloves.

Department Response: The department did not make changes to the report in response to this comment. This question is outside the scope of the sunrise review.

3. The 54 hours of post-DPT training is the standard in a majority of states that allow dry needling by physical therapists and compared Bastyr's acupuncture curriculum stating

that musculoskeletal treatment coursework is equivalent to about 30 student hours which is far below what physical therapists receive.

Department Response: The department has added details to the training of physical therapists and acupuncturists in the report.

Benjamin Boyle, Physical Therapist

Dr. Boyle's rebuttal was to a specific statement in the draft report. He asks that the following statement be removed:

WEAMA also noted that not all dry needling resources are in agreement on the safety of dry needling during pregnancy, noting that Dr. Gunn of IMS dry needling considers dry needling to be contraindicated during pregnancy.

He provided a critical review of the topic that is currently being reviewed for publication, "*Dry needling of "Forbidden Points" During Pregnancy: Does the Evidence Support the Stated Risk?*"

Department Response: The department did not make any changes to the draft report in response to this rebuttal. The quote was included in a section of the report that cited comments from WEAMA. It was not included as a finding in the report or in recommendations.

Robin Schoenfeld, Physical Therapist

In addition to providing similar comments to those discussed above, Dr. Schoenfeld states that overlap is expected between professions for access to high quality care. She points out that acupuncturists recently changed their practice act to reflect that their practice includes more than acupuncture alone. RCW 18.06.005 states intent to change the professional designation of acupuncturist to East Asian medicine practitioners to recognize treatments, methods, and techniques used in East Asian medicine.

She also asks for clarification on the draft recommendations and whether the department was recommending another sunrise review or that the legislature act on the proposal if more detailed language were added to the proposed bill.

Department Response: The department has clarified its position on overlap between professions. We are not recommending another sunrise review, but have included recommendations regarding alternative language for the legislature's consideration.

Additional Comments from Physical Therapists

In addition, we received:

- Additional rebuttals that stated the same comments as those listed above.
- A few letters from physical therapists indicating general support for the proposal, which were not considered rebuttals to the draft report.

Rebuttal from WEAMA

WEAMA states they agree with the draft report's findings that the proposal does not meet the sunrise criteria and with the statement that dry needling is within the acupuncture scope of practice. However, they object to all recommendations in the report regarding potential options for future proposals on this issue. They object to the recommendation for further study into adequate training to perform dry needling, reiterating their argument that standards for acupuncture licensure are the only option. They state that since the proposal does not meet the sunrise criteria, any additional recommendations to add dry needling to the physical therapy scope of practice should go through another sunrise review.

Department Response: The department did not make changes to the report in response to these comments. We do not believe dual licensure is the appropriate option and believe that the applicants have demonstrated dry needling may be appropriate in the physical therapy scope of practice with appropriate legislation.

Rebuttal from American Alliance or Professional Acupuncture Safety

Their rebuttals were in agreement with WEAMA's above. In addition, they reiterate the opinion that insertion of acupuncture needles into trigger points to cure, mitigate, treat, or prevent disease or other conditions is the practice of acupuncture regardless of intent. They provided other documents they consider evidence of attempts by the applicant to frame dry needling as an invention of Western medicine. They state this is a classic case of cultural appropriation that disrespects an important aspect of Chinese history and culture. They reiterate many of the arguments we received in response to the applicant's proposal regarding the history of acupuncture and origins of dry needling and that they believe there is no public safety or medical basis for requiring a different level of training for physical therapists to perform what they believe is acupuncture.

Department Response: See response to WEAMA above. In addition, the department finds that health care is constantly evolving and overlap between scopes of practice is often appropriate as long as patients are protected. The department believes the analysis we added in the Dry Needling Compared to Acupuncture section explains our position on the relevance of these comparisons.

Rebuttal from National Center or Acupuncture Safety and Integrity (NCASI)

NCASI states that they are strongly opposed to the proposal. They submitted the following specific rebuttals to the draft report:

- They state the following statements in the draft report are inaccurate:
 - On page 8, statements that there is a *debate* on interpretation of FDA regulations and regarding different analyses on whether federal law restricts acupuncture needles to sale by or on the order of acupuncturists. NCASI states that this is not up to interpretation.
 - On page 10, statements regarding an FDA approved needle for use in dry needling. NCASI stated they researched the FDA web site and there is no such label.

- On page 19, the statement that acupuncture needles are, and have always been, one of the main tools used by EAMPs. They stated these needles are Class II prescription medical devices, not tools.

Department Response: The department did not make changes to the report in response to these comments because our statements were accurate. The statement on page 19 regarding acupuncture needles being one of the main tools used by EAMPs was removed from the report in response to earlier comments.

Rebuttal from Society for Acupuncture Safety (SAS)

They state they agree with the draft recommendation to not add dry needling to the physical therapy scope of practice because the applicant did not provide meaningful evidence regarding claims of cost-effectiveness, patient preference, and safety. They state the applicant also neglected to include vital information related to patient injuries caused by physical therapists inserting needles.

Their rebuttals were in agreement with WEAMA and the other acupuncture organizations above. They re-state that they believe there are already minimum training and oversight requirements, which are those for acupuncturists and requested the final report affirm that dual-licensure is the only appropriate pathway for a physical therapist to “practice acupuncture.”

They object to the recommendations in the draft report suggesting a revised definition of dry needling to clarify it or distinguish it from the practice of acupuncture. They ask that the department strike the statement that requiring an EAMP degree as the minimum level of training would not be the least burdensome alternative, stating that truncated training for the benefit of the physical therapy profession does not ensure safe practice.

They assert that it is illegal per FDA regulations for physical therapists to purchase, possess or use acupuncture needles or similar devices because the legislature hasn’t deemed physical therapists “qualified practitioners of acupuncture.” They re-state that Washington courts and case law have upheld that physical therapists cannot practice acupuncture. They state that scopes of practice set what procedures practitioners may perform and procedures with more risk, such as acupuncture, are more closely regulated. They attached two documents, *Top Two Things You Should Really Need to Know about Dry Needling* and *Motion for Partial Summary Judgment* (State of Washington vs. Kinetacore, et al) as evidence to support these rebuttals.

Department Response: The department did not make changes to the draft report in response to these rebuttals. The court decisions and Attorney General Opinion have determined physical therapists cannot legally perform dry needling within their current scope of practice. However, the purpose of this sunrise review is to determine whether dry needling could safely be added to their scope of practice through statutory change, and for the department to make recommendations to the legislature on this issue. The department considered the information submitted by the applicants and the opponents regarding safety of physical therapists performing dry needling. We do not believe dual licensure is the appropriate option and have included reasoning to support this in the final report.

Rebuttal from Lisa vanHaagen, EAMP

Ms. vanHaagen states that the department should not recommend the addition of dry needling and in addition since the applicant has not provided evidence of a clear and easily recognizable

threat to public health and safety, the remainder of the recommendations should be withdrawn because they would:

1. Put the public at risk. RCW 18.06 already sets minimum requirements for core training and supervised oversight to protect the public.

Department Response: The department has addressed this issue in our analyses in the Dry Needling Compared to Acupuncture and Evidence of Harm sections, as well as our assessment of the third sunrise criterion. Acupuncture training related to needle techniques and safety may be beneficial for performing dry needling, but completing a full EAMP training curriculum and clinical experience would not be necessary to safely perform this procedure in the scope of physical therapy practice.

2. Create confusion for the public, creating a false distinction between acupuncture and dry needling. Dry needling is acupuncture and all trigger points are acupuncture points. If a distinction is created how will the public know when the physical therapist is practicing only dry needling versus acupuncture?

Department Response: The department has addressed this issue in our analysis in the Dry Needling Compared to Acupuncture section and our assessment of the first sunrise criterion and have found that distinctions can be made between the two procedures. Dry needling may fit within the physical therapist's scope of practice in treating neuromusculoskeletal pain and movement impairments with adequate training.

3. Create a billing nightmare because the Medicare billing code for manual therapy does not include use of acupuncture or syringe needles. The draft recommendations do not address the financial burden faced by clients that may be injured by a physical therapist using acupuncture needles.

Department Response: Insurance coding is not part of the sunrise criteria and is not addressed in the final report. The financial burden faced by clients who may be injured by a physical therapist using acupuncture needles is speculation and not substantiated by evidence submitted during this review.

4. She adds that the final recommendations should state “because the applicant has not provided “evidence demonstrating the need for the practice of dry needling (i.e. acupuncture) to be added to their scope of practice, and as acupuncture is available state-wide from urban centers to rural areas, the department recommends physical therapists follow the requirement in their scope of practice, RCW 18.74.015 Referral to health care practitioners-When required. “(1) Physical therapists shall refer persons under their care to authorized health care practitioners if they have reasonable cause to believe symptoms or conditions are present which require services beyond the scope of their practice or for which physical therapy is contraindicated. (2) A violation of this section is unprofessional conduct under this chapter and chapter 18.130 RCW.”

Department Response: The department did not make changes to the draft report in response to these comments. We disagree with this interpretation of the sunrise criteria and believe that the applicants needed to provide evidence that physical therapists are adequately trained to safely perform dry needling if added to their scope of practice. We believe the final report addresses the concerns in these rebuttal comments.

Ten other EAMPs and patients of EAMPs wrote this same exact letter as rebuttals.

Rebuttal from James (no last name was provided)

He sent the following documents in rebuttal to the draft report:

- Link to an adverse event report submitted to the FDA of an injury on a patient who suffered a pneumothorax after receiving dry needling from an acupuncturist. This adverse event report that was submitted stated that physical therapists and acupuncturists are attempting to bypass the acupuncture practice act with 54 hours of training, no educational standards, no state registration, no board exams, and no clinical time.
- American Academy of Medical Acupuncture (AAMA) Position Statement on dry needling
- AMA statement on dry needling

Department Response: These were not considered rebuttals to the draft report because the FDA adverse event report was not relevant and the department had already received the comments from WEAMA and others on these organizations' positions.

Rebuttal from Iman Majd, EAMP

Dr. Majd states he did not accurately comprehend a question asked at the public hearing regarding appropriate hours of training and inadvertently concurred that 300 hours would be sufficient for physical therapists to perform dry needling. He wants to correct that statement to say that he unequivocally believes that 300 hours of training is insufficient for physical therapists to perform dry needling and stands by his written testimony and position that agrees with WEAMA's position.

Department Response: Inclusion of this statement here serves as the requested correction to Dr. Majd's early statements.

Rebuttal from Mona Lee-Yuan

She states she is a New York licensed physical therapist and acupuncturist with extensive background in orthopedics, neurology, anatomy/physiology, and western diseases. She states her extensive training and 30 years of experience as a physical therapist has taught her that dry needling performed by any profession other than a clinical acupuncturist or MD poses a serious threat to public safety. She then reiterates earlier testimony by EAMPs regarding their training and licensure requirements. She adds that there have been multiple accidents that include bone infections, nerve damage, and pneumothorax from untrained individuals such as physical therapists and cited a recent report by HPSCO, an insurance company that provides malpractice insurance to physical therapists, which states that malpractice insurance will increase due to an increase in suits caused by dry needling.

Department Response: See responses above regarding evidence of adverse events. The HPSCO report was not included in the rebuttal and the department could not locate it.

Rebuttal from Mary Ann Swain, Health Care Consumer

Ms. Swain states that she has used the services of physical therapists and acupuncturists and sees them as professions with different areas of expertise who should have separate and extensive

educational requirements. She states that she feels dry needling is acupuncture under a different name and she would not want someone with less training than an acupuncturist to perform dry needling on her. She states that the draft recommendations should not include options for further study of training or alternative options for potential future legislation for dry needling.

Department Response: The department has not made changes to the report in response to these comments, however, some of the changes we have made relate to this issue. We have added an analysis in the Dry Needling Compared to Acupuncture section where we explain the relevance of this discussion and where we have determined that dry needling can be distinguished from acupuncture.

James Shinol

Mr. Shinol submitted what he calls new malpractice from physical therapists loaded with increased claims and injuries to patients. The link provided was to the 2016 CNA report, Physical Therapy Professional Liability Exposure: 2016 Claim Report Update. This was not new information and the department had already included it in the draft report.

This page intentionally left blank.

Appendix A

Request from Legislature and Draft Bill



Washington State Senate

March 11, 2016

John Wiesman, DrPH, MPH
Secretary
Washington State Department of Health
P.O. Box 47890
Olympia, Washington 98504-7890

Dear Secretary Wiesman:

I am requesting that the Department of Health (Department) consider a sunrise review application for a proposal that would add dry needling to the physical therapy scope of practice. Under the attached proposal (SB 6374), physical therapists would be able to perform dry needling only upon completing at least one year of full time practice, 54 hours of education and training in dry needling, and receiving an endorsement from the Department. In addition, I would like the Department to review the evidence on the efficacy of dry needling.

I appreciate your consideration of this application, and I look forward to receiving your report. Please contact my office if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "Randi Becker". The signature is written in a cursive style and is followed by a horizontal line.

Senator Randi Becker
Chair, Health Care Committee

SENATE BILL 6374

State of Washington 64th Legislature 2016 Regular Session

By Senators Dammeier, Becker, Cleveland, Warnick, and Jayapal

Read first time 01/18/16. Referred to Committee on Health Care.

1 AN ACT Relating to allowing physical therapists to perform dry
2 needling; reenacting and amending RCW 18.74.010; and adding a new
3 section to chapter 18.74 RCW.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 **Sec. 1.** RCW 18.74.010 and 2014 c 116 s 3 are each reenacted and
6 amended to read as follows:

7 The definitions in this section apply throughout this chapter
8 unless the context clearly requires otherwise.

9 (1) "Authorized health care practitioner" means and includes
10 licensed physicians, osteopathic physicians, chiropractors,
11 naturopaths, podiatric physicians and surgeons, dentists, and
12 advanced registered nurse practitioners: PROVIDED, HOWEVER, That
13 nothing herein shall be construed as altering the scope of practice
14 of such practitioners as defined in their respective licensure laws.

15 (2) "Board" means the board of physical therapy created by RCW
16 18.74.020.

17 (3) "Close supervision" means that the supervisor has personally
18 diagnosed the condition to be treated and has personally authorized
19 the procedures to be performed. The supervisor is continuously on-
20 site and physically present in the operatory while the procedures are

SB 6374

1 performed and capable of responding immediately in the event of an
2 emergency.

3 (4) "Department" means the department of health.

4 (5) "Direct supervision" means the supervisor must (a) be
5 continuously on-site and present in the department or facility where
6 the person being supervised is performing services; (b) be
7 immediately available to assist the person being supervised in the
8 services being performed; and (c) maintain continued involvement in
9 appropriate aspects of each treatment session in which a component of
10 treatment is delegated to assistive personnel or is required to be
11 directly supervised under RCW 18.74.190.

12 (6) "Dry needling" means a skilled intervention that uses a thin
13 filiform needle to penetrate the skin and stimulate underlying
14 myofascial trigger points, muscular, and connective tissues for the
15 management of neuromusculoskeletal pain and movement impairments. Dry
16 needling does not include the stimulation or treatment of acupuncture
17 points and meridians. "Dry needling" is also known as intramuscular
18 manual therapy or trigger point manual therapy.

19 (7) "Indirect supervision" means the supervisor is not on the
20 premises, but has given either written or oral instructions for
21 treatment of the patient and the patient has been examined by the
22 physical therapist at such time as acceptable health care practice
23 requires and consistent with the particular delegated health care
24 task.

25 (~~(7)~~) (8) "Physical therapist" means a person who meets all the
26 requirements of this chapter and is licensed in this state to
27 practice physical therapy.

28 (~~(8)~~) (9)(a) "Physical therapist assistant" means a person who
29 meets all the requirements of this chapter and is licensed as a
30 physical therapist assistant and who performs physical therapy
31 procedures and related tasks that have been selected and delegated
32 only by the supervising physical therapist. However, a physical
33 therapist may not delegate sharp debridement to a physical therapist
34 assistant.

35 (b) "Physical therapy aide" means a person who is involved in
36 direct physical therapy patient care who does not meet the definition
37 of a physical therapist or physical therapist assistant and receives
38 ongoing on-the-job training.

39 (c) "Other assistive personnel" means other trained or educated
40 health care personnel, not defined in (a) or (b) of this subsection,

SB 6374

1 who perform specific designated tasks related to physical therapy
2 under the supervision of a physical therapist, including but not
3 limited to licensed massage practitioners, athletic trainers, and
4 exercise physiologists. At the direction of the supervising physical
5 therapist, and if properly credentialed and not prohibited by any
6 other law, other assistive personnel may be identified by the title
7 specific to their training or education.

8 ~~((9))~~ (10) "Physical therapy" means the care and services
9 provided by or under the direction and supervision of a physical
10 therapist licensed by the state. Except as provided in RCW 18.74.190,
11 the use of Roentgen rays and radium for diagnostic and therapeutic
12 purposes, the use of electricity for surgical purposes, including
13 cauterization, and the use of spinal manipulation, or manipulative
14 mobilization of the spine and its immediate articulations, are not
15 included under the term "physical therapy" as used in this chapter.

16 ~~((10))~~ (11) "Practice of physical therapy" is based on movement
17 science and means:

18 (a) Examining, evaluating, and testing individuals with
19 mechanical, physiological, and developmental impairments, functional
20 limitations in movement, and disability or other health and movement-
21 related conditions in order to determine a diagnosis, prognosis, plan
22 of therapeutic intervention, and to assess and document the ongoing
23 effects of intervention;

24 (b) Alleviating impairments and functional limitations in
25 movement by designing, implementing, and modifying therapeutic
26 interventions that include therapeutic exercise; functional training
27 related to balance, posture, and movement to facilitate self-care and
28 reintegration into home, community, or work; manual therapy including
29 soft tissue and joint mobilization and manipulation; therapeutic
30 massage; assistive, adaptive, protective, and devices related to
31 postural control and mobility except as restricted by (c) of this
32 subsection; airway clearance techniques; physical agents or
33 modalities; mechanical and electrotherapeutic modalities; and
34 patient-related instruction;

35 (c) Training for, and the evaluation of, the function of a
36 patient wearing an orthosis or prosthesis as defined in RCW
37 18.200.010. Physical therapists may provide those direct-formed and
38 prefabricated upper limb, knee, and ankle-foot orthoses, but not
39 fracture orthoses except those for hand, wrist, ankle, and foot
40 fractures, and assistive technology devices specified in RCW

1 18.200.010 as exemptions from the defined scope of licensed orthotic
2 and prosthetic services. It is the intent of the legislature that the
3 unregulated devices specified in RCW 18.200.010 are in the public
4 domain to the extent that they may be provided in common with
5 individuals or other health providers, whether unregulated or
6 regulated under this title (~~(18-RCW)~~), without regard to any scope of
7 practice;

8 (d) Performing wound care services that are limited to sharp
9 debridement, debridement with other agents, dry dressings, wet
10 dressings, topical agents including enzymes, hydrotherapy, electrical
11 stimulation, ultrasound, and other similar treatments. Physical
12 therapists may not delegate sharp debridement. A physical therapist
13 may perform wound care services only by referral from or after
14 consultation with an authorized health care practitioner;

15 (e) Reducing the risk of injury, impairment, functional
16 limitation, and disability related to movement, including the
17 promotion and maintenance of fitness, health, and quality of life in
18 all age populations; and

19 (f) Engaging in administration, consultation, education, and
20 research.

21 (~~(11)~~) (12) "Secretary" means the secretary of health.

22 (~~(12)~~) (13) "Sharp debridement" means the removal of
23 devitalized tissue from a wound with scissors, scalpel, and tweezers
24 without anesthesia. "Sharp debridement" does not mean surgical
25 debridement. A physical therapist may perform sharp debridement, to
26 include the use of a scalpel, only upon showing evidence of adequate
27 education and training as established by rule. Until the rules are
28 established, but no later than July 1, 2006, physical therapists
29 licensed under this chapter who perform sharp debridement as of July
30 24, 2005, shall submit to the secretary an affidavit that includes
31 evidence of adequate education and training in sharp debridement,
32 including the use of a scalpel.

33 (~~(13)~~) (14) "Spinal manipulation" includes spinal manipulation,
34 spinal manipulative therapy, high velocity thrust maneuvers, and
35 grade five mobilization of the spine and its immediate articulations.

36 (~~(14)~~) (15) Words importing the masculine gender may be applied
37 to females.

38 NEW SECTION. **Sec. 2.** A new section is added to chapter 18.74
39 RCW to read as follows:

SB 6374

1 A physical therapist may perform dry needling only after being
2 issued a dry needling endorsement by the secretary. The secretary,
3 upon approval by the board, shall issue an endorsement to a physical
4 therapist who has shown evidence of adequate education and training
5 that includes a minimum of fifty-four hours of dry needling education
6 and training and at least one year of licensed practice. A physical
7 therapist may not delegate dry needling.

--- END ---

Appendix B

Applicant Report and Follow Up



Applicant Report: Dry Needling in Physical Therapist Scope of Practice

- Legislative proposal being reviewed under the sunrise process (include bill number if available): Allowing physical therapists to perform dry needling SB 6374
- Name and title of profession for which the applicant seeks to change scope of practice: Physical therapist
- Approximate number of individuals practicing in Washington: 6,400 licensed physical therapists (there are also 2,100 licensed physical therapist assistants who would not be affected by this law).
- Information about applicant's organization:
 - Organization name: Physical Therapy Association of Washington
 - Contact person: Emilie Jones, PT, DPT, GCS
 - Address: 208 Rogers St NW, Olympia, WA 98502
 - Telephone number: (360) 352-7290 x10
 - Email address: ejones8@aol.com
 - Number of members in the organization: 2,676 (2,047 physical therapists, 203 physical therapist assistants, 426 students)
- Name(s) and address(es) of national organization(s) with which the state organization is affiliated and number of members in the organization:
 - American Physical Therapy Association, 1111 North Fairfax St, Alexandria, VA 22314
 - Number of members in national organization: 93,000
- Name(s) of other state or national organizations representing the profession: None
- List states where this profession includes this expanded scope of practice:
 - Dry needling is allowed via regulatory board opinion, Attorney General, AG, opinion, PT statute, or PT Board regulation in 19 states, with no additional education/training specific to dry needling required: Alaska, Georgia (in statute), Iowa, Kansas, Kentucky (AG opinion), Massachusetts, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Rhode Island, South

Carolina, Texas (AG opinion), Vermont, West Virginia, and Wisconsin.

- Dry needling is allowed via regulatory board opinion, AG opinion, PT statute, or PT Board regulation in 13 states, with additional education and training required: Arizona, Colorado, Delaware, District of Columbia, Illinois, Louisiana, Maryland (rules in process), Mississippi, Montana, Tennessee (rules in process), Utah, Virginia, and Wyoming.
- There are nine states that are silent on the issue of physical therapists performing dry needling: Arkansas, Connecticut, Florida, Indiana, Maine, Missouri, Minnesota, Oklahoma, and Pennsylvania.
- Dry needling is also performed by physical therapists in all branches of the United States military.

Dry Needling in Physical Therapist Scope of Practice

Executive Summary

Definition of the problem and why the change in regulation is necessary

The Physical Therapy Association of Washington (PTWA) seeks the inclusion of dry needling in the physical therapy scope of practice, as outlined in SB 6374, an act relating to allowing physical therapists to perform dry needling. The issue of physical therapists performing dry needling has been debated in Washington state for several years: by the Washington State Board of Physical Therapy, the King County Superior Court, the legislature, and most recently the Washington State Attorney General. In 2016, HB 2606 and its companion bill, SB 6374, were introduced. These bills would allow physical therapists who receive a dry needling endorsement from the Secretary of Health to perform dry needling. In an effort to examine and analyze this issue away from the legislative process, PTWA requested a sunrise review on SB 6374. It is our intent to demonstrate that dry needling is a safe, effective and appropriate tool for physical therapists to use in treating patients with musculoskeletal impairments. In addition, we feel that the endorsement approach in SB 6374 will ensure safe practice by defining the educational requirements for physical therapists to perform this technique.

Definition of the problem and benefits to the public

According to physiatrist Steven R. Goodman, M.D., "Chronic pain is a national epidemic that not only created immeasurable suffering, impairment, disability and addiction but is also a major contributor to health care expenditures." Myofascial pain, including "trigger points," are common sources of pain that are underdiagnosed and undertreated. Studies have shown that myofascial trigger points are the primary source of pain in 30-85% of patients in primary care and pain clinic settings.

Dry needling is used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, diminish persistent peripheral nociceptive (pain) inputs, and reduce or restore impairments of body structure and function leading to improved movement and function (APTA Resource Paper 2013). Many patients with musculoskeletal pain are already receiving physical therapy, at a fraction of the cost of other interventions. Physical therapists' practice of dry needling has the potential to reduce the cost of more expensive medical procedures such as imaging, surgery, opioid pain medication and long-term disability. To quote Dr. Goodman again: "Physical therapists have the proper education in the biomedical sciences, are already treating neuro-musculoskeletal injuries and conditions associated with trigger point myofascial pain, and significantly, can provide these patients with the proper exercise and functional rehabilitation programs they also require. Indeed physical therapists are the ideal practitioners to provide dry needling to the truly enormous numbers of people who could benefit from it."

It is acknowledged that some physical therapists in Washington state were performing dry needling prior to the 2015 statement by PTWA urging physical therapists to cease performing this technique and the 2016 Attorney General opinion. It is in the best interest of the public to define clear legislative scope of practice language clarifying the conditions under which physical therapists may safely and legally perform dry needling. More information on efficacy and cost-effectiveness can be found in sections 3 and 4 of this report.

Minimum level of education and training necessary to perform dry needling

In 2015, the Federation of State Boards of Physical Therapy (FSBPT), commissioned the nonprofit organization Human Resources Research Organization (HumRRO) to organize a practice analysis on dry needling in physical therapy. A task force formed by HumRRO to analyze the data concluded that 86% of the knowledge requirements needed to be competent in dry needling is acquired during the course of physical therapy entry-level education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety and professional responsibilities.

This analysis shows that the overwhelming majority of education necessary for physical therapists to perform dry needling is taught in the entry-level physical therapy doctorate education. Fourteen percent of the knowledge requirements related to competency in dry needling must be acquired through post-graduate education or specialized training in dry needling. The only skill that was determined not to be included in entry-level education was the actual handling of the needle.

The language of the proposed legislation (SB 6374) is based on this practice analysis. Fifty-four hours of post-licensure continuing education is the average length of the advanced, postgraduate training for dry needling in order to satisfy the HumRRO task force's recommendations. Dry needling postgraduate education is readily available across the United States and Canada. Dry needling is taught by physicians and physical therapists at many medical institutions and clinics, including Regis University in Colorado, Mercer University in Georgia and the University of British Columbia. Details of entry level and post-doctoral education can be found in Section 5 of this report.

Ensuring public safety for dry needling

Studies have shown that dry needling is safe when performed by physical therapists. In a study published in the Journal of Manual and Manipulative Therapy (Brady 2013), researchers reported that the risk of adverse effects of dry needling performed by physical therapists is less than 0.04 percent - lower than for common over-the-counter pain medication such as ibuprofen (.137 percent). All reported adverse events were considered "mild" (bleeding, bruising, pain while being needled) and no significant adverse events were reported.

The Washington State Legislature has determined that the physical therapist scope of practice includes other tissue penetrating procedures such as sharps debridement and needle electromyography. Recognizing that dry needling is not an entry-level skill, nor are the skills needed to perform this technique solely related to needle handling, the proposed legislation requires physical therapists to have at least one year of clinical practice prior to receiving an endorsement to perform dry needling. Only those physical therapists who meet the minimum of one-year full-time practice experience and the 54 hours of additional education and training will qualify for the endorsement. Furthermore, while physical therapists are able to supervise both licensed physical therapist assistants and physical therapy aides, this legislation would prohibit physical therapists from delegating dry needling. Details of safety considerations can be found in section 6 on Public Safety. More details on safety can be found in Section 6 of this report.

Current education and training adequately prepares practitioners to perform dry needling.

Graduation from any accredited program in the United States, including the three programs in the state of Washington (University of Washington, Eastern Washington University and University of Puget Sound), confers a Doctorate of Physical Therapy (DPT). At the University of Washington, School of Rehabilitation Medicine, Doctor of Physical Therapy Program, students obtain their doctorate after successfully completing 162 credits, which amounts to 4,860 hours of class and lab time, not counting outside practice and study time. This includes 1,500 hours of supervised clinical education.

The doctoral education of physical therapists includes anatomy, histology, physiology, biomechanics, kinesiology, neuroscience, pharmacology, pathology, clinical sciences, clinical interventions, clinical applications, differential diagnosis and screening. Much of the basic anatomical, physiological, and biomechanical knowledge that dry needling uses is taught as part of the core physical therapist education; the specific dry needling skills are supplemental to that knowledge.

According to a study by Childs et al. in 2005, physical therapists rank ahead of family medicine practitioners, internists, general surgeons and other non-orthopedic physicians in their knowledge of musculoskeletal conditions management. Only orthopedic surgeons rank ahead of physical therapists in their knowledge of musculoskeletal conditions management. This again was supported by research from Moore, et al 2005, which shows that clinical diagnostic accuracy by physical therapists and orthopedic surgeons on patients with musculoskeletal injuries was significantly greater than non-orthopedic surgeons, with no statistical difference between orthopedic surgeons and physical therapists. These research studies suggest that physical therapists have the knowledge, training and skills necessary to clinically diagnose and manage musculoskeletal injuries beyond most non-orthopedic physicians.

Continuing education courses on dry needling for physical therapists are ubiquitous throughout the United States, Canada and internationally. Dry needling course outlines and more information are found in Section 5 “Dry Needling Post-Doctoral Continuing Education” and in the appendix of this report. A list of common dry needling educational courses for physical therapists can be found at the end of this report. According to their class descriptions, these courses require pre-study to review anatomy, individual testing at the end of each course and advanced techniques that are not introduced until the students have a basic grasp on the technique. Courses require the student to pass a practical examination at the end of each course before being allowed to practice on patients. Any safety concerns result in an automatic failure and inability to progress further.

Physical therapist academic preparation for dry needling

The FSBPT competency analysis found that 86% of the knowledge requirements needed to be competent in dry needling is acquired during the course of physical therapy clinical education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety and professional responsibilities. The remaining 14% of the knowledge requirements related to competency in dry needling must be acquired through post-graduate education or specialized training in dry needling. Dry needling is not an entry-level skill for physical therapists and such, no changes should be made to the academic education for physical therapists. Furthermore, doctoral education programs as they currently exist adequately prepare students in the foundational sciences of anatomy, histology, physiology, biomechanics, kinesiology, neuroscience, pharmacology, pathology, clinical sciences, clinical interventions, clinical applications, differential diagnosis and screening. Specific dry needling skills are supplemental to that knowledge and require additional training outside of the professional degree. Details can be found in Section 5 “Dry Needling Post-Doctoral Continuing Education” and in the appendix of this report.

Ensuring that only qualified practitioners are authorized to perform dry needling

The proposed legislation expands the physical therapy scope of practice to include dry needling as an endorsement on the physical therapist license. Standard physical therapist licensure includes the ability to perform therapeutic techniques and manual therapy. The Washington State Legislature has determined that the physical therapist scope of practice includes other tissue penetrating procedures such as sharps debridement and needle electromyography. The proposed legislation requires physical therapists to have at least one year of clinical practice prior to receiving an endorsement to perform dry needling. Only those physical therapists who meet the minimum of one year full-time practice experience and the 54 hours of additional education and training will qualify for the endorsement. Furthermore, while physical therapists are able to supervise both licensed physical therapist assistants and physical therapy aides, this legislation would prohibit physical therapists from delegating dry needling.

Dry Needling in Physical Therapist Scope of Practice

1. INTRODUCTION
2. BACKGROUND: The History and Definition of Dry Needling in Physical Therapy.
3. EFFICACY
 - a. Pain Reduction
 - b. Patient Benefits of Dry Needling Treatment
4. COST EFFECTIVENESS
5. EDUCATION
 - a. Competencies
 - b. Entry Level Physical Therapy Education Competencies
 - c. Dry Needling Post-Doctoral Continuing Education
 - d. Doctoral Education
6. PUBLIC SAFETY
 - a. Risk of Pneumothorax
 - b. Risks during Pregnancy
 - c. Adverse Events Statistics Specific to Physical Therapist in the United States.
 - d. Summary of Risk
7. DRY NEEDLING IN CONTRAST TO OTHER THERAPIES
 - a. Dry Needling in Contrast to Acupuncture
 - i. Purpose of Treatment
 - ii. Trigger Points v. Ashi Points
 - iii. Tools for Treatment
 - b. Dry Needling in Contrast to Medical Acupuncture
8. CURRENT PHYSICAL THERAPY DRY NEEDLING LAWS
 - a. Overlap in Scopes of Practice
 - b. Dry Needling in the Military
 - c. Comparative Scope of Practice within the States.
9. CONCLUSION
10. CITATIONS
11. APPENDICES

1. INTRODUCTION

The Physical Therapy Association of Washington (PTWA) seeks the inclusion of dry needling in the physical therapy scope of practice, as outlined in SB 6374, an act relating to physical therapists to perform dry needling.

The issue of physical therapists performing dry needling has been debated in Washington for several years. The Washington State Board of Physical Therapy (Board of PT) solicited comments from interested stakeholders over the past four years on this issue. In December of 2014, they passed a motion stating that the Board would not address the dry needling issue until the Legislature provided further direction. In 2015, Rep. Eileen Cody introduced HB 1042, a bill specifically prohibiting physical therapists from performing dry needling. That bill did not pass the Legislature.

Following the 2015 legislative session, PTWA advised and requested that all PTs who had been previously performing dry needling cease the practice until legislation was passed defining qualifications.

In 2016, HB 2606 and its companion bill, SB 6374, were introduced. These bills would allow physical therapists who have a dry needling endorsement from the Secretary of Health to perform dry needling. The proposed legislation expands the physical therapy scope of practice to include dry needling as an endorsement on the physical therapist license. Standard physical therapist licensure includes the ability to perform therapeutic techniques and manual therapy. The Washington State Legislature has determined that the physical therapist scope of practice includes other tissue penetrating procedures such as sharps debridement and needle electromyography. The basis for this determination was that physical therapists possess the knowledge, skills and competency to safely and capably provide these techniques.

Recognizing that dry needling is not an entry-level skill, nor are the skills needed to perform this technique solely related to needle handling, the proposed legislation requires physical therapists to have at least one year of clinical practice prior to receiving an endorsement to perform dry needling. Furthermore, while physical therapists are able to supervise both licensed physical therapist assistants and physical therapy aides, this legislation would prohibit physical therapists from delegating dry needling.

Adding an endorsement for dry needling would have no additional costs to the state or the Department of Health as the cost of the endorsement would be borne by the licensee.

Neither HB 2602 nor SB 6374 passed the Legislature in 2016. In an effort to examine and analyze this issue away from the legislative process, PTWA requested a sunrise review on SB 6374. It is our intent to demonstrate that dry needling is a safe, effective, and appropriate tool for physical therapists to use in treating patients with musculoskeletal impairments. In addition, we feel that the endorsement approach in SB 6374 will ensure safe practice. Only those physical therapists who meet the minimum of one-year full-time practice experience and the 54 hours of additional education and training will qualify for the endorsement.

2. BACKGROUND: The history and definition of dry needling in physical therapy

Dry needling is a technique that originates in Western medicine. Dry needling uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments. (APTA Resource Paper 2013). Dry needling is used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, diminish persistent peripheral nociceptive (pain) inputs, and reduce or restore impairments of body structure and function leading to improved movement and function (APTA Resource Paper 2013).

Physical therapists treat myofascial pain and trigger points using a variety of physical therapy techniques: stretching, manual therapy/massage, ultrasound, transcutaneous electrical nerve stimulation, biofeedback, etc. (Kalichman 2010). Though physical therapists use dry needling to treat myofascial pain, they also use dry needling to treat restrictions in range of motion due to contractures in muscle fibers, fascial adhesions or scar tissue.

The theoretical origin of dry needling is attributed to the pioneering work of Janet Travell, M.D. and David Simons, M.D., whose original research mapped all the myofascial trigger points in the body in the 1950s and 1960s. They used .22-gauge hypodermic needles to treat myofascial pain with trigger point therapy (i.e., needling of taut bands of muscle fibers). They originally injected these taut bands of muscle with a medication or saline, but later studies showed that it was the needle piercing the skin that caused the change in the muscle, not what was being injected (Karl Lewit, 1989). Hence, the term dry needling came about, as the needle was dry and was not injecting anything into the body.

Dry needling is a procedural intervention used by physical therapists to treat pain, functional impairments, and disabilities. Myofascial pain is a common form of pain that is caused by muscles or fascia. Myofascial trigger points are small, tight areas of muscle fiber that are highly irritable. Studies have shown that myofascial trigger points are the primary source of pain in 30-85% of patients in primary care and pain clinic settings. (Skootsky 1989, Han 1989).

Trigger points are very common and have been described in numerous diagnoses: radiculopathies, joint dysfunction, disc pathology, tendonitis, craniomandibular dysfunction, migraines, tension headaches, carpal tunnel syndrome, whiplash associated disorders, spinal dysfunction, pelvic pain and urologic syndromes, post-herpetic neuralgia, complex regional pain syndrome, phantom pain, among others (APTA Dry Needling in Clinical Practice Resource Paper).

The dry needling technique involves the insertion of solid filament needles into the skin and underlying tissue to disrupt pain sensory pathways and relax contracted fibers (Dommerholt & Fernandez-de-las-Penas, 2014). Clinical research suggests that dry needling helps reduce local and peripheral pain and sensitization, thereby speeding up the restoration of muscle function and range of motion (Lewit, 1979; Dommerholt, 2011; Clewley, Flynn, & Koppenhaver, 2014). Dry needling (alone or with other physical therapy interventions) has been shown to be an effective treatment for neuro-musculoskeletal diseases or conditions, including arthritis, tendonitis, carpal tunnel syndromes and chronic pain (Gerwin 2004; Kalichman, & Vulfsons, 2010).

Over the past several decades, practitioners have adopted variations on the original approach including superficial and deep needling techniques (Gunn, 1997; Baldry, 2002). Modern dry needling has largely abandoned hypodermic needles in favor of round tip, solid filament needles ranging from .22 to .30 millimeters in diameter, as the beveled tip of hypodermic needles causes greater tissue damage than necessary. In addition, modern dry needling is used to treat a variety of conditions and dysfunction that impact the musculoskeletal and nervous systems of the body.

The technique of dry needling can be visualized by this video from the Netherlands: <https://www.youtube.com/watch?v=l75OAZzr6V4&index=49&list=FLJZHGN5-n5P2nJEP2TeVcow>

3. EFFICACY OF DRY NEEDLING

a. Pain reduction

Dry needling has been shown to reduce pain and improve outcomes in patients with myofascial pain. Research in the medical community on the benefits of dry needling date back to the 1970s and 80s.

A study by Chan Gunn in 1980 randomized 56 patients with chronic low back pain that had not improved with 8 weeks of standard care that included physical therapy, occupational therapy and exercise. The dry needling group underwent dry needling once or twice a week for an average of 7.9 treatments. They were assessed at the end of their treatment, at 12 weeks and at 6 months. The group that had been treated with dry needling was clearly and significantly better than the control group at all points. Eighteen of the 29 patients who had undergone dry

needling had returned to their original employment and 10 had returned to lighter employment, compared with the control group where only 4 had returned to full employment and 14 to lighter employment. The reduced burden of the cost of ongoing treatment for chronic pain, as well as the societal costs of being unable to work, are significant.

The efficacy of dry needling in patients with neck and shoulder pain was evaluated in an article by Gerber et al. The patients had myofascial pain for longer than 3 months and underwent 9 sessions of dry needling over 3 weeks. Dry needling changed the trigger point status from active (spontaneously painful) to latent or resolved. Importantly, pain reduction was significantly correlated with improvement in range of motion including cervical spine side bending and rotation. Patient self-reports revealed a reduction in disability as well as improved physical and emotional well-being and mood (Gerber 2015).

Dry needling has also been shown to be effective in costly chronic conditions such as fibromyalgia. A study in the journal "Rheumatology International" evaluated the short-term efficacy of dry needling therapy in patients severely affected by fibromyalgia. One hundred and twenty fibromyalgia patients were randomly divided into two groups. The control group (56 women and 4 men) and the dry needling group (54 women and 6 men) who, in addition to continuing their medical treatment, also underwent weekly one-hour sessions of dry needling for six weeks. At the end of treatment, the experimental group showed significant improvements in most tests, including pain, fatigue, and global subjective improvement. Six weeks after the end of the treatment, the dry needling group still showed significant improvements in most tests (Casanueva 2014).

Dry needling can have additional benefits in reducing spasticity in patients with neurologic impairments. A study in the "Journal of Manipulative Physiologic Therapy" found that patients who had had a stroke and who underwent one session of dry needling in their calf and shin muscle had reduced spasticity and decreased pressure sensitivity after the intervention (Salom-Moreno 2014). This type of benefit can then be immediately translated to therapeutic exercise and gait training during a physical therapy session.

b. Patient benefits of dry needling treatment

Many patients with myofascial pain and trigger points are already receiving physical therapy or are referred to physical therapy for treatment of their muscle imbalance and pain. In states that allow physical therapists to perform dry needling, patients who receive dry needling during their treatment have received it as part of their overall physical therapy plan of care, not as an individual therapy. Thus, dry needling enhances the success of their overall physical therapy treatment.

According to Washington physiatrist Steven Goodman, M.D., physical therapist practice of dry needling has the potential to reduce the cost of more expensive medical procedures such as imaging, surgery, opioid pain medication and long-term disability.

In addition, patients with neuromuscular pain need access to this targeted technique in order to prevent chronic pain, opioid dependence, work restrictions and disability. The recently published Centers for Disease Control Guidelines for prescribing opioids attempted to quantify the cost of chronic pain in the United States. They cited an article by Stagnitti which stated that in 2012, total expenses for outpatient prescription opioids were estimated at \$9.0 billion, an increase of 120% from 2002. Physical therapy was specifically mentioned as a more effective and lower cost treatment for chronic pain (CDC Guideline 2016).

4. COST EFFECTIVENESS OF PHYSICAL THERAPISTS PERFORMING DRY NEEDLING

Musculoskeletal conditions are among the costliest to manage. Low back pain (LBP) (acute, subacute and chronic) is a common condition and the leading cause of disability in the United States as of 2010. At least 80% of adults will have LBP at some point in their life and approximately 20-30% of the adult population has LBP at any given time. Expensive, non-conservative modalities (e.g., imaging, opioids and spinal injections) are often used for acute LBP in the absence of a clear indication for those services, further driving up LBP costs.

According to the Bree Collaborative, the total direct health care costs attributable to low back pain in the United States were estimated to be \$26.3 billion in 1998. In 2010, King County government's self-insured health plan (KingCare) spent more than \$31 million for surgical and non-surgical interventions specifically for low back pain. Similarly, Costco Wholesale spent approximately \$124 million (107,951 claimants) in 2011 on musculoskeletal and connective tissue conditions. Indirect costs related to days lost from work are also substantial; one study found that mechanical low back pain was the fourth costliest physical health condition for businesses and 41% of those costs were attributable to absence or disability. It is estimated that only 15% of all LBP has an identifiable anatomic or physiologic cause (e.g., herniated disc, lumbar spinal stenosis). The remaining 85% of low back pain diagnoses are for acute or non-specific low back pain. Yet in 2010, Washington had the 14th highest back surgery rate of all states. Furthermore, LBP has a high risk to become a chronic, costly condition. In long-term follow-up (one year or more), about one in three patients report intermittent or persistent pain of at least moderate intensity, one in seven continue to report back pain of severe intensity, and one in five report substantial activity limitations (Bree Collaborative 2013).

The high cost of LBP and related musculoskeletal conditions make them a major source of concern to all health care stakeholders, especially employers and other purchasers such as the Washington State Department of Labor and Industries. The total direct health care costs attributable to LBP in the United States were estimated to be \$26.3 billion in 1998.

The Bree Collaborative recommends, "Patients with complex low back pain (defined as having significant functional deficits) may require referral to a physical medicine and rehabilitation physician and/or to a physical therapist or mental health specialist for further evaluation and rehabilitative services directed at helping patients resume life activities."

Many patients with musculoskeletal pain are already receiving physical therapy, at a fraction of the cost of other interventions like opioids, imaging, or surgery. As described in the earlier section on efficacy, allowing physical therapists to perform dry needling would lead to improved participation in rehabilitation and improved outcomes.

Access to dry needling treatment improves outcomes and facilitates patient participation with other physical therapy techniques like manual therapy and active exercise. Many patients are *already receiving physical therapy care* and prefer to get treatment within the western medical model. If physical therapists are not able to utilize this technique, patients will require many more sessions of physical therapy to treat their condition or the patient may need additional treatment from another healthcare practitioner.

Other practitioners who perform dry needling include physiatrists, orthopedic doctors, and naturopaths, whose visits are usually more expensive. Many physicians do not have the availability or desire to provide this technique at the frequency that it may be required to achieve results. There are approximately 6,400 physical therapists in Washington state and they practice in most geographic areas. Physical therapists have the capacity to provide this treatment and are already treating patients with myofascial pain. Limiting this technique to physician providers will limit the patient's choice of providers as well as being potentially cost prohibitive to patients. Allowing patients who are already receiving physical therapy to receive dry needling as part of their treatment will accelerate their care and thus reduce the cost to insurers and patients.

5. DRY NEEDLING POST-DOCTORAL CONTINUING EDUCATION

In 2015, the Federation of State Boards of Physical Therapy (FSBPT), commissioned the nonprofit organization Human Resources Research Organization (HumRRO) to organize a practice analysis on dry needling in physical therapy. This months-long process included a literature review of dry needling tasks and knowledge requirements by and a practitioner survey of over 350 physical therapists. Then a task force of dry needling experts processed the information from the literature

review and the practitioner survey to determine a final set of dry needling competencies. (See Appendices.)

a. Competencies

The task force analyzed what competencies, including knowledge, skills and abilities, are necessary for a physical therapist to perform dry needling competently. The task force also analyzed physical therapy entry-level education (education necessary for licensure) to determine what competencies are already taught in physical therapy school. The practice analysis results showed two important segments of physical therapy education and dry needling.

b. Entry level physical therapy education competencies

Eighty-six percent of the knowledge requirements needed to be competent in dry needling is acquired during the course of physical therapy entry-level education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety, and professional responsibilities.

This analysis shows that the overwhelming majority of education necessary for physical therapists to perform dry needling is taught in the entry-level physical therapy doctorate education.

c. Dry needling post-doctoral continuing education

Fourteen percent of the knowledge requirements related to competency in dry needling must be acquired through post-graduate education or specialized training in dry needling. The only skill that was determined not to be included in entry-level education was the actual handling of the needle.

The language of the proposed legislation (SB 6374) is based on this practice analysis. Fifty-four hours of post-licensure continuing education is the average length of the advanced, postgraduate training for dry needling in order to satisfy the task force's recommendations. Dry needling postgraduate education is readily available across the United States and Canada. It is taught by physicians and physical therapists at many medical institutions and clinics, including Regis University in Colorado, Mercer University in Georgia and the University of British Columbia.

Continuing education courses on dry needling for physical therapists are ubiquitous throughout the United States, Canada, and internationally. Most continuing education courses on dry needling for physical therapists are divided into two levels of courses. One cannot move to the second course level without successfully passing the first level. Most of these courses require at least one year of practice as a licensed physical therapist before taking the first level class (SB 6374 requires this as well).

The first level objectives focus on understanding the theory and practice of dry needling; what trigger points are and how they relate to dry needling; neuromuscular dysfunction; a review of anatomy, function, and safety concerns; and indications and contraindications for using dry needling. Here is an example of one course's first level objectives:

Level 1: Objectives

- Define and understand what trigger points and motor banding are and how they relate to treatment with dry needling.
- Present and review both the common and uncommon presentations of neuromuscular dysfunction as well as utilize other common evaluation procedures.
- Review and become familiar with current literature regarding efficacy and treatment rationale for dry needling.
- Instruct safe and efficient application of dry needling for orthopedic and neuromuscular conditions.
- Review anatomy, function and safety concerns of regions.
- Instruct and apply dry needling technique that considers safety, indications and contraindications for treatment and proper integration into the clinical or sports setting.

The second level courses that, again, can only be taken after successfully completing level one, focus on similar objectives in level one, but more in-depth:

Level 2: Objectives:

- Define trigger points, motor banding, and neurological presentations of neuromuscular dysfunction.
- Review literature supporting efficacy and treatment rationale of dry needling.
- Instruct application of dry needling for more advanced orthopedic and neuromuscular conditions.
- Review anatomy of regions to be taught in Level 2 course.
- Review and discuss safety concerns.
- Discuss indications and contraindications for treatment.
- Discuss specific treatment rationale for various diagnoses.
- Integration of dry needling into a physical therapy treatment program.

A recent survey by PTWA found that of 232 responses from Washington physical therapists, 52 had taken dry needling continuing education in some capacity. Thirty of those 52 were former members of the military or had moved to Washington from another state where they were able to perform dry needling.

A list of common dry needling educational courses for physical therapists can be found in the Appendices. According to their class descriptions, these courses require pre-study to review anatomy, individual testing at the end of each course and advanced techniques that are not introduced until the students have a basic grasp on the technique. Courses require the student to pass a practical examination at the end of each course before being allowed to practice on patients. Any safety concerns result in an automatic failure and inability to progress further.

d. Doctoral education

As of January 1, 2016, the Commission on the Accreditation of Physical Therapy Education (CAPTE) made the doctor of physical therapy degree (DPT) the required degree for all entry-level physical therapist education programs in the United States. In fact, as of 2014, all physical therapy programs were at the doctoral level.

Graduation from any accredited program in the United States, including the three programs in the state of Washington (University of Washington, Eastern Washington University and University of Puget Sound), confers a DPT. Training in differential diagnosis is a distinguishing aspect of becoming doctors. This allows graduates to discern who is appropriate to treat and who is outside their skill set and should be referred to a different practitioner. Physical therapists are licensed medical practitioners. At the University of Washington, School of Rehabilitation Medicine, Doctor of Physical Therapy Program, students obtain their doctorate after successfully completing 162 credits, which amounts to 4,860 hours of class and lab time, not counting outside practice and study time. This includes 1,500 hours of supervised clinical education.

For the University of Washington’s School of Rehabilitation Medicine’s Doctor of Physical Therapy (DPT) program, which is a CAPTE (Commission on the Accreditation in Physical Therapy Education) accredited program, students complete the following hours to become a DPT: (December 2015 CAPTE report):

The institutional academic calendar is based on: **Quarter**

Number of terms (semesters, quarters, trimesters) required for completion of the professional/technical phase of the program	11
Total length of the professional/technical program in weeks	118
Number of CREDITS required for completion of the program:	
Pre-professional phase	180
Professional phase - Classroom/Laboratory courses (including independent study courses, distance learning courses, etc.)	12
Professional phase - Clinical Education courses	34
Total number of CONTACT HOURS during professional education	
Classroom, laboratory, distance learning or independent study	2660
Part-time clinical education	60
Full-time clinical education (35 hours or more per week)	1440 (36 wks)

To calculate total hours a student puts into becoming a DPT, for every contact hour in the classroom, lab, distance learning or independent study, add 2 more hours. Therefore, to become a DPT at the UW it takes approximately **9480** hours ($2660 + 5320 + 60 + 1440 = 9480$). This number is an underestimate, since many students continue to study while they are involved in their clinical rotations, preparing for the next day's patients and to provide in-service trainings to colleagues. A more accurate number would be to add 2 hours on to every 8 hours of clinical time, which would add 375 more hours, totaling **9855 hours in order to attain a doctorate in physical therapy.**

The doctoral education of physical therapists includes anatomy, histology, physiology, biomechanics, kinesiology, neuroscience, pharmacology, pathology, clinical sciences, clinical interventions, clinical applications, differential diagnosis and screening. Much of the basic anatomical, physiological, and biomechanical knowledge that dry needling uses is taught as part of the core physical therapist education; the specific dry needling skills are supplemental to that knowledge.

According to a study by Childs et al. in 2005, physical therapists rank ahead of family medicine practitioners, internists, general surgeons and other non-orthopedic physicians in their knowledge of musculoskeletal conditions management. Only orthopedic surgeons rank ahead of physical therapists in their knowledge of musculoskeletal conditions management. This again was supported by research from Moore, et al 2005, which shows that clinical diagnostic accuracy by physical therapists and orthopedic surgeons on patients with musculoskeletal injuries was significantly greater than non-orthopedic surgeons, with no statistical difference between orthopedic surgeons and physical therapists. These research studies suggest that physical therapists have the knowledge, training, and skills necessary to clinically diagnose and manage musculoskeletal injuries beyond most non-orthopedic physicians.

Physical therapists maintain a code of ethics that includes making judgments within their scope of practice and level of expertise. They are required to report colleagues that are unable to perform their professional responsibilities with adequate skill and safety. Physical therapists take responsibility for their professional development based on critical self-assessment and reflection on changes in physical therapist practice, education, and health care delivery, and being good stewards of healthcare resources (APTA Code of Ethics for the Physical Therapist).

Dry needling was listed in the most recent revision of the American Physical Therapy Association's (APTA) "Guide to Physical Therapist Practice 3.0" (2014) under the list of manual therapy techniques that a physical therapist may employ along with massage, traction, and mobilization of tissues and joints.

The APTA Board of Directors further acknowledged dry needling to be within the scope of practice of physical therapy when they approved “Guidelines: Physical Therapist Scope of Practice” in 2014. The FSBPT and the Academy of Orthopaedic Manual Physical Therapists (AAOMPT) also recognize dry needling as within the physical therapy scope of practice.

The 2014 version of the “Guide to Physical Therapist Practice” reflects updates to physical therapist practice that have occurred in the last 10 years. While physical therapists have been performing dry needling since 1984, research regarding its efficacy and subsequent adoption of the technique have become more common in the last ten years. APTA, AAOMPT and FSBPT published positions that dry needling is within the physical therapist’s scope of practice as challenges were being posed to physical therapists practice of the dry needling technique in 2009 throughout the United States.

In October 2009, AAOMPT issued the following statement in support of the use of dry needling in physical therapy practice: “Dry needling is a neurophysiological evidence-based treatment technique that requires effective manual assessment of the neuromuscular system. Physical therapists are well trained to utilize dry needling in conjunction with manual physical therapy interventions. Research supports that dry needling improves pain control, reduces muscle tension, normalizes biochemical and electrical dysfunction of motor endplates, and facilitates an accelerated return to active rehabilitation.”

Physical therapists are regulated by the Board of PT and are required to perform 40 hours of continuing education during each 2-year licensing cycle. Washington state law mandates that physical therapists shall recognize the need for continuing education and shall be open to new procedures and changes (WAC 246-915-180). Therefore, it is a physical therapist’s professional duty to pursue novel approaches, especially when the literature and clinical practice substantiate the effectiveness of that approach, such as dry needling. Much has changed in our understanding and practice as physical therapists in the 10 years that have passed since needle EMG and sharps debridement language was explicitly written into our scope of practice.

6. PATIENT SAFETY

Studies have shown that dry needling is safe when performed by physical therapists. In a study published in the “Journal of Manual and Manipulative Therapy” (Brady 2013), researchers reported that the risk of adverse effects of dry needling performed by physical therapists is less than 0.04 percent - lower than for common over-the-counter pain medication such as ibuprofen (.137 percent). The physical therapists in this study had received 64 hours of dry needling education and performed 7,629 total dry needling treatments. All reported adverse events were considered “mild” (bleeding, bruising, pain while being needled) and no significant adverse events were reported.

a. Risk of pneumothorax

Pneumothorax (puncture of the lung leading to collapse) is a very rare but serious complication associated with needling around the thoracic region. A study by Brady et al. surveyed physical therapists over 7,629 dry needling treatments. There were no reports of pneumothorax.

Searches of Pubmed in May 2016 did not return any studies investigating pneumothorax beyond the level of a case study. Evidence on safety of needling techniques comes primarily from prospective studies investigating adverse events following acupuncture. Results from acupuncture studies cannot be applied to dry needling as it differs in both location and depth of needle from acupuncture.

b. Risks during pregnancy

Unintended miscarriage is considered to be a potential consequence of needling what the acupuncture literature terms “forbidden points” in pregnant women. A 2015 study in the journal “Acupuncture Medicine” reviewed 15 clinical trials where 823 women were needled at forbidden points during all stages of pregnancy. The data showed that rates of preterm birth and stillbirth are equivalent to those in untreated control groups and consistent with background rates of these complications in the general population (Carr 2015).

Another study Carr reviewed was a large observational study of 5,885 women needled at “forbidden points” in all stages of pregnancy. The rates of miscarriage, preterm birth, preterm pre-labor rupture of membranes and preterm contractions were comparable with untreated controls and/or consistent with their anticipated incidence. They concluded that there is no reliable evidence that acupuncture can induce miscarriage/labor.

Nonetheless, the APTA document “Description of Dry Needling in Clinical Practice” counsels caution when dry needling pregnant women in their first trimester of pregnancy. Notwithstanding the study’s findings, physical therapists are accountable for vigilant decision-making where risks may explicitly and implicitly be present.

c. Adverse events statistics specific to physical therapists in the United States.

In 2012 APTA requested CNA, the largest healthcare malpractice insurer of physical therapists, to provide information about claims against physical therapists related to dry needling. CNA reported that, “After reviewing 5,800 closed physical therapist claims, there were no trends relative to dry needling identified that would indicate this procedure presents a significant risk factor.” Data showed six claims arising from the practice of dry needling with a total indemnity paid for all claims of \$79,000. “CNA does not foresee the practice of dry needling by a licensed physical therapist as having any immediate claim or rate impact.”

Another example is Maryland. According to the Maryland Department of Health and Mental Hygiene, Maryland has permitted physical therapists to perform dry needling since the 1980s. Maryland has 6,178 licensed physical therapists. To date, there has been one complaint related to dry needling that resulted in a public order. This case was related to a physical therapist who performed dry needling on a patient without any formal training, education, or experience in dry needling at the time of the treatment. There was no reported patient injury, however the physical therapist's license was reprimanded and he was fined \$1,000.

The FSBPT's Disciplinary Database, the database showing all disciplinary actions taken by physical therapy regulators across the country, has no reports of serious harm or injury from dry needling performed by a physical therapist, as of May 25, 2016. In 2015, there was one instance of disciplinary action taken against a physical therapist regarding dry needling. In 2014, there were two instances of discipline, but neither case described any harm to the patient. In 2013, there was one disciplinary action taken against a physical therapist for inappropriate training and failure to properly document. There were no instances of any disciplinary action against a physical therapist for dry needling prior to 2013. Altogether, .2% of the total disciplinary actions against physical therapists between 2010 and 2015 were related to dry needling.

Additionally, physical therapists in Washington have a history of safe and appropriate practice. According to Department of Health disciplinary records, only three physical therapists have had disciplinary action taken against them related to standards of care in the last five years. In one case, the allegations stated that an elderly patient fell down and suffered a broken hip when being trained to use a walker. In another, the allegations stated that the PT allowed aides to perform beyond their scope of practice. Allegations in the third case stated that the physical therapist repeatedly did not submit Physical Capacity Evaluation paperwork.

d. Summary of risk

Acupuncture itself is not without risk of adverse events, and any comparison of risk with dry needling by physical therapists must be taken in light of the inherent risk in inserting a needle into muscle tissue. Witt et al. carried out the largest prospective acupuncture study to date. Of the 229,233 patients who received 2.2 million acupuncture treatments, 8.6% of patients (n=519,726) experienced at least one adverse event. In this study, 24,377 adverse events were reported, amounting to approximately one event per 90 treatments (0.9%).

It would be inappropriate to deny the risk, however small, of serious injury with the practice of dry needling. In fact, a Canadian Olympic athlete suffered a double pneumothorax after undergoing acupuncture performed by a massage therapist. However, the baseline education of physical therapists is much more thorough and intensive than that of a massage therapist. In fact, most dry needling courses offered in the United States are not open to massage therapists.

7. DRY NEEDLING IN CONTRAST TO OTHER THERAPIES

a. Dry needling in contrast to acupuncture

Health care education and practice have developed in such a way that most professions today share some procedures, tools, or interventions with other regulated professions. It is unreasonable to expect a profession to have exclusive domain over an intervention, tool or modality. The theoretical understanding of how and why a specific tool is used and the context in which it is used is what separates dry needling from acupuncture.

Dry needling is not the practice of acupuncture. The practice of acupuncture by acupuncturists and the performance of dry needling by physical therapists differ in terms of historical, philosophical, indicative and practical context. The performance of modern dry needling by physical therapists is based on western neuroanatomy and modern scientific study of the musculoskeletal and nervous systems and does not rely on traditional Eastern medicine theories. In East Asian medicine, acupuncture is used to stimulate acupuncture points and meridians and restore energy flow within the body. A summary of educational differences can be seen in the appendix.

i. Purpose of treatment

Physical therapists that perform dry needling do not use traditional acupuncture theories or acupuncture terminology. Acupuncture has a long and reputable history, based on a system of 'energy flow' along meridians throughout the body. Dry needling is a much more recent approach, introduced about 40 years ago, and based on modern scientific study of the neuromusculoskeletal system including anatomy, physiology, histology, biomechanics, neuroscience, kinesiology, pharmacology and pathology. Proper practice of dry needling requires a neuro-musculoskeletal physical examination which forms the basis for treatment." ("Why Trigger Point Dry Needling is Not Acupuncture" Dr. Steven Goodman; see Appendices).

Carol Kari, L.Ac, RN (President of the Maryland Acupuncture Society from 1992 to 1997) testified to the Maryland Secretary of Health in a letter dated September 13, 2012: "Yes, both professions hold the same tool, a needle, but the physical therapists are not working from a perspective of acupuncture meridians or chi flow in the body." The difference between dry needling and acupuncture technique is apparent when viewing this video that demonstrates the technique of dry needling: <https://www.youtube.com/watch?v=l75OAZzr6V4&index=49&list=FLJZHGN5-n5P2nJEP2TeVcow>

According to the World Health Organization, acupuncture has been proven to be an effective treatment for allergic rhinitis, depression, dysentery, dysmenorrhea, epigastralia, hypertension, colic, in addition to musculoskeletal conditions. Acupuncture diagnoses are significantly different from physical therapy diagnoses,

and physical therapists do not and should not treat acupuncture diagnosis. Physical therapists do not consider energy flow or meridians to treat systemic issues.

ii. Trigger points v. ashi points

The statement that trigger points and acupuncture points are the same has not been born out in the literature (Birsch, 2008; see Appendices). Acupuncture points are predetermined points mapped out on the body based on thousands of years of empirical study in Chinese medicine. A different type of point used by acupuncturists that is not based on these predetermined acupuncture points and that more closely correlate with trigger points is called an Ashi point. In East Asian practice, these discrete Ashi points are specifically tender points, also known as the “ah yes” points. According to Andrew Nugent Head, the way these are treated in traditional acupuncture is in the context of the whole treatment, not just a stand-alone treatment (see article “Ashi Points in Clinical Practice,” Andrew Nugent-Head, *Journal of Chinese Medicine*, February, 2013). Nugent’s article underscores their importance in treating musculoskeletal issues. He refers to these same points as trigger points in Western literature. He concludes that working on these points has a positive effect on musculoskeletal dysfunction.

Physical therapists are known musculoskeletal experts, so whether or not Ashi and trigger points are the same, this acknowledgment that working on these tender points is beneficial to the musculoskeletal system underscores the importance of addressing these painful points in improving a patient’s function. In sum, physical therapist are not using acupuncture points in their treatment, but it is possible that both acupuncturists and physical therapists are addressing tender points in the body, found via assessment and not a predetermined spot.

iii. Tools for treatment

Concerns have been raised by the National Center for Acupuncture Safety and Integrity (NCASI) regarding the use of acupuncture needles in the practice of dry needling. To comply with the prescription device regulation special control generally, according to 21 C.F.R. § 801.109(b)(1), prescription devices must bear the following statement: “Caution: Federal law restricts this device to sale by or on the order of a _____”, the blank to be filled with the word “physician”, “dentist”, “veterinarian”, or with the description designation of *any other practitioner licensed by the law of the State in which he practices to use or order the use of the device.*” (Emphasis added.) Many boxes of acupuncture needles contain the warning: “Caution: Federal law restricts this device to sale by or on the order of an Acupuncturist.” However, it should be noted that there are several commercially available needles for dry needling that do not contain this warning.

NCASI alleged that dry needling by physical therapists is inconsistent with the requirements for acupuncture needles under federal law. In response, the APTA commissioned a legal analysis from the law firm of Hogan Lovells US LLP to investigate whether NCASI’s allegation against physical therapists and the physical

therapy licensing boards has merit. Based on the legal analysis, APTA concluded that the allegations were without merit and provided the following rationale: “FDA regulates acupuncture needles as class II medical devices. When the FDA down-classified acupuncture needles and promulgated 21 C.F.R. § 880.5580, the FDA stated that acupuncture needles are for use by qualified practitioners as determined by the states. We believe that the FDA, in doing this, was clearly signaling that it would not involve itself in determining who is a qualified practitioner to use acupuncture needles, leaving it to the states to decide. The regulations require that acupuncture needles comply with the following special controls: (1) “labeling for single use only and conformance to the requirements for prescription devices set out in 21 C.F.R. § 801.109” (“prescription device regulation”), (2) “material biocompatibility,” and (3) “sterility.” Id. § 880.5580(b). This regulation does not designate acupuncture needles as restricted devices but rather categorizes them as prescription devices requiring compliance with 21 C.F.R. § 801.109.

This approach is consistent with the principle behind § 1006 of the FDC Act, 21 U.S.C. § 396, which says that nothing in the FDC Act limits the authority of a health care practitioner to administer a legally marketed device for any condition within a legitimate practitioner-patient relationship. The legislative history for this provision indicates that Congress intended to emphasize that the FDA should not interfere in the practice of medicine.” (See Appendices.)

b. Dry needling in contrast to medical acupuncture

It has been suggested that for physical therapists to be qualified to perform dry needling, they should have similar training as physicians who do medical acupuncture. However, medical acupuncture is different from dry needling. Medical acupuncture is a form of acupuncture and is based on eastern medicine philosophy (see the American Academy of Medical Acupuncture). Physicians need 220 hours of training to become certified in medical acupuncture (<http://www.medicalacupuncture.org/For-Physicians/Membership/Membership-Categories-Join>). Medical acupuncture courses list their objectives as including the foundation of acupuncture science and theory, channel and point location, needling techniques, approaches to diagnosis and therapy, patient management, and practice set up, building, and billing. See appendix for details on medical acupuncture training.

However, to become certified in dry needling, physicians can take classes alongside physical therapists. Anatomy and technique are taught based on western medicine, and this does not include any eastern medicine training. (Why TDN is not Acupuncture, Goodman). These dry needling continuing education courses in dry needling assume a strong foundation in western medicine, in anatomy, physiology, kinesiology, pathology. These entry and advanced level continuing education courses, which usually amount to about 50 hours, focus on handling skills, contraindications, and patient selection for this specific technique.

8. CURRENT PHYSICAL THERAPY DRY NEEDLING LAWS

a. Overlap in scopes of practice

It is not uncommon for health care providers' scope of practice to overlap. In Washington, for example, physical therapists, chiropractors, osteopaths, medical doctors and naturopaths all have joint manipulation in their respective scopes of practice. Physical therapists and occupational therapists both have exercise and wound care management in their respective scopes of practice. Massage therapists, East Asian medicine practitioners, physical therapists and many other practitioners may all perform manual treatments or "massage" techniques to muscles. Overlap is to be expected between disciplines in order for access to high quality care.

In fact, the publication "Changes in Healthcare Professions Scope of Practice: Legislative Considerations" asserts that no one health care profession owns a skill or modality. They can be shared if the profession has the education and training and appropriate legal authority. Further, a profession is not defined by one modality. Physical therapy is defined as "the care and services provided by or under the direction and supervision of a physical therapist licensed by the state." The physical therapy practice act goes on to define the practice of physical therapy using terms such as "examining," "evaluating," "testing," "functional limitations in movement," not as a laundry list of treatment techniques. In fact, PTWA pursued an overhaul of the practice act in 1999 to modernize the statute to reflect the body of knowledge of a physical therapist, not a list of modalities.

Similarly, East Asian medicine in Washington is defined as "a health care service utilizing East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders..." The East Asian medicine statute does go on to list modalities (dry needling is not among them). However, it is clear that the philosophy of East Asian medicine is the overarching description.

Many professions' practice acts have language allowing the practice by another health care provider practicing under his or her authorized scope of practice. This is found in RCW 18.74.150 in the physical therapy statute and in RCW 18.06.045 in the East Asian medicine statute.

The recent Washington Attorney General's Opinion (AGO 2016 No. 3) also supports this idea of overlapping scopes of practice. It states that, "It is undisputed that dry needling uses the same type of needles used in acupuncture, which is separately regulated under RCW 18.06. However, nothing in the statutes governing East Asian medicine show legislative intent to make it the only health care practice that uses inserted solid needles."

b. The United States military

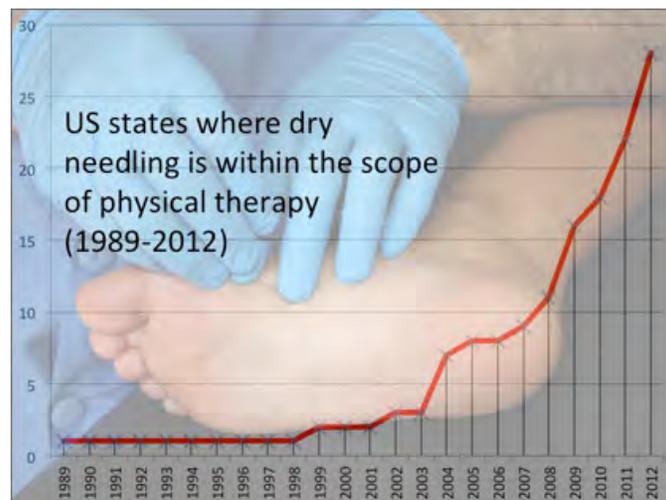
All branches of the United States military allow physical therapists to perform dry needling. The United States Army Medical Department allows physical therapists to

perform dry needling. United States Army Medical Command Regulation 40-60 *“allows the performance of dry needling by qualified health care providers, particularly physical therapists”* (emphasis added). Military-based physical therapists practicing on patients are allowed to use dry needling as a treatment technique if they show appropriate dry needling education in either entry-level or postgraduate education. They are required to have supervision for the first 25 cases and then may be deemed to practice independently.

The requirement is similar for the United States Air Force. The United States Navy allows non-physician privileged providers to perform dry needling by providing written documentation of successful completion of certification courses or training in residency programs. The Department of Veterans Affairs released a toolkit in 2013 that provides guidance for individual facilities in setting up an approach to enable physical therapists to perform dry needling upon completion of a publicly available continuing education course.

c. Comparative scope of practice within the states

Dry needling has been practiced by physicians and physical therapists nationally and internationally for over 40 years. As early as 1984, physical therapy state boards began petitioning for dry needling to fall under their respective state practice acts. More and more states are deeming dry needling to be within scope of practice in their states. In fact, many states have reversed their decision to ban dry needling and now recognize dry needling is within their physical therapy scopes of practice (Dommerholt 2014).



Dry needling is allowed via regulatory board opinion, Attorney General, AG, opinion, PT statute, or PT Board regulation in 19 states, with no additional education/training specific to dry needling required: Alaska, Georgia (in statute), Iowa, Kansas, Kentucky (AG opinion), Massachusetts, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Rhode Island, South Carolina, Texas (AG opinion), Vermont, West Virginia, and Wisconsin.

Dry needling is allowed via regulatory board opinion, AG opinion, PT statute, or PT Board regulation in 13 states, with additional education and training required: Arizona, Colorado, Delaware, District of Columbia, Illinois, Louisiana, Maryland (rules in process), Mississippi, Montana, Tennessee (rules in process), Utah, Virginia, and Wyoming.

There are nine states that are silent on the issue of physical therapists performing dry needling: Arkansas, Connecticut, Florida, Indiana, Maine, Missouri, Minnesota, Oklahoma, and Pennsylvania.

There are several states where dry needling by physical therapists is prohibited or likely prohibited. Idaho, New York and South Dakota prohibit the practice through state regulatory board opinion. Florida's and Michigan's respective Assistant Attorneys General have advised the regulatory boards that dry needling by physical therapists is prohibited in those states. There is no official opinion yet from California, but there is language in the California PT practice act that restricts tissue penetration for anything other than EMG testing. In Hawaii, the practice act prohibits physical therapists from puncturing the skin.

Dry needling is being challenged in several states through active litigation, Attorney General opinion, or challenges to regulatory board opinions. These states include Nebraska, North Carolina and Oregon.

In Washington, Attorney General Ferguson issued an opinion on April 15, 2016 (AGO 2016 No. 3) stating that dry needling is not within the current physical therapy scope of practice.

9. CONCLUSION

Through this report, we have shown that this proposal to allow physical therapists to perform dry needling benefits the patients in our state. We have outlined the history of dry needling in physical therapy, the patient health benefits of dry needling treatment by physical therapists, and how dry needling within physical therapy treatment lowers health care costs.

We have summarized the extensive education and training at the doctoral level that physical therapy students receive, including many of the competencies necessary for safe dry needling treatment. In addition, we have outlined the dry needling post-doctoral continuing education that is required in SB 6374 that will ensure that only physical therapists with adequate education, training, and practice experience will be performing dry needling.

We have demonstrated that physical therapists are safe practitioners of dry needling. In addition, we have shown the difference between dry needling by physical therapists and other types of therapies. Finally, we have shown that the majority of

states and the branches of the United States military allow physical therapists to perform dry needling.

We thank you for the opportunity to present this applicant report to the Department of Health. We look forward to answering any further questions you may have on the subject of physical therapists performing dry needling.

10. CITATIONS

American Academy of Orthopedic Manual Physical Therapists. Dry Needling Position Statement. 10/17/2009. <https://www.aaompt.org/about/statements.cfm> Accessed 5/18/2016.

American Physical Therapy Association. Code of Ethics for the Physical Therapist. Initial 1973, last updated 2009. Retrieved from http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/CodeofEthics.pdf

American Physical Therapy Association. Description of Dry Needling in Clinical Practice: An Educational Resource Paper. Produced by the APTA Public Policy, Practice, and Professional Affairs Unit. February 2013.

American Physical Therapy Association. *Guide to Physical Therapist Practice 3.0*; 2014. Available at: <http://guidetoptpractice.apta.org/> Accessed 4/1/2016.

American Physical Therapy Association. Guidelines: Physical Therapist Scope of Practice. Initial 1978, Last updated 2014. [http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/ScopePractice.pdf#search=%22guidelines scope of practice%22](http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/ScopePractice.pdf#search=%22guidelines%20scope%20of%20practice%22) . Accessed 5/27/2016.

Baldry P. Superficial versus deep dry needling. *Acupunct Med.* 2002;20(2-3):78-81.

Brady, S. Adverse events following trigger point dry needling: a prospective survey of chartered physiotherapists. *Journal of Manual and Manipulative Therapy.* 2013;00:1-7.

Bree Collaborative. Spine/Low Back Pain Topic: Report & Recommendations. Foundation for Health Care Quality, home of the Bree Collaborative, for the Washington State Health Care Authority. Published November 2013. http://www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf

Caranagno J, et al. Analysis of Competencies for Dry Needling by Physical Therapists. July 10, 2015. https://www.fsbpt.org/Portals/0/documents/free-resources/DryNeedlingFinalReport_20150812.pdf

Carr DJ. The safety of obstetric acupuncture: forbidden points revisited. *Acupunct Med.* 2015;33(5):413-9

Casanueva B; Rivas P; Rodero B; Quintial C; Llorca J; González-Gay MA . Short-term improvement following dry needle stimulation of tender points in fibromyalgia. *Rheumatol Int.* 2014;34(6):861-6.

Centers for Disease Control and Prevention. Guideline for Prescribing Opioids for Chronic Pain. *MMWR Recomm Rep* 2016;65.

Childs JD, Whitman JM, Sizer PS, Pugia ML, Flynn TW, Delitto A. A description of physical therapists' knowledge in managing musculoskeletal conditions. *BMC Musculoskeletal Disorders*. 2005;6:32.

Clewley D, Flynn TW, Koppenhaver S. Trigger point dry needling as an adjunct treatment for a patient with adhesive capsulitis of the shoulder. *J Orthop Sports Phys Ther*. 2014 Feb;44(2):92-101.
<http://www.ncbi.nlm.nih.gov/pubmed/?term=Clewley%2C+Flynn%2C+%26+Koppenhaver%2C+2014>

Dommerholt, J. Dry Needling in Orthopedic Physical Therapy Practice. *Orthopaedic Practice* 2014;16;3:04.

Dommerholt J. Dry needling - peripheral and central considerations. *J Man Manip Ther*. 2011;19(4):223-7. <http://www.ncbi.nlm.nih.gov/pubmed/23115475>

Dommerholt J, Fernández-de-las-Peñas C. Myofascial trigger points: peripheral or central phenomenon? *Curr Rheumatol Rep*. 2014;16(1):395.

Gerber et al. Dry Needling Alters Trigger Points in the Upper Trapezius Muscle and Reduces Pain in Subjects with Chronic Myofascial Pain. *PMR*. 2015;7:711-720.

Gerwin RD, Dommerholt J, Shah JP. An expansion of Simons' integrated hypothesis of trigger point formation. *Curr Pain Headache Rep*. 2004;8(6):468-75.

Gunn CC. *The Gunn approach to the treatment of chronic pain*. 2nd Ed. New York: Churchill Livingstone; 1997.

Gunn et al. Dry Needling of Muscle Motor Points. *Spine*.1980;5:279-291.

Han SC, Harrison P. Myofascial pain syndrome and trigger-point management. *Reg Anesth*. 1997;22(1):89-101. <http://www.ncbi.nlm.nih.gov/pubmed/9010953>

Kalichman L, Vulfsons S. Dry needling in the management of musculoskeletal pain. *J Am Board Fam Med*. 2010;23(5):640-6.
<http://www.ncbi.nlm.nih.gov/pubmed/?term=Kalichman%2C+%26+Vulfsons%2C+2010>

Lewit K. The needle effect in the relief of myofascial pain. *Pain*. 1979;6(1):83-90.
<http://www.ncbi.nlm.nih.gov/pubmed/424236>

Leigh McCutcheon , Michael Yelland. Iatrogenic pneumothorax: safety concerns when using acupuncture or dry needling in the thoracic region. *Physical Therapy Reviews*. 2016; 16:126-132.

Moore J, Goss DL, Baxter RE, DeBerardino TM. Clinical Diagnostic Accuracy and Magnetic Resonance Imaging of Patients Referred by Physical Therapists,

Orthopaedic Surgeons, and Nonorthopaedic Providers. *J Orthop Sports Phys Ther.* 2005; 35:67-71.

Nugent-Head, A. Ashi Points in Clinical Practice. *Journal of Chinese Medicine.* 2013; 101:5-12.

Salom-Moreno J, et al. Changes in spasticity, widespread pressure pain sensitivity, and baropodometry after the application of dry needling in patients who have had a stroke: a randomized controlled trial. *J Manipulative Physiol Ther.* 2014; 37:569-79.

Skootsky SA, Jaeger B, Oye RK, Prevalence of myofascial pain in general internal medicine practice. *West J. Med.* 1989; 151:157–160.

<http://www.ncbi.nlm.nih.gov/pubmed/?term=skootsky+1989>

Stagnitti MN. Trends in prescribed outpatient opioid use and expenses in the U.S. civilian noninstitutionalized population, 2002–2012. Statistical Brief No. 478. Rockville, MD: Agency for Healthcare Research and Quality; 2015.

Witt CM, Pach D, Brinkhaus B, Wruck K, Tag B, Mank S, et al. Safety of acupuncture: results of a prospective observational study with 229,230 patients and introduction of a medical information and consent form. *Forsch Komplementmed.* 2009; 16:91–7.



11. APPENDICES

A. Outline of Dry Needling Continuing Education Courses for Physical Therapists

Institution	Number of CEUs	Levels	Description of class
KineticCore	Level 1: 27 contact hrs; Level 2: 27 contact hrs Functional Therapeutics: 27 contact hours	Level 1: 3 day onsite training. All participants must have 1 year practicing as a physical therapist before registering for class. Level 2: 3 day course. Must have completed level 1 and logged 200 dry needling treatments or completed level 1 and functional Therapeutics and logged 100 dry needling treatments. Functional Therapeutics: Must have completed level 1 DN can be used to meet state requirements prior to doing level 2. Each level requires passing theoretical and practical exam to gain certificate and move onto next level.	<p>Level 1: Objectives:</p> <ul style="list-style-type: none"> - Define and understand what trigger points and motor banding are and how they relate to treatment with Dry Needling. - Present and review both the common and uncommon presentations of neuromuscular dysfunction as well as utilize other common evaluation procedures. - Review and become familiar with current literature regarding efficacy and treatment rationale for Dry Needling. - Review safe and efficient application of Dry Needling for orthopedic and neuromuscular conditions. - Review anatomy, function and safety concerns of regions which are covered in the Functional Dry Needling Level 1 course. - Instruct and apply Dry Needling technique which considers safety, indications and contraindications for treatment and proper integration into the clinical or sports setting. - Muscles that will be taught include: Hip, Lumbar Spine, Thigh, Cervical Spine, Shoulder, Upper and lower extremity. <p>Level 2: Objectives:</p> <ul style="list-style-type: none"> - Define trigger points, motor banding, and neurological presentations of neuromuscular dysfunction. - Review literature supporting efficacy and treatment rationale for FDN. - Instruct application of FDN for more advanced orthopedic and neuromuscular conditions. - Review anatomy of regions to be taught in Level 2 course. - Review and Discuss safety concerns. - Discuss indications and contraindications for treatment. - Discuss indications and contraindications for various diagnoses. - Muscles will be needling UJLE, advanced lumbar spine, TML/face, advanced cervical spine, thoracic spine, advanced UJLE, tendons/ligaments. <p>Functional Therapeutics: Objectives:</p> <ul style="list-style-type: none"> - Take material learned in Level 1 FDN and apply it clinically from start to finish (Evaluation => treatment approach => assessment => follow-up care => end of episode). - Further reasoning for evaluation, assessment and application for dry needling. - Improve understanding of how dysfunction and pain may affect movement patterns. - Provide a more systematic approach to dry needling treatment. - When to incorporate other manual techniques and modalities to dry needling. - Proper follow-up care to enhance and sustain results from dry needling. <p>DN-1: objectives include</p> <ul style="list-style-type: none"> - Understand the basic principles of applied pain sciences - Identify select muscles of the body by surface anatomy and by function - Identify the features of the trigger point by physical examination and apply this knowledge to individual muscles in different regions of the body - Understand common precipitating and perpetuating factors of trigger points. - Perform muscle and region-specific manual therapy treatments to deactivate myofascial trigger points and restore movement patterns and posture, integrating various treatment techniques including dry needling and manual trigger point therapy. - Understand basic principles of dry needling and trigger point injections. - Muscles include: pectoralis, deltoid, trapezius, deltoid, trapezius, deltoid, triceps, biceps, brachialis, levator scapulae (partially), the latissimus dorsi (partially), the subscapularis (partially), the latissimus dorsi (partially), the quadratus lumborum (partially), the iliocostalis, the gluteal muscles (minimus, medius, and maximus), the hip adductor muscles, the quadriceps and hamstrings, and gastrocnemius and soleus muscles. <p>DN-2:</p> <ul style="list-style-type: none"> - Identify select muscles of the body by surface anatomy and by function - Identify the features of the trigger point by physical examination and apply this knowledge to individual muscles in different regions of the body - Understand common precipitating and perpetuating factors of trigger points. - Perform muscle and region-specific manual therapy treatments to deactivate myofascial trigger points and restore movement patterns and posture, integrating various treatment techniques including dry needling and manual trigger point therapy. - Understand the basic principles of dry needling - Many muscles commonly addressed in clinical practice are included, such the posterior cervical muscles, the oblique capitis inferior, the cervical and thoracic and lumbar multifid, levator scapulae (partially), the latissimus dorsi (partially), supraspinatus, teres major and minor, pectoralis major (partially), pectoralis minor, the coracobrachialis, pronator teres, wrist flexors, oblique abdominal muscles and rectus abdominus, the lumbar paraspinals, the deep hip rotators, the lower trapezius, the serratus anterior, rhomboids, and the pelvic floor muscles. <p>DN-3:</p> <ul style="list-style-type: none"> - Identify select muscles of the body by surface anatomy and by function - Identify the features of the trigger point by physical examination and apply this knowledge to individual muscles in different regions of the body - Perform muscle and region-specific manual therapy treatments to deactivate myofascial trigger points and restore movement patterns and posture, integrating various treatment techniques including dry needling and manual trigger point therapy. - Perform dry needling for scar tissue, fascial adhesions, enthesopathies, and tendinopathies.
Myopain Seminars	DN-1: 27 contact hrs DN-2: 27 contact hrs DN-3: advanced course: 27 contact hrs	DN-1: 3 day face to face. DN-2: 3 day face to face. DN-3: unsure of hours. (each course requires passing practical and theoretical exam to gain certificate)	<p>DN-1: objectives include</p> <ul style="list-style-type: none"> - Understand the basic principles of applied pain sciences - Identify select muscles of the body by surface anatomy and by function - Identify the features of the trigger point by physical examination and apply this knowledge to individual muscles in different regions of the body - Understand common precipitating and perpetuating factors of trigger points. - Perform muscle and region-specific manual therapy treatments to deactivate myofascial trigger points and restore movement patterns and posture, integrating various treatment techniques including dry needling and manual trigger point therapy. - Understand basic principles of dry needling and trigger point injections. - Muscles include: pectoralis, deltoid, trapezius, deltoid, triceps, biceps, brachialis, levator scapulae (partially), the latissimus dorsi (partially), the subscapularis (partially), the latissimus dorsi (partially), the quadratus lumborum (partially), the iliocostalis, the gluteal muscles (minimus, medius, and maximus), the hip adductor muscles, the quadriceps and hamstrings, and gastrocnemius and soleus muscles. <p>DN-2:</p> <ul style="list-style-type: none"> - Identify select muscles of the body by surface anatomy and by function - Identify the features of the trigger point by physical examination and apply this knowledge to individual muscles in different regions of the body - Understand common precipitating and perpetuating factors of trigger points. - Perform muscle and region-specific manual therapy treatments to deactivate myofascial trigger points and restore movement patterns and posture, integrating various treatment techniques including dry needling and manual trigger point therapy. - Understand the basic principles of dry needling - Many muscles commonly addressed in clinical practice are included, such the posterior cervical muscles, the oblique capitis inferior, the cervical and thoracic and lumbar multifid, levator scapulae (partially), the latissimus dorsi (partially), supraspinatus, teres major and minor, pectoralis major (partially), pectoralis minor, the coracobrachialis, pronator teres, wrist flexors, oblique abdominal muscles and rectus abdominus, the lumbar paraspinals, the deep hip rotators, the lower trapezius, the serratus anterior, rhomboids, and the pelvic floor muscles. <p>DN-3:</p> <ul style="list-style-type: none"> - Identify select muscles of the body by surface anatomy and by function - Identify the features of the trigger point by physical examination and apply this knowledge to individual muscles in different regions of the body - Perform muscle and region-specific manual therapy treatments to deactivate myofascial trigger points and restore movement patterns and posture, integrating various treatment techniques including dry needling and manual trigger point therapy. - Perform dry needling for scar tissue, fascial adhesions, enthesopathies, and tendinopathies.

<p>Integrative Dry Needling (IDN)</p>	<p>Foundation course: 27 contact hrs Advanced Course: 27 contact hrs</p>	<p>Foundation course: 3 day face to face (no pre req) Advanced course: 3 days face to face (need to have taken foundation course)</p> <p>Foundation course: Based on Dr. Yun-Tao Ma's The systemic concept of IDN allows the practitioner to view and treat the human body as an inter-related organism, essentially the gestalt theory, yet allowing the clinical freedom to adapt the treatment for each patient. As a result, IDN provides the framework upon which to address all types of physical dysfunction. The IDN system is designed to be a comprehensive approach to create an effective treatment system and address the underlying functional dysfunction while providing clinical efficacy. As a result, the IDN system and dry needling will develop a clinical protocol to allow immediate integration of dry needling into their clinical practice.</p> <p>Advanced course: The examination and management of peripheral nerve inflammation/sensitization, neuromuscular dysfunction and biomechanical imbalance of the musculoskeletal system will be presented. We will discuss the negative effects that peripheral nerve inflammation has on muscle function and how integrative dry needling can assist in maximizing human (athlete) performance. Integration of Manual Therapy and other treatment options will be included that will complement the efficacy of dry needling treatment. A considerable amount of lab time is focused on assuring safe and effective advanced dry needling skills with an emphasis on clinical decision-making.</p> <p>Objectives:</p> <ul style="list-style-type: none"> - Discuss the ability and appropriateness of physical therapists in providing trigger point dry needling to patients with musculoskeletal disorders. - Review and define the concept of trigger points and their contribution to musculoskeletal syndromes. - Compare and contrast the differences in acupuncture and dry needling in terms of eastern vs. western treatment philosophies, needling technique, and goals of intervention. - Discuss the evidence surrounding the proposed mechanisms of action, treatment effectiveness, and relative safety for TDN. - Perform and develop proficiency/competency in using safe and appropriate application of TDN on muscles of the lower quarter. - Demonstrate the appropriate integration of TDN into a comprehensive treatment plan for patients with lower extremity dysfunction that may include joint mobilization/manipulation, manual and foot assisted soft tissue mobilization, manual stretching, and therapeutic exercise. - Demonstrate appropriate safety precautions and articulate legal issues regarding TDN. - Level 1 lower quarter muscles and level 2 upper quarter muscles.
<p>Evidence in Motion (EIM)</p>	<p>Level 1: two different options depending on what state practicing in and requirements of that state: 26 contact hrs or 35 CEU. Level 2: same</p>	<p>Level 1: lower quarter anatomy, 2 day intensive or 3 day intensive depending on state requirements for CEUs Level 2: upper quarter anatomy, 2 day intensive or 3 day intensive not clear these can be taken out of order or if there are requirements to take the courses.</p> <p>Level 1: Dry Needling for Cervicofacial, Cervicohoracic & Upper Extremity Conditions (Part 1 of Certification in Dry Needling) - Participants will learn superficial and deep dry needling techniques for the treatment of chronic pain syndromes (e.g., tension headaches, cervicogenic headaches, and trigger points) as originally introduced by Travell & Simons. That is, peri-neural needling and needle puncture of tendons, ligaments, musculoskeletal junctions, teno-osseous junctions, and bone (i.e., periosteal plexiform) will also be taught as essential components of musculoskeletal needling practice. More specifically, peri-neural and peri-vascular needling will be instructed for the purpose of improving microcirculation and disrupting fibrosis in chronic neurogenic pain conditions (e.g., an impacted median nerve in carpal tunnel syndrome). Level 2: Dry Needling for Lumbopelvic & Lower Extremity Conditions: an Evidence-Based Approach (Part 2 of the Certification in Dry Needling) - Participants will learn superficial and deep dry needling techniques for the treatment of lumbopelvic and lower extremity musculoskeletal conditions. This course does include, but is not limited to, needling of lat bands of muscle (i.e., trigger points) as originally introduced by Travell & Simons. That is, peri-neural needling and needle puncture of tendons, ligaments, musculoskeletal junctions, teno-osseous junctions, and bone (i.e., periosteal plexiform) will also be taught as essential components of musculoskeletal needling practice. More specifically, peri-neural and peri-vascular needling will be instructed for the purpose of improving microcirculation and disrupting fibrosis in chronic neurogenic pain syndromes.</p>
<p>Spinal Manipulative Institute</p>	<p>Total 54 hours of hands-on dry needling education</p>	<p>DN-1: 3 days 24 hours (no pre req) DN-2: 3 days 24 hrs (no pre req)</p>
<p>International Academy of Orthopedic Medicine (IACM)</p>	<p>Level 1 - Pending 35.5 CEU Level 2 - Pending 35.5 CEU Anatomy - pending 8 CEU</p>	<p>Dry Needling Level 1, 3 days Dry Needling Level II Dry Needling Anatomy</p>
<p>Dry Needling Institute</p>	<p>12 hour (2 day) course or 54 hour (two 3-day non-consecutive weekends) course</p>	<p>No levels, just two different course options, abbreviated or full</p> <p>DN-1/Needling Level 1 is a basic level course which teaches the theory and practice of dry needling of trigger points in the neck, head and neck, superficial and deep dry needling techniques of the lumbar, cervical, abdominal wall. It is a competency-based course, which will introduce more of the recent research, teach the use of eslim with needles, and ends with a competency exam. Dry Needling Anatomy: Objectives: Using prosected cadavers, to review the relationship of deep and superficial musculature and relevant nerve and blood vessel and organs. To highlight areas where safety is concerned when dry needling. To consider myofascial patterns and common muscle involvement in common conditions. To discuss needling approaches in the different body regions to enable the therapists using Dry Needling techniques to be safe and effective with their techniques. By the end of this one day course participants will have an appreciation of the deeper anatomical structures in the areas they will need to practice. Objectives for foot courses are the same. Understand the various theories and models that underlie dry needling technique Learn and apply dry needling techniques to various case scenarios presented by the instructor to demonstrate integration of the three previous elements. Course descriptions don't really differentiate between the two courses.</p>

Institution	Number of CEUs	Levels	Description of class
Institute of Advanced Musculoskeletal Treatments (IAMT)	20 contact hrs per course	<ul style="list-style-type: none"> - Level I: 20 contact hrs: 2, 8hr days - Level II: 20 contact hrs: 2, 8hr days - Level III: no information currently available - Understanding is PT must understand own state's laws before practicing*** 	<ul style="list-style-type: none"> - Level I: Website description: "...designed to teach introductory level techniques for trigger point dry needling throughout the entire body. The course also presents the clinical reasoning and scientific rationale behind the application of dry needling and teaches the local and global proposed mechanisms that occur with its application. This lab intensive course consists of a vast number of needling techniques in conjunction with soft tissue mobilization, tapping and functional case based treatments." - Level II: Website description: "...addition of more challenging techniques. The course covers techniques surrounding the thoracic region, face, head and neck as well as the deep muscles in the lower extremities. The lab intensive course consists of a vast number of needling techniques in conjunction with soft tissue mobilization and functional case based treatments." - Level III: Website description: "...utilizes a case study approach to enhance clinical reasoning skills for the physical therapist and to formulate an integrative plan of care utilizing dry needling, manual therapy techniques and exercise to treat common conditions. This course combines manual therapy interventions with dry needling techniques and functional retraining to restore biomechanics and normalize function in their patients."
Therapy Concepts Inc	Level I: 23777 (not stated) Level II: 23 contact hrs	<ul style="list-style-type: none"> - Level I: 3 day course. Introduces Trigger Point Dry Needling as an intervention for treating a variety of diagnoses. Participants are introduced to the theory and physiology of myofascial trigger points, and the history of dry needling. Anatomy of each muscle will be reviewed, including the trigger points and their corresponding referral patterns. - Muscle groups included: cervical and lumbar spine, hip, lower extremity, shoulder and forearm. - This course will be limited to 20 participants and attendees will need to provide a copy of their licenses in order to be considered for professional status course. All participants must have a minimum of 2 years of experience. - Level II: 3 day course, consists of a combination of lecture, testing, demonstration and a large amount of hands-on laboratory sessions. In the advanced Trigger Point Dry Needling Training course, participants will use the skills they have learned and practiced in the first course to treat musculature that was deemed more difficult due to various safety concerns. Additionally participants will be given an assessment tool to enhance evaluation of chronic myofascial pain patients and help with the clinical decision making process for the use of dry needling. - Will benefit physical therapists, medical doctors, and doctors of osteopathy who work with patients suffering from chronic myofascial pain. - Limited to people who have taken the Level I Trigger Point Dry Needling Training course and have completed their treatment logs consisting of 250 or more treatment sessions over a 5 – 6 month period. - Prior to the course participants should review C. Chan Gunn's book Treatment of Chronic Pain and Travel and Simons two volumes of Myofascial Pain and Dysfunction: The Trigger Point Manual. - Participants should also be prepared to share their experiences since integrating Trigger Point Dry Needling into their practice. 	<ul style="list-style-type: none"> - Level I: Objectives: <ul style="list-style-type: none"> - Define trigger points, motor haphing, and neurological presentations of neuromuscular dysfunction. - Review the clinical application of Trigger Point Dry Needling for more advanced orthopedic and neuromuscular conditions. – Review anatomy of regions to be taught in Level II course. - Discuss with participants their own experiences regarding legal and billing issues integrating Trigger Point Dry Needling into their practice setting. - Discuss safety. - Discuss indications and contraindications for treatment. - Discuss specific treatment rationale for various diagnoses. - Level II: Objectives: <ul style="list-style-type: none"> - Define trigger points, motor haphing, and neurological presentations of neuromuscular dysfunction. - Review the clinical application of Trigger Point Dry Needling for more advanced orthopedic and neuromuscular conditions. – Review anatomy of regions to be taught in Level II course. - Discuss with participants their own experiences regarding legal and billing issues integrating Trigger Point Dry Needling into their practice setting. - Discuss safety. - Discuss indications and contraindications for treatment. - Discuss specific treatment rationale for various diagnoses.
Double E PT Education	Level I and II: 28 in NC only - Designed for licensed physical therapists who are allowed to use dry needling in their practice and jurisdiction.	<ul style="list-style-type: none"> - Level I: 3 day, 28-hour course delivered via on-site lectures and extensive hands-on/lab/practical instruction using a regional approach in order to facilitate participant learning. - Purpose: <ul style="list-style-type: none"> - Learn about trigger points and the different interventions used to treat them, focusing heavily on the intervention of dry needling. While dry needling is emphasized in this course, it is presented as one intervention or tool that the clinician can integrate into his or her treatment program. Participants will learn palpation skills to identify trigger points, then learn palpation skills to effectively locate trigger points to include evidence for soft tissue manual therapy—to resolve trigger points and restore function in the spine, lower, and upper quarter musculoskeletal disorders. This course will also investigate the emerging evidence/research regarding the treatment effectiveness, proposed mechanisms of action, and safety considerations for trigger point dry needling. Participants take a didactic test and a hands-on practical test that investigate the participant's palpation skills to accurately identify trigger points, correct hand placement for dry needling, knowledge of landmarks, safety considerations for various muscles, and correct and safe handling/disposal of needles. A heavy focus is placed on the integration of these techniques in clinical practice using clinical reasoning. 	<ul style="list-style-type: none"> - Level I: Objectives: <ul style="list-style-type: none"> - Discuss the history of myofascial pain. - Review and define the concept of trigger points and supporting literature around this concept. - Define trigger point, taut band, and neurological presentations of neuromuscular dysfunction. - Define and understand the concept of trigger points, their pathogenesis, and hypothetical constructs of Chad Gunn and Janet Travell. - Discuss and define attributes/features of trigger points and discuss the various interventions used in the treatment of trigger points. - Explain understanding of appropriate use of trigger point dry needling within a clinical reasoning framework. - Describe the identification of needling and develop moderate proficiency using trigger point needling on separate muscles of the spine, lower, and upper quadrant. - Level II: Objectives: <ul style="list-style-type: none"> - Discuss the effect of dry needling in treatment of costochondritis, plantar fasciitis, Achilles tendinitis, neck pain, headaches, TMJ, upper back pain and a variety of regional myofascial pain complaints. - Employ trigger point dry needling in muscles over the lung fields with full safety and confidence. - Understand the mechanisms, attributes, and hypothetical constructs of myofascial trigger points and dry needling and become familiar with the most recent publications of research in this field. - Utilize as five different varieties of style safety to tailor dry needling to the individual case and patient. - Discuss appropriate use of trigger point dry needling and integration into a treatment program, and perform and develop proficiency using trigger point needling on select muscles of the thoracic spine, hand, foot, and face.

B. Summary of Educational Differences between Traditional Chinese Medicine (TCM) Acupuncture Training and Physical Therapist Dry Needling Training (State of Arizona)

Summary of Educational Differences

	TCM ACUPUNCTURE	DRY NEEDLING
Minimum requirements by law A.R.S. § 32	<p>Certified or licensed with at least 1850 hours of training (of that, 800 hours of clinical training)A.R.S. § 32-3924</p> <p>***Only 1050 hours of in class hours needed to practice</p>	<p>Graduate of an accredited Physical Therapy Program*</p> <p>Successfully passed national board exam</p> <p>Successfully passed Arizona State Jurisprudence Exam</p> <p>(*All current entry level physical therapy programs are at the professional doctorate level)A.R.S. § 32-2022)</p>
Bachelors Degree Requires	NO, ***NO GED REQUIRED	YES
Average National Training	1950 hours of Traditional Chinese Medicine/ Acupuncture Training (Average according to Council of Colleges of Acupuncture and Oriental Medicine)	Current entry level degree: Doctor of Physical Therapy 2676 hours (Avg. in 2004)

C. Comparison of training needed for dry needling based on medical acupuncture training from two specific model courses.

Highlighted in Yellow	These sections that do not relate the acupuncture or eastern medicine specifically, and are part of regular PT school curriculum
Highlighted in Green	These sections that do not relate to acupuncture or eastern medicine specifically, but would need to be a part of training for dry needling
Combination Yellow/Green	Sections that are covered in PT school curriculum and parts that need to be further addressed in DN training
Not highlighted	Relates only to acupuncture or eastern medicine/ not at all related to dry needling.

Five Element <http://www.5elements.com/training/program/>
210 hours; one weekend a month for 9 months

As the only program of its kind offered in Southern California, the Classical Five-Element Acupuncture Program offers Acupuncturists and other licensed medical professionals the opportunity to become certified as Classical Five-Element practitioners. The program is taught by Neil R. Gumenick, M.Ac. (UK), C.T. (Adv.), L.Ac., Dipl.Ac. (NCCAOM), and a team of [faculty and guest faculty](#) approved by the Director.

The program includes extensive training in:

- **Five-Element Theory:**
The Five Elements; Organ/Meridian Theory; Levels of Energy: Body, Mind, and Spirit; Laws and Cycles of the Five Elements; **Significance of Symptoms**; Balancing of Energy; Specialized Treatment Patterns and Groupings of Points, including Windows of the Sky, Possession and Use of Internal and External Dragons, Aggressive Energy, Husband/Wife Imbalances, Seas and Oceans, Akabani, Entry-Exit Blocks; Energy Transfers; **Causes of Disease**; Pulse Reading and Diagnosis within the Five-Element System
- **Point Location and Uses:**
Twelve Meridians, Conception and Governor Vessels; Source, Junction, Horary, Tonification and Sedation Points, Element Points, Entry and Exit Points, Associated Effect Points, Alarm Points, First Aid Points; Unique Physical, Emotional, and Spiritual Actions of Points and Combination.
- **Traditional Diagnosis:**
Awakening the Natural Ability to See, to Hear, to Ask, and to Feel, Using the Diagnostic Indicators of Color, Sound, Emotion, and Odor; **Taking Case Histories**; Assessing the Causative Factor and Level of Disease; **Physical Examination**; Practitioner/Patient Rapport Skills
- **Clinical Work Discussion:**
Presentation and Analysis of **Class Patients, Diagnosis, and Treatment**
- **Treatment Planning:**
Principles and Priorities; Translation of Traditional Diagnosis into Treatment Plan; Addressing the Needs of the Mind and Spirit; **Methods of Treatment**; **Evaluation of Treatment**; **Determining Future Treatments**
- **Public Speaking:**
How to Give Effective and Informative Practice Building Presentations
- **Treatment Techniques:**
Needling; Tonification and Sedation, Uses of Moxabustion
- **Practice/Patient Management and Ethics:**
Communication Skills; Trust; Confidentiality; Listening and Counseling, Patient Homework, Appropriate Referrals, Finances, Advertising; **Public Service.**
- **Clinical Observation:**
100 hours outside of Class (may be arranged with approved practitioners in students' local areas)

Acupuncture Course: http://www.acupuncturecourse.org/a_outline.php
330 hours in 3 phases:

PHASE 1: Essentials of Acupuncture

- **Basics of Acupuncture:** Anatomy and physiology of acupuncture points, the basics of running an acupuncture practice, and useful information for patients.
- **Acupuncture Theories:** Knowledge of Traditional Chinese Medicine (TCM), the very foundation of successful practice of acupuncture, encompasses many seemingly abstruse concepts such as Yin and Yang, Qi, Five Elements, Meridians, Convergence Points, Remote Actions of Acupuncture Points, Tonification vs. Sedation, Eight Categories, Six Excesses, Organ Phenomena, etc. These concepts will be presented in easy- to-understand modern scientific terms.
- **Acupuncture Diagnostics:** Instruction on diagnostic methodology in accordance with TCM principles to enhance successful therapeutic outcomes, such as pulse diagnosis, tongue diagnosis, diagnosis by palpation, diagnosis by patient history and observation, and meridian diagnosis.
- **Demonstration of Acupuncture Techniques on Actual Patients.**

PHASE 2: Practical Clinical and Hands-On Training

- **Acupuncture Techniques:** Painful and non-painful medical conditions may vary in their responses to different acupuncture modalities, hence a range of important techniques: traditional body acupuncture, ear acupuncture, scalp acupuncture, needleless techniques such as moxibustion, cupping and electrical stimulation will be taught and demonstrated in this face-to- face training session. Participants will also have the opportunity to practice various modalities under the supervision of a faculty of experts.
- **Therapeutic approach:** Instruction in both the formula approach, based on empirical efficacy, and the analytical approach, based on theoretical reasoning, and their application to a spectrum of common medical conditions will enable participants to more effectively apply their knowledge to improve patient care.
- **Practical experience:** Face-to-face clinical instruction sessions, with ample opportunities for hands-on training in acupuncture point locating, needling techniques for body and ear acupuncture and pulse and tongue diagnoses, among other training exercises.

PHASE 3: Enhancement of Clinical Experience

- **Research:** Presentation on historically important clinical and basic scientific research on acupuncture in various medical fields.
- **Additional Acupuncture Modalities:** Instruction in trigger point injection and acupuncture point injection techniques, which use local anesthetic, normal saline, and ultra-low-dose steroids.
- **Clinical Cases Presentation:** In-depth discussion on actual clinical cases to illustrate the principles of diagnosis and formulation of treatment protocols.

- **Clinical runs consisting of detailed analysis of diagnostic findings and therapeutic interventions relating to actual patients.**
- **Contemporary Explanation of TCM Syndromes:** Lectures on the common pathways of the symptom complexes of diverse medical conditions and how such concepts can be used to simplify and facilitate therapeutic approaches.



Analysis of Competencies for Dry Needling by Physical Therapists

Final Report

Prepared for: Federation of State Boards of Physical Therapy
124 West Street South, Third Floor
Alexandria, VA 22314

Date: July 10, 2015

Authors: Joseph Caramagno
Leslie Adrian
Lorin Mueller
Justin Purl

Acknowledgements

Many people, in addition to the authors, helped conceptualize and complete the work described in this report. The Task Force organized by the Federation of State Boards of Physical Therapy (FSBPT) was instrumental in completing this work, and we would like to recognize their commitment to the profession and their expertise in the practice of dry needling. Without their participation, this work would not have been possible. Members of the Task Force are listed individually in the appendix. We would also like to thank all the physical therapists who completed the Dry Needling Competency Survey in support of this important effort.

Dr. Lorin Mueller, FSBPT's Managing Director of Assessment, oversaw the work and provided invaluable guidance and assistance throughout the process. His responsiveness to HumRRO's various requests for information ensured this project progressed smoothly and efficiently. We would also like to acknowledge the support and insights of Leslie Adrian, DPT (FSBPT's Director of Professional Standards) throughout the course of this project. Her knowledge of the physical therapy profession, the issues surrounding dry needling in the U.S., and the diverse perspectives and philosophies on dry needling were tremendous contributions in ensuring discussions with the Task Force were productive and thoughtful. Finally, we would like to express gratitude for the assistance provided by Ashley Ray (Assessment Research Associate).

From HumRRO, we wish to thank Drs. Deirdre Knapp and Teresa Russell for their recommendations and guidance on numerous aspects of the planning and conduct of the competency development and in the preparation of this report.

Executive Summary

Dry needling is a skilled technique performed by a physical therapist using filiform needles to penetrate the skin and/or underlying tissues to affect change in body structures and functions for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disability.

Since 2010, jurisdictions have sought information from the Federation of State Boards of Physical Therapy (FSBPT) regarding the ability of physical therapists (PTs) to perform dry needling; however, no publically available studies have explicitly examined what PTs must know and be able to do to perform dry needling safely and effectively. To provide its members with objective, professionally-developed guidance, FSBPT sponsored a practice analysis of the competencies required of physical therapists to perform dry needling. Competencies are measurable or observable knowledge, skills, and/or abilities an individual must possess to perform a job competently.

The practice analysis drew from multiple sources of information (i.e., extant literature on dry needling; licensed physical therapists; dry needling experts) to provide an authentic and accurate assessment of the knowledge, skills, and abilities needed to perform dry needling safely and effectively. The process for developing the dry needling competencies included three main steps.

1. **Background Review** –Information gleaned from a review of the literature on dry needling was used to develop a preliminary set of dry needling “tasks” that describe job-related actions and a separate set of dry needling knowledge requirements that describe factual or procedural information directly involved in the performance the intervention.
2. **Practitioner Survey** – A survey of more than 350 licensed PTs, including individuals working in hospitals, private practice, clinics, academia, and the military, was administered to identify entry-level knowledge, skills, and abilities that are important for competency in dry needling.
3. **Task Force Meeting** – Seven dry needling experts, supported by observers from the American Physical Therapy Association (APTA) and FSBPT’s Board of Directors, met to consolidate the information collected in the previous two steps and construct a final set of competencies.

Steps 1 and 2 were conducted concurrently between February and May, 2015. The Task Force meeting was held at FSBPT’s headquarters on May 29-31, 2015.

The Task Force’s primary objective was to identify knowledge, skills, and abilities that are specifically needed for competency dry needling. To accomplish this objective, they performed five activities.

1. **Define Dry Needling** – constructed a definition of dry needling that clearly communicates the purpose and defining features of the intervention
2. **Define the Standard for Competence (Safe and Effective Practice)** – clarified the standard of competence for dry needling representing the minimum level of proficiency needed to perform the technique competently
3. **Review and Refine Dry Needling Tasks** – identified job tasks that PTs perform when applying dry needling as part of a physical therapy treatment plan

4. **Review and Refine Dry Needling Knowledge Requirements** – identified the knowledge required to carry out the tasks identified in the previous activity
5. **Identify Dry Needling Skills and Abilities** – determined which skills and abilities are needed for safe and effective dry needling

The task force members were also charged with evaluating to what extent entry-level knowledge (i.e., knowledge required for licensure in physical therapy) is needed for safely and effectively using dry needling. To that end, the results of the 2011 Analysis of Practice for the Physical Therapy Profession (Bradley, Waters, Caramagno, & Koch, 2011) were incorporated into the analysis as a starting point. First, the Task Force identified which entry-level physical therapy job tasks and knowledge are relevant to competency in dry needling. Then, they identified additional tasks and knowledge that are needed specifically for performing the dry needling technique.

Major results from the dry needling practice analysis are presented below.

- Of the 214 entry-level and 27 dry needling-specific job tasks analyzed, 123 were identified as directly relevant to the competent performance of dry needling.
- Of the 116 entry-level and 22 dry needling-specific knowledge requirements, 117 were identified as important for competency in dry needling.
- 86% of the knowledge requirements needed to be competent in dry needling is acquired during the course of PT entry-level education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety, and professional responsibilities.
- 16 (14%) of the knowledge requirements related to competency in dry needling must be acquired through post-graduate education or specialized training in dry needling.
- In terms of skill and ability requirements, psychomotor skills needed to handle needles and palpate tissues require specialized training. This skill was the only skill or ability noted as not being required to be an entry-level physical therapist.

The job tasks specifically involved in the use of dry needling are presented on the following pages along with the 16 knowledge requirements that are acquired through advanced or specialized training are displayed.

Table i. Dry Needling-specific Tasks

ID#	Tasks
PATIENT/CLIENT ASSESSMENT	
Information Gathering & Synthesis	
	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to...
1.	...identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements)
2.	...identify contraindications and precautions related to dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
3.	Sequence dry needling with other procedural interventions and techniques (e.g., therapeutic exercises, neuromuscular reeducation, manual therapy, physical modalities) to augment therapeutic effects and minimize risk due to adverse outcomes and/or contraindications.
INTERVENTIONS	
Manual Therapy Techniques	
	Position the patient/client to...
4.	...expose the area(s) to be needled
5.	...reduce the risk of harm to the patient/client and/or therapist
6.	Educate the patient/client on the impact of movement during treatment
7.	Perform palpation techniques to identify the area(s) to be needled
8.	Apply needle handling techniques that ensure compliance with relevant and current professional standards (e.g., wash hands, wear gloves, minimize needle contamination)
9.	Apply draping materials (e.g., linens, towels) to minimize unnecessary exposure and respect patient privacy
10.	Perform dry needling techniques consistent with treatment plan (e.g., place, manipulate, and remove needles)
11.	Manage needle removal complications (e.g., stuck needle, bent needle)
12.	Monitor patient/client's emotional and physiological response to dry needling
13.	Facilitate hemostasis as necessary
14.	Dispose of medical waste (e.g., needles, gloves, swabs) in accordance with regulatory standards and local jurisdictional policies and procedures (e.g., sharps container)
15.	Discuss post-treatment expectations with the patient/client or family/caregiver
ID#	Tasks
Education	
16.	Educate patient/client or family/caregiver about dry needling (e.g., purpose, technique, methods of action, benefits, tools and equipment)
17.	Educate patient/client or family/caregiver about potential adverse effects associated with dry needling (e.g., fainting, bruising, soreness, fatigue)
18.	Educate patient/client or family/caregiver about precautions and contraindications for dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
Patient/client & Staff Safety	
Emergency Procedures	
19.	Implement emergency response procedures to treat patient/client injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding, broken needles)
20.	Implement emergency response procedures to treat practitioner injuries sustained during dry needling (e.g., needle stick)

Table i. (Continued)

ID#	Tasks
Environmental Safety	
21.	Prepare and maintain a safe and comfortable environment for performing dry needling (e.g., unobstructed walkways, areas for patient/client privacy)
22.	Stock dry needling supplies and equipment in safe proximity during treatment
Infection Control	
23.	Implement infection control procedures to mitigate the effects of needle stick injuries
24.	Clean and disinfect blood and bodily fluids spills in accordance with regulatory standards and local jurisdictional policies and procedures
25.	Replace surfaces that cannot be cleaned
Professional Responsibilities	
26.	Determine own ability to perform dry needling safely and effectively

Table ii. Specialized Knowledge Required for Competency in Dry Needling

Anatomy and Physiology	
1.	Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks
Emergency Preparedness and Response	
2.	Emergency preparedness and/or response procedures related to secondary physiological effects or complications associated with dry needling (e.g., shock, vasovagal)
3.	Emergency preparedness and/or response procedures related to secondary emotional effects or complications associated with dry needling (e.g., claustrophobia, anxiety, agitation)
4.	Standards for needle handling (e.g., hand hygiene, application of single-use needles)
Safety and Protection	
5.	Factors influencing safety and injury prevention
6.	Personal protection procedures and techniques as related to dry needling (e.g., positioning self to access treatment area, use of personal protective equipment)
7.	Theoretical basis for dry needling (e.g., applications for rehabilitation, health promotion, fitness and wellness, performance)
8.	Theoretical basis for combining dry needling with other interventions
9.	Secondary effects or complications associated with dry needling on other systems (e.g., gastrointestinal, cardiovascular/pulmonary, musculoskeletal)
10.	Theoretical basis of pain sciences, including anatomy, physiology, pathophysiology, and relation to body structures and function
11.	Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions)
12.	Palpation techniques as related to dry needling
13.	Needle insertion techniques
14.	Needle manipulation techniques
15.	Physiological responses to dry needling
16.	Solid filament needles (e.g., physical characteristics)

Analysis of Competencies for Dry Needling by Physical Therapists

Table of Contents

Acknowledgements.....	i
Executive Summary	ii
Introduction and Overview.....	1
Dry Needling in the Physical Therapy Scope of Practice	1
Scope and Purpose of the Project.....	2
Research Design.....	2
Competency Development Process	3
Background Information Review.....	3
Practitioner Survey	4
Task Force Meeting.....	5
Outcomes	10
Dry Needling Job Tasks	10
Dry Needling Competencies.....	11
Role of the Physical Therapist Assistant in Dry Needling.....	13
Conclusions	13
References	15
Appendix A Background Review Source Materials.....	1
Appendix B Draft Dry Needling-Specific Tasks and Knowledge Requirements	1
Appendix C Task Force Members	1
Appendix D Physical Therapy Tasks Required for the Competent Performance of Dry Needling	1
Appendix E Tasks NOT Related to Competency in Dry Needling.....	1
Appendix F Knowledge Requirements Related to Competency in Dry Needling	1
Appendix G Knowledge Requirements NOT Related to Competency in Dry Needling	1
Appendix H Skills and Abilities Needed for the Competent Performance of Dry Needling	1
FSBPT Addendum to Report.....	1
Selection of HumRRO	1

List of Tables

Table 1. Dry Needling-Specific Tasks	10
Table 2. Specialized Knowledge Required for Competency in Dry Needling	12
Table B1. Draft List of Dry Needling Tasks.....	B-1
Table B2. Draft List of Dry Needling Knowledge Requirements.....	B-2

Analysis of Competencies for Dry Needling by Physical Therapists

Introduction and Overview

Dry Needling in the Physical Therapy Scope of Practice

Dry needling is a procedural intervention used by physical therapists (PT) to treat pain, functional impairments, and disabilities. The technique involves the insertion of solid filament needles into the skin and underlying tissue to disrupt pain sensory pathways and relax contracted fibers (Dommerholt, & Fernández-de-las-Peñas, 2013). Clinical research suggests that dry needling helps reduce local and peripheral pain and sensitization, thereby hastening the restoration of muscle function and range of motion (Lewit, 1979; Dommerholt, 2011; Clewley, Flynn, & Koppenhaver, 2014). Dry needling (alone or with other physical therapy interventions) has been shown to be an effective treatment for neuromusculoskeletal diseases or conditions, including arthritis, tendonitis, carpal tunnel, and chronic pain (Dommerholt, 2004; Kalichman, & Vulfsons, 2010).

The theoretical genesis of dry needling is attributed to the pioneering work of Janet Travell, M.D. and David Simons, M.D. (Simons, Travell, & Simons, 1999) who used .22-gauge hypodermic needles to treat myofascial pain with trigger point therapy (i.e., needling of taut bands of muscle fibers). Over the past several decades, practitioners have adopted variations on the original approach including superficial and deep needling techniques (Gunn, 1997; Baldry, 2002; Ma, 2011). Modern dry needling has largely abandoned hypodermic needles in favor of round tip, solid filament needles ranging from .22 to .30 millimeters in diameter as the beveled tip of hypodermic needles causes greater tissue damage. In addition, modern dry needling is used to treat a variety of conditions and dysfunction of neuromusculoskeletal structures (Ma, 2011; Dommerholt & Fernández-de-las-Peñas, 2013; Dunning, et al, 2014).

The use of needles to treat health conditions is not unique to physical therapy. Needles of similar design are used by practitioners of Acupuncture and Oriental Medicine. However, the use of needles, per se, does not imply that one needling approach is equivalent to another or that one medical profession is infringing on the scope of practice of another. It is not the specific individual procedures or tools that define a profession, but the totality of the scope of practice (National Council of State Boards of Nursing, 2012).

Dry needling in the context of physical therapy is based on a distinct philosophical and theoretical framework supported by modern scientific study of the musculoskeletal and nervous systems (American Physical Therapy Association, 2012; Cummings, 2013; Dunning, et al, 2014). At every stage of the physical therapy visit, from patient selection to the actual needling of the affected areas, the PT is guided by his/her education, clinical training and experience, professional responsibilities and competence, and legally defined scope of practice, as well as the patient's reaction to needling. For example, the type and number of needles used, as well as their location, depth, and manipulation, are heavily influenced by the PT's knowledge of anatomy, histology, physiology, biomechanics, kinesiology, neuroscience, pharmacology, and pathology, as well as the overall plan of care.

In the United States, physical therapy practice is governed by occupational and regulatory standards for ensuring public protection and professional integrity. Statutes (i.e., practice acts) define the scope of practice for a particular jurisdiction and licensure laws ensure practitioners meet and maintain prescribed standards for the competent performance of their jobs. However, practice acts are often ambiguous regarding the procedures and techniques PTs are allowed to perform because methodologies and evidence-based treatments continually evolve with

advances in education, research, and technology. As a result, interpretation of the law falls to state boards/agencies which develop rules and regulations to define, in practical terms, whether or not a specific procedure, technique, or modality is within the scope of practice. Because each state creates its own licensure laws, the scopes of practice vary—an allowed technique in one state may be restricted in another. Currently, dry needling is specifically allowed in 33 states and strictly prohibited in eight; the remaining states are either undeclared or have conflicting rulings.

Scope and Purpose of the Project

Since 2010, many jurisdictions have sought information from the Federation of State Boards of Physical Therapy (FSBPT) regarding the ability of PTs to perform dry needling. Much of the empirical research on dry needling has focused on the clinical aspects of the technique, such as methods of action and treatment effects (Dommerholt & Fernández-de-las-Peñas, 2013; Dommerholt, 2011; Dunning, et al, 2014). However, no publically available studies have explicitly examined what PTs must know and be able to do to perform dry needling safely and effectively, or what factors (personal capacities or environmental conditions) contribute to competent performance. To provide its members with objective, professionally-developed guidance, FSBPT sponsored a study of the competencies required for safe and effective dry needling.¹

The primary objectives of this research were to:

1. Define Dry Needling Competencies for Physical Therapists

- a. What must physical therapists know and be able to do to perform dry needling safely and effectively?
- b. When, where, and how do physical therapists acquire the knowledge, skills, and abilities needed to perform dry needling?

2. Evaluate Factors that Impact Safe and Effective Practice

- a. What characteristics of the individual contribute to safe and effective dry needling?
- b. What institutional and environmental factors influence the safe and effective practice dry needling?

Research Design

The systematic process for developing competencies in a licensure context is often referred to as “practice analysis”. The process begins with an analysis of the work itself to identify the tasks individuals perform on the job. This is followed by an investigation of the knowledge, skills, and abilities needed to perform those tasks. Finally, additional information is collected to determine the requirements for evaluating the quality of performance on a task (e.g., effective versus not effective). The result of this process is a list of the knowledge, skills, and ability requirements for competent performance.

¹ Competencies are defined as measurable or observable knowledge, skills, or abilities an individual must possess to perform a job effectively. They possess both descriptive and evaluative information (i.e., what characteristics an individual must possess and to what extent or level of quality). Because they describe behavioral characteristics of the individual in terms of the job being performed, competencies can provide a strong foundation for a variety of professional and regulatory functions, including the establishment of education and training requirements, performance assessment and management, professional guidelines, and practice regulations. They are also useful for communicating with and educating the public on the dry needling technique and how it fits with the physical therapy scope of practice.

Practice analysis relies on the input and judgment of subject matter experts (SMEs) to provide an authentic and accurate assessment of the job tasks and competencies. Their primary role is to bring their education, training, and on-the-job experience to bear in identifying knowledge, skills, and abilities that are relevant and important for competent practice. In this way, SME participation adds credibility and validity to the outcomes of the research.

FSBPT contracted with the Human Resources Research Organization (HumRRO) to conduct the study in accordance with current best-practices in practice analysis procedures. HumRRO is a non-profit, social and behavioral science research and consulting firm dedicated to the measurement and improvement of human and organizational performance. As an independent contractor, HumRRO was instrumental in carrying out an objective, unbiased analysis. In addition, HumRRO provided an external perspective of the nature of physical therapy work, particularly the human and environmental factors related to competent job performance.

Competency Development Process

The process for developing the dry needling competencies included three main steps. First, HumRRO staff conducted a background review of the literature on dry needling and constructed draft versions of the competencies. Concurrently with the background review, FSBPT surveyed a broad sample of licensed PTs to identify knowledge, skills, and abilities that are important for dry needling. Finally, HumRRO and FSBPT convened a task force meeting with experts in dry needling to consolidate the information collected in the previous two steps and construct a final list of competencies. Each step is described in more detail in the following sections.

Background Information Review

The purpose of the background review was to obtain current theoretical, procedural, and descriptive information on dry needling and translate it into a preliminary set of competencies. The review began with an internet search to identify source material containing information related to: dry needling knowledge and skills, tasks and/or duties, contraindications, adverse effects, safety, needle techniques, patient education and communication, and emergency preparedness and response. This search returned 30 sources encompassing websites, resource papers, text publications, peer-reviewed research journals, instructional curricula, and testing materials. FSBPT identified an additional seven electronic documents covering FSBPT periodicals and testing materials related to the National Physical Therapy Licensure Exam (NPTE). The complete list of source materials is provided in Appendix A.

During the review, text fragments (e.g., sentences, phrases, paragraphs) that provided potentially useful information were extracted and stored in an electronic database. A total of 937 fragments were collected ranging in size from 19 to 2,329 characters (including spaces). The average size of an extracted fragment was 229 characters. Examples include:

- "...inquiries specifically about reactions to needles..."
- "Sustained contractures of taut bands cause local ischemia and hypoxia in the core of trigger points."
- "The muscle and treatment area needled should be compressed immediately following needle with-drawal for hemostasis for up to 30 seconds or until any bleeding has stopped. A cotton swab may be used and should be discarded as appropriate."
- "The clinician should be cognizant of anatomical structures within the treatment area that are vulnerable to [dry needling], e.g. neurovascular structures and the lung, and ensure

that the needling technique avoids penetration of vulnerable anatomical structures. Also, voluntary and involuntary patient movement may compromise safe [dry needling], which is why the needling hand should always rest on the patient's body.”

The extracted information was analyzed, sorted, and coded into groupings reflecting common (or recurrent) topics or themes. For example, the following sentences provided information related to knowledge of body systems affected by dry needling.

- “Dry needling is a neurophysiological evidence-based treatment technique that requires effective manual assessment of the neuromuscular system”
- “Anatomical knowledge of the vascular system is important as there is a potential to puncture blood vessels during needling”
- “Identify specific bony landmarks of the pelvis and differentiate individual pelvic muscles for needling”
- “Anatomical knowledge of internal organs is important as there is potential for internal organ penetration such as the kidney with needling of [trigger points] in the psoas major and quadratus lumborum muscles or organs within the peritoneal cavity with needling of TrPs in the abdominal muscles”

In some instances, a single fragment provided information across multiple topics and was coded accordingly. After sorting and grouping the information, common topics with each grouping were identified and used to construct draft lists of dry needling tasks and knowledge requirements.

Tasks are defined as discrete job-related actions taken to achieve some goal or purpose, and the tools, conditions, and reasons for doing so. Twenty-seven tasks were derived from the background review materials. Below is an example of a task statement.

Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements).

Knowledge requirements describe organized bodies of factual or procedural information that are directly involved in the performance of a job or job task. Twenty-seven knowledge requirements were derived from the background review. An example of a knowledge requirement statement is presented below.

Knowledge of contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications).

The draft lists of tasks and knowledge requirements were reviewed with FSBPT to (a) identify content gaps, (b) make adjustments to the phrasing or content, and (c) organize the information in a meaningful way for review by the Task Force. The complete list of draft statements is presented in Appendix B.

Practitioner Survey

The purpose of the practitioner survey was to identify entry-level physical therapy tasks and knowledge (required at the time of licensure) that are also required for dry needling. A large sample

of licensed PTs (n=353) was recruited to complete the survey. This sample included individuals working in hospitals, private practice, clinics, academia, and the military. Respondents were presented with two lists: 214 entry-level tasks (a.k.a., work activities) and 116 entry-level knowledge statements. Both lists were drawn verbatim from the results of the 2011 Analysis of Practice for the Physical Therapy Profession (Bradley, Waters, Caramagno, & Koch, 2011).² The practitioner survey was conducted concurrently with the review of background materials. Therefore, draft competencies from the review were not included in the practitioner survey. Respondents were instructed to rate whether each task (or knowledge) was relevant or not relevant to competency in performing dry needling. Tables indicating the percent of respondents selecting each task or knowledge as relevant were prepared for presentation to the Task Force.

Respondents were also asked to identify qualities or capabilities that PTs need to be effective in the practice of dry needling that were not already covered by the lists of tasks and knowledge statements. HumRRO content analyzed their responses and identified commonly cited characteristics. Broadly, the responses could be categorized into three areas of dry needling-specific information: skills and abilities, tasks, and knowledge. For example, some of the respondents suggested adding tasks related to needle selection and placement, identification of contraindications, and palpation. A small portion of respondents observed that PTs need knowledge of surface and cross-sectional anatomy, adverse effects related to needling, and clean needle techniques. The information identified by the survey respondents was incorporated into the draft list of tasks and competencies developed during the background review.

Task Force Meeting

The purpose of the Task Force meeting was to review the draft competencies and survey results and consolidate the information into a final set of dry needling competencies. FSBPT extended invitations to a group of dry needling experts who were employed in a variety of sectors (e.g., private, academia) and were geographically dispersed. Because more individuals were interested than there were positions to fill, FSBPT requested from each individual a short summary of his/her training and professional experience with dry needling as well as his/her availability to attend the Task Force meeting on the selected dates (see below). Based on the narratives, FSBPT looked for individuals who possessed regulatory experience with FSBPT or FSBPT's licensing boards and/or have been involved in the legislative process with regard to dry needling.

Seven individuals were selected to participate on the Task Force based on their depth and breadth of experience and education in dry needling. Their years of professional experience performing dry needling ranged from five to fourteen. All participants were licensed PTs with a minimum of fourteen total years of experience in physical therapy and a maximum of 31. Five participants possessed Doctorate level degrees (i.e., DPT); one had a Master's level degree (i.e., MPT/MSPT), and one had a Bachelor's degree. All were certified to practice dry needling, and five were currently in an educational or training role (e.g., faculty, instructor) providing dry needling instruction in addition to their clinical employment as therapists. One was a full-time faculty member.³

The Task Force meeting was held at FSBPT's headquarters on May 29-31, 2015. HumRRO staff facilitated the meeting with technical support from FSBPT as well as observers from the American Physical Therapy Association (APTA) and FSBPT's Board of Directors. The agenda covered the following activities:

² Available at: https://www.fsbpt.org/download/pa2011_ptfinalreport20111109.pdf

³ At this time there are no required certifications, or certifications that are acknowledged by a regulatory board. All Task Force members have extensive training in dry needling and practice it regularly.

1. Define Dry Needling
2. Define the Standard for Competence (Safe and Effective Practice)
3. Review and Refine Dry Needling Tasks
4. Review and Refine Dry Needling Knowledge Requirements
5. Identify Dry Needling Skills and Abilities

Define Dry Needling

The first activity was aimed at constructing a definition of dry needling that clearly communicates the purpose and defining features of the intervention without inadvertently narrowing the scope. A draft definition was presented to the Task Force for review and is presented below.⁴

*Draft definition: Dry needling is a skilled intervention using a thin, filiform needle, without injectate, to penetrate the skin in order to stimulate and effect change in underlying tissues.*⁵

The Task Force noted several issues with the draft definition they believed would confuse certain audiences and narrow its applicability across individual practitioners and practice settings. These included the following.

- Dry needling is not limited to physical stimulation of acutely affected tissue.
- There is a neural component that includes the peripheral and central nervous system.
- Dry needling can be used to stimulate as well as inhibit the neuromusculoskeletal system.
- Dry needling is a method for evaluating, treating, and managing functional impairment and pain.
- Dysfunction and disability are also treated with dry needling.
- The term filiform should be kept; however, some needles are thicker than others so “thin” might be misleading.
- Needles may penetrate more than just the dermal layer (i.e., skin).

The definition adopted by Arizona Physical Therapy Board which was developed to address many of the same issues was presented. The Task Force elected to use this definition as a starting point and made a few additional revisions, such as adding “disability” to the list of things dry needling can be used to treat. The final definition is presented below.

Dry needling is a skilled technique performed by a physical therapist using filiform needles to penetrate the skin and/or underlying tissues to affect change in body structures and functions for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disability.

Define the Standard for Competence (Safe and Effective Practice)

⁴ This version was developed by FSBPT staff with contributions from two practicing physical therapists that have expertise in dry needling. The draft version was primarily developed as a starting point to facilitate discussion.

⁵ Draft definition; do not cite.

The second activity was conducted to clarify the standard of competence for dry needling. This standard represents the minimum level of proficiency needed to perform the technique competently. Although there are many ways to define competence (e.g., efficiency, cost, speed, quality, satisfaction), the criteria “safe and effective” were selected because (a) they are meaningful to the practice of dry needling (and physical therapy in general), and (b) this approach is consistent with the 2011 practice analysis (Bradley, Waters, Caramagno, & Koch, 2011).

To begin, the Task Force participated in a brainstorming task to identify (at a broad level) what PTs do when applying dry needling, what they must know to do so safely and effectively, and what psychological or physical characteristics they must possess (e.g., skills, abilities). Examples of their responses include:

- DO: assess and evaluate; determine need for intervention, educate patients, establish goals, handle needles safely, manage waste disposal
- KNOW: anatomy; palpation techniques; dosing; informed consent; adverse effects; reimbursement
- POSSESS: psychomotor skills; social skills; ability to communicate; ethics; self-awareness; empathy/compassion; cultural competence

This activity helped orient the Task Force to the practice analysis approach and establish a common frame of reference regarding the meaning of safe and effective practice.

The Task Force noted that safety and effectiveness are related but distinct concepts so both criteria are warranted. They unanimously agreed that the concept of safety applies to both patient and practitioner and includes prevention as well as emergency response. Prevention covers direct actions such as safe needle handling and infection control, as well as more indirect actions like attending to and correctly interpreting patient data. In relation to the minimum standard for competence, they defined safe practice as the prevention and mitigation of harm to the patient or therapist, directly or indirectly, through careful patient selection, evaluation, and treatment.

The concept of effectiveness was more difficult to define because dry needling can be used to achieve a variety of therapeutic responses and outcomes (e.g., reduced pain and/or sensitization, increased mobility). Each patient’s needs are dependent on his/her symptoms or conditions and whether dry needling is appropriate. Measuring the effectiveness of the treatment requires careful pre- and post-treatment assessment to establish a baseline health status, select the patient for dry needling, and detect change. Accordingly, the Task Force opted to define the standard for effectiveness in relation to the entire physical therapy session (or visit). In other words, dry needling is effective when the PT continually assesses and evaluates the patient and adjusts the treatment according to the patient’s specific needs or presentation.

Review and Refine Dry Needling Tasks

The objective of the third activity was to identify job tasks that PTs perform when applying dry needling as part of a physical therapy treatment plan. Job tasks are not included as part of the competencies but the identification of tasks is essential for linking the competencies to the actions that PTs perform on the job. In other words, in order to identify the competencies required for a job, one must first understand the job itself. The job task analysis served this purpose.

The analysis was carried out in two parts. First, the Task Force reviewed a list of entry-level physical therapy tasks. These tasks were identified during the 2011 practice analysis (Bradley, Waters,

Caramagno, & Koch, 2011) and, as such, reflect the actions expected of all licensed, entry-level PTs. Because the same list was used in the practitioner survey, the Task Force reviewed the survey results (i.e., percent of respondents endorsing each task as relevant). Through discussion and consensus-building, the Task Force made a final determination of the relevance of each task. For this activity, relevance was based on the standard for competence defined in the previous section (i.e., a task is relevant if it is necessary for safe and effective practice).

Next, the Task Force reviewed the list of draft task statements developed during the background review. These tasks describe the procedural actions involved in performing the dry needling intervention and are at a somewhat finer grain of analysis than the entry-level tasks. As a result, the Task Force spent more time editing these tasks to improve their clarity and accuracy.

During the review, the Task Force noted that dry needling is always performed as part of a comprehensive treatment plan and almost never the only physical therapy intervention included in the plan. As a result, the Task Force initially identified all of the entry-level interventions as relevant to dry needling. However, this decision created redundancy with the list of entry-level physical therapy tasks and obscured the purpose and usefulness of the dry needling task list.⁶ Because dry needling is frequently combined with other interventions, the Task Force observed that an important part of a PT's role is determining the proper sequence of events to reduce or eliminate the risk of relative contraindications. Therefore, instead of including every physical therapy intervention/treatment on the task list, the Task Force created a new statement that specifically addressed the action of sequencing dry needling with other interventions.

Sequence dry needling with other procedural interventions and techniques (e.g., therapeutic exercises, neuromuscular reeducation, manual therapy, physical modalities) to augment therapeutic effects and minimize risk due to adverse outcomes and/or contraindications.

The statements describing the other interventions were excluded from the final dry needling task list.

Review and Refine Dry Needling Knowledge Requirements

The objective of the fourth activity was to identify the knowledge required to carry out the tasks identified in the previous activity. The Task Force began by reviewing the 116 entry-level knowledge requirements identified in the 2011 practice analysis as well as the practitioner survey results. They identified 13 statements as clearly unrelated to the safe and effective practice of dry needling and excluded them from further consideration. These statements covered knowledge of biofeedback, electromagnetic radiation, data collection techniques, and measurement science, to name a few. Next, the Task Force reviewed the 27 dry needling-specific knowledge requirements developed during the background review. This list was heavily refined to ensure the knowledge requirements were clear and accurate. During the review, the Task Force eliminated eight and created two new knowledge requirements.

Once the Task Force was comfortable with the content of the lists, they performed a rating task to evaluate the importance of the knowledge requirements. The importance rating reflects the extent to which the knowledge described by a particular statement is needed for safe and

⁶ From a methodological standpoint, task lists should include only actions/activities necessary to perform the work. The inclusion of other interventions on the dry needling task list suggests they are essential to the proper implementation of technique.

effective dry needling. If lack of the knowledge would lead to very serious negative consequences, the importance rating should be higher. If none or few consequences would result from a lack of the knowledge, the importance rating should be lower. The importance rating scale is shown below.

How important is the knowledge for the safe and effective performance of dry needling by a licensed physical therapist?

1. Minimally important
2. Somewhat important
3. Important
4. Very important
5. Extremely important

The Task Force members' rated each of the remaining 103 knowledge requirements. HumRRO compiled and analyzed the ratings to identify knowledge requirements for which there were large discrepancies in judgment (e.g., split-decisions, no clear majority) were marked for review. All of these discrepancies were resolved through a process of discussion to reinforce the purpose and goals of the activity and reach agreement regarding the knowledge that is required for competent dry needling.

Identify Dry Needling Skills and Abilities

The process for determining which skills and abilities are needed for safe and effective dry needling differed from that used for the tasks and knowledge requirements. To date, no publicly available description of skills and abilities needed for dry needling exists. However, the U.S. Department of Labor developed a comprehensive database called the Occupational Information Network (O*NET) which contains information on skills and abilities that are related to job performance in different industries, including physical therapy (Tsacoumis & Van Iddekinge, 2006). The data analysis conducted by the Department identified 21 skills and 22 abilities that apply to the physical therapy occupation. Accordingly, to identify attributes specifically related to dry needling, HumRRO integrated the O*NET information with expert judgments made by the Task Force.

First, the Task Force brainstormed a set of attributes needed for performing dry needling safely and effectively and identified five general activities.

1. Communicating with patients
2. Adapting behavior or treatment to accommodate patient's needs/preferences
3. Handling and controlling needles and palpating tissues
4. Reflecting on and evaluating own competence to perform dry needling (e.g., only treating areas for which the PT has specific training)
5. Abiding by professional and ethical standards (e.g., adhering to OSHA regulations)

They noted that PTs acquire the skills and abilities to perform these activities competently during their general physical therapy education, residency, and/or clinical internships, with one exception; the psychomotor skills needed to physically perform dry needling (e.g., needle insertion) are not learned in physical therapy school and must be developed as part of specialized training on the technique.

Next, HumRRO mapped the activities identified by the Task Force to the skills and abilities listed in the O*NET database. Two HumRRO analysts reviewed the definition of each O*NET

skill or ability as well as any behavioral examples provided and used this information to “link” the two sets of information. For instance, writing skill is defined in the O*NET database as “Communicating effectively in writing as appropriate for the needs of the audience” (e.g., taking a phone message, writing a memo to staff outlining new directives) and corresponds with the Task Force-identified activity focused on patient communication.

Outcomes

Dry Needling Job Tasks

Of the 214 job tasks required of entry-level, licensed PTs, 97 were judged to be relevant to dry needling. These tasks describe activities related to information gathering and systems review (n = 17), testing and measurement (n = 33), evaluation and diagnosis (n = 11), prognosis and plan of care (n = 5), non-procedural interventions (n = 16), and patient/client and staff safety (n = 15). Of the 27 tasks derived from the background review, 26 were identified as specifically relevant to dry needling (see Table 1). Nearly half (n = 12) of these tasks describe procedural actions such as positioning the patient, palpating the area(s) to be needled, needle handling, monitoring the patient, and disposing of medical waste. The remaining 14 tasks describe activities related to information gathering, prognosis and plan of care, non-procedural interventions, and patient/client and staff safety. The final list of 123 dry needling tasks is displayed in Appendix D. Tasks that were deemed not relevant to dry needling are presented in Appendix E.

Table 1. Dry Needling-Specific Tasks

ID#	Tasks
PATIENT/CLIENT ASSESSMENT	
Information Gathering & Synthesis	
	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to...
1.	...identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements)
2.	...identify contraindications and precautions related to dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
3.	Sequence dry needling with other procedural interventions and techniques (e.g., therapeutic exercises, neuromuscular reeducation, manual therapy, physical modalities) to augment therapeutic effects and minimize risk due to adverse outcomes and/or contraindications.
INTERVENTIONS	
Manual Therapy Techniques	
	Position the patient/client to...
4.	...expose the area(s) to be needled
5.	...reduce the risk of harm to the patient/client and/or therapist
6.	Educate the patient/client on the impact of movement during treatment
7.	Perform palpation techniques to identify the area(s) to be needled
8.	Apply needle handling techniques that ensure compliance with relevant and current professional standards (e.g., wash hands, wear gloves, minimize needle contamination)
9.	Apply draping materials (e.g., linens, towels) to minimize unnecessary exposure and respect patient privacy
10.	Perform dry needling techniques consistent with treatment plan (e.g., place, manipulate, and remove needles)
11.	Manage needle removal complications (e.g., stuck needle, bent needle)
12.	Monitor patient/client’s emotional and physiological response to dry needling

Table 1 (Continued)

ID#	Tasks
13.	Facilitate hemostasis as necessary
14.	Dispose of medical waste (e.g., needles, gloves, swabs) in accordance with regulatory standards and local jurisdictional policies and procedures (e.g., sharps container)
15.	Discuss post-treatment expectations with the patient/client or family/caregiver
Education	
16.	Educate patient/client or family/caregiver about dry needling (e.g., purpose, technique, methods of action, benefits, tools and equipment)
17.	Educate patient/client or family/caregiver about potential adverse effects associated with dry needling (e.g., fainting, bruising, soreness, fatigue)
18.	Educate patient/client or family/caregiver about precautions and contraindications for dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
Patient/client & Staff Safety	
Emergency Procedures	
19.	Implement emergency response procedures to treat patient/client injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding, broken needles)
20.	Implement emergency response procedures to treat practitioner injuries sustained during dry needling (e.g., needle stick)
Environmental Safety	
21.	Prepare and maintain a safe and comfortable environment for performing dry needling (e.g., unobstructed walkways, areas for patient/client privacy)
22.	Stock dry needling supplies and equipment in safe proximity during treatment
Infection Control	
23.	Implement infection control procedures to mitigate the effects of needle stick injuries
24.	Clean and disinfect blood and bodily fluids spills in accordance with regulatory standards and local jurisdictional policies and procedures
25.	Replace surfaces that cannot be cleaned
Professional Responsibilities	
26.	Determine own ability to perform dry needling safely and effectively

Dry Needling Competencies

Physical Therapy Knowledge Needed for Dry Needling

Determination of the knowledge needed for competency in dry needling was based on the average of Task Force members' importance ratings for each knowledge requirements. Mean importance ratings ranged from 1.57 to 4.71. Requirements with a mean rating of less than 2.00 ("Somewhat Important") were marked for potential elimination and discussed with the Task Force (n = 9). Of these, one statement (i.e., *knowledge of pneumatic compression modalities*) was retained as important because PTs must understand potential interactions between the interventions. Knowledge requirements falling near the threshold were discussed and reassessed. Of the 116 entry-level knowledge requirements, 95 were identified as important for dry needling. All 22 of the dry needling-specific knowledge requirements were identified as important for dry needling. The final list of 117 dry needling knowledge requirements is presented in Appendix F.

Knowledge requirements rated less than 2.00 were deemed not important to dry needling (n = 8). These included knowledge of other equipment and devices (e.g., prosthetics), other therapeutic modalities (e.g., mechanical), ultrasound imaging, and gastrointestinal interventions. Knowledge not related to competency in dry needling is presented in Appendix G.

Although much of the knowledge needed for dry needling is acquired during the course of a PT's entry-level education (e.g., coursework; clinical internships), dry needling is not an entry-level technique. Therefore, some knowledge must be developed through specialized training.⁷ Sixteen knowledge requirements were identified as requiring advanced/specialized training for dry needling (see Table 2). All but one (i.e., *Factors influencing safety and injury prevention*) cover dry needling-specific knowledge such as surface anatomy, emergency preparedness and response procedures and standards (as related to dry needling), theoretical basis for dry needling, aspects of the technique itself, and secondary effects or contraindications related to the use of needles.

Table 2. Specialized Knowledge Required for Competency in Dry Needling

DRY NEEDLING-SPECIFIC KNOWLEDGE	
Anatomy and Physiology	
1.	Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks
Emergency Preparedness and Response	
2.	Emergency preparedness and/or response procedures related to secondary physiological effects or complications associated with dry needling (e.g., shock, vasovagal)
3.	Emergency preparedness and/or response procedures related to secondary emotional effects or complications associated with dry needling (e.g., claustrophobia, anxiety, agitation)
4.	Standards for needle handling (e.g., hand hygiene, application of single-use needles)
Safety and Protection	
5.	Factors influencing safety and injury prevention
6.	Personal protection procedures and techniques as related to dry needling (e.g., positioning self to access treatment area, use of personal protective equipment)
7.	Theoretical basis for dry needling (e.g., applications for rehabilitation, health promotion, fitness and wellness, performance)
8.	Theoretical basis for combining dry needling with other interventions
9.	Secondary effects or complications associated with dry needling on other systems (e.g., gastrointestinal, cardiovascular/pulmonary, musculoskeletal)
10.	Theoretical basis of pain sciences, including anatomy, physiology, pathophysiology, and relation to body structures and function
11.	Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions)
12.	Palpation techniques as related to dry needling
13.	Needle insertion techniques
14.	Needle manipulation techniques
15.	Physiological responses to dry needling
16.	Solid filament needles (e.g., physical characteristics)

Physical Therapy Skills and Abilities Needed for Dry Needling

⁷ The Task Force defined specialized training as a full course on a particular topic or set of topics—short (e.g., half-day) workshops do not fulfill this requirement—and recommended that opportunities to practice actual needling should be incorporated into and provided immediately after the training to reinforce learning.

As mentioned, the determination of skills and abilities needed for competent dry needling was made by coupling Task Force members' judgment with information from the O*NET database. HumRRO linked the five Task Force-identified activities to 16 O*NET skills and abilities. The list covers attributes that are needed to perform dry needling safely and effectively, including communication (e.g., reading, writing, speaking), active listening and clinical thinking, social skills, psychomotor abilities, and judgment and decision-making. The Task Force observed that the majority of these skills and abilities are acquired through entry-level training and education. However, because dry needling is not included in most entry-level physical therapy programs (Adrian, 2013), the psychomotor skills needed to handle needles and palpate tissues require specialized training.⁸ The final list of skills and abilities is presented in Appendix H.

Role of the Physical Therapist Assistant in Dry Needling

Physical therapist assistants (PTAs) are health care workers who are directed and supervised by PTs. In this role, they are involved in direct patient care, including (but not limited to) observation and records management, therapeutic exercise, gait and balance training, massage, and patient education. However, PTAs do not evaluate, diagnose, assess/reassess, or prepare treatment plans for patients. They also do not make recommendations for various types of treatments modalities and equipment.

Task differences between PTs and PTAs are partly related to the scope of educational curricula provided by accredited physical therapist assistant degree programs. Whereas assistants receive instruction in many of the same domains as PTs (e.g., anatomy and physiology, biomechanics, kinesiology, neuroscience, clinical pathology, behavioral sciences, communication, ethics/values), the depth and breadth of education and training is not equivalent. PTAs spend roughly 16 weeks in clinical education, whereas PTs spend more than 27. In addition, PTAs receive no didactic or clinical training in evaluation and differential diagnosis. Because this report focused on the competencies required of the PT to perform dry needling, which are based on a strong foundation in evaluation and differential diagnosis, it is not appropriate to assume the same competencies would qualify a PTA to perform the treatment.

Conclusions

The practice analysis of dry needling revealed several important characteristics about PTs' capabilities for performing the intervention as part of their scope of practice. First, of the 116 entry-level and 22 dry needling-specific knowledge requirements, 117 were identified as important for competency in dry needling. More than four-fifths (86%) of what PTs need to know to be competent in dry needling is acquired during the course of their entry-level education, including knowledge related to evaluation, assessment, diagnosis and plan of care development, documentation, safety, and professional responsibilities. Advanced or specialized training (e.g., dry needling course, residency program) is required for 16 of the knowledge areas

⁸ Although additional training is needed for the development of psychomotor skills (as well as the 16 knowledge requirements noted previously), there does not appear to be widespread agreement regarding the minimum number of practice hours necessary (Kalichman & Vulfsons, 2010). Indeed, the acquisition of knowledge and skills is dependent on more than just the number of hours of deliberate practice (Hambrick, Oswald, Altman, Mainz, Gobet, & Campitelli, 2014). The Task Force argued that variation across individuals in terms of their aptitude, education, experience, and clinical specialization results in different rates of development. Additionally, any practice hour metric should be theoretically or practically linked to the professional standard for safe and effective practice (AERA, APA, NCME, 2014).

needed for dry needling and these are almost solely related to the needling technique (e.g., selection, placement, and manipulation of needles; identification of contraindications). In addition, the psychomotor skills needed to handle needles and palpation of tissues specifically in regard to dry needling appropriately require specialized training. Because this report focused on the competencies required of the PT to perform dry needling, which are based on a strong foundation in evaluation and differential diagnosis, it is not appropriate to assume the same competencies would qualify a PTA to perform the treatment.

References

- AERA, APA, & NCME (1999). Standards for educational and psychological testing. Washington, D.C.: Author.
- Baldry, P. (2002). Superficial versus deep dry needling. *Acupuncture in Medicine*, 20(2-3), 78-81.
- Bradley, K. M., Caramagno, J. P., Waters, S. D., & Koch, A. (2011). Analysis of practice for the physical therapy profession: Entry-level physical therapists (FR-11-70). Alexandria, VA: Human Resources Research Organization.
- Clewley, D., Flynn, T.W., & Koppenhaver, S. (2014). Trigger point dry needling as an adjunct treatment for a patient with adhesive capsulitis of the shoulder. *Journal of Orthopaedic & Sports Physical Therapy*, 44(2), 92-100.
- Cummings, M. (2013). Dry needling from a Western medical acupuncture perspective. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 173-207). London, England: Churchill Livingstone Elsevier.
- Dommerholt, J., & Fernández-de-las-Peñas, C. (2013). Proposed mechanisms and effects of trigger point dry needling. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 21-27). London, England: Churchill Livingstone Elsevier.
- Dommerholt, J. (2011). Dry needling: Peripheral and central considerations. *Journal of Manual and Manipulative Therapy*, 19(4), 223-237.
- Dommerholt, J. (2004). Dry needling in orthopedic physical therapy practice. *Orthopedic Practice*, 16(3), 15-20.
- Dunning, J., Butts, R., Mourad, F., Young, I., Flannagan, S., & Perreault, T. (2014). Dry needling: a literature review with implications for clinical practice guidelines. *Physical Therapy Reviews*, 19(4), 252-265.
- Gunn, C.C. *The Gunn approach to the treatment of chronic pain: Intramuscular stimulation for myofascial pain of radiculopathic origin*. 2nd ed. New York: Churchill Livingstone; 1997.
- Hambrick, D.Z., Oswald, F. L., Altmann, E.M., Meinz, E.J., Gobet, F., & Campitelli, G. (2014). Deliberate practice: Is that all it takes to become an expert? *Intelligence*, 45, 34-45.
- Kalichman, L., & Vulfsons, S. (2010). Dry needling in the management of musculoskeletal pain. *Journal of the American Board of Family Medicine*, 23(5), 640-646.
- Ma, Y.T. *Biomedical acupuncture for sports and trauma rehabilitation: dry needling techniques*. St Louis, MO: Churchill Livingstone; 2011.
- National Council of State Boards of Nursing. (2012). *Changes in healthcare professions' scope of practice: Legislative considerations*. Chicago, IL: Author.
- Simons, D.G., Travell J.G., Simons, L.S. *Travell and Simons' myofascial pain and dysfunction: the trigger point manual. Volume 1. Upper half of body*. 2nd ed. Baltimore, MD: Williams & Wilkins; 1999.

Appendix A

Background Review Source Materials

1. Adrian, L. (2013). *FSBPT Dry Needling Resource Paper*, 4th Edition (Intramuscular Manual Therapy). Alexandria, VA: Federation of State Boards of Physical Therapy. Retrieved February 18, 2015, from https://www.fsbpt.org/download/DryNeedlingResourcePaper_4thEdition.pdf
2. American Physical Therapy Association. (2012). *Physical therapists & the performance of dry needling: An educational resource paper*. Alexandria, VA: Author.
3. Australian Society of Acupuncture Physiotherapists Inc. (2007). *Guidelines for safe acupuncture and dry needling practice*. Retrieved from: www.dryneedling.com.au/wp-content/.../asap-safety-guidelines-2007.pdf
4. Bachmann, S., Colla, F., Gröbli, C., Mungo, G., Gröbli, L., Reilich, P., & Weissmann, R. (2014). *Swiss guidelines for safe dry needling: Version 1.7*. Retrieved from: http://www.dryneedling.ch/fileadmin/documents/Swiss_Guidelines_for_safe_1.7_Dry_Needling_01.pdf
5. Bradley, K. M., Caramagno, J. P., Waters, S. D., & Koch, A. (2011). *Analysis of practice for the physical therapy profession: Entry-level physical therapists (FR-11-70)*. Alexandria, VA: Human Resources Research Organization.
6. Brady, S., McEvoy, J., Dommerholt, J., & Doody, C. (2014). Adverse events following trigger point dry needling: A prospective survey of chartered physiotherapists. *Journal of Manual Manipulative Therapy*, 22(3), 134-140.
7. Bron, C., Franssen, J.L.M., & Beersma, B.T.M. (2013). Deep dry needling of the shoulder muscles. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 93-105). London, England: Churchill Livingstone Elsevier.
8. Cagnie, B., Castelein, B., Pollie, F., Steelant, L., Verhoeyen, H., & Cools, A. (2015). Evidence for the Use of Ischemic Compression and Dry Needling in the Management of Trigger Points of the Upper Trapezius in Patients with Neck Pain: A systematic review. *American Journal of Physical Medicine & Rehabilitation*, Published ahead of print.
9. Clewley, D., Flynn, T.W., & Koppenhaver, S. (2014). Trigger point dry needling as an adjunct treatment for a patient with adhesive capsulitis of the shoulder. *Journal of Orthopaedic & Sports Physical Therapy*, 44(2), 92-100.
10. Cummings, M. (2013). Dry needling from a Western medical acupuncture perspective. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 173-207). London, England: Churchill Livingstone Elsevier.
11. College of Physical Therapists of Alberta. *Dry needling competency profile for physical therapists*. Calgary, AL: Author. Retrieved from http://www.physiotherapyalberta.ca/files/competency_profile_dry_needling.pdf

12. College of Physical Therapists of British Columbia. (2013). *CPTBC practice standard No. 10 acupuncture and dry needling for physical therapists*. Vancouver, BC: Author. Retrieved from <http://cptbc.org/resources/practice-standards/>
13. Dommerholt, J., & Fernández-de-las-Peñas, C. (2013). Proposed mechanisms and effects of trigger point dry needling. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 21-27). London, England: Churchill Livingstone Elsevier.
14. Dommerholt, J. (2011). Dry needling: Peripheral and central considerations. *Journal of Manual and Manipulative Therapy*, 19(4), 223-237.
15. Dommerholt, J. (2004). Dry needling in orthopedic physical therapy practice. *Orthopedic Practice*, 16(3), 15-20.
16. Dunning, J., Butts, R., Mourad, F., Young, I., Flannagan, S., & Perreault, T. (2014). Dry needling: a literature review with implications for clinical practice guidelines. *Physical Therapy Reviews*, 19(4), 252-265.
17. Fernández-de-las-Peñas, C., Iglesias, J.G., Gröbli, C., & Weissmann, R. (2013). Deep dry needling of the arm and hand muscles. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 107-118). London, England: Churchill Livingstone Elsevier.
18. Fernández-de-las-Peñas, C., Isabel-de-la-Llave-Rincón, A., Ortega-Santiago, R., & Torres-Chica, B. (2013). Deep dry needling of the head and neck muscles. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 73-92). London, England: Churchill Livingstone Elsevier.
19. Gunn, C.C. *The Gunn approach to the treatment of chronic pain: Intramuscular stimulation for myofascial pain of radiculopathic origin*. 2nd ed. New York: Churchill Livingstone; 1997.
20. Gunter, J. (2004). Chronic pelvic pain: The myofascial component. *The Female Patient*, 29, 9-16.
21. Health Quality Council of Alberta. (2014). *The safe practice of dry needling in Alberta: Summary report*. Calgary, AL: Author. Retrieved from https://d10k7k7mywg42z.cloudfront.net/assets/5445339bd4c96163370154ed/FINAL___Dry_Needling_Report_10202014.pdf
22. Hsieh, Y.L., Kao, M.J., Kuan, T.S., Chen, S.M., Chen, J.T., & Hong, C.Z. (2007). Dry needling to a key myofascial trigger point may reduce the irritability of satellite MTrPs. *American Journal of Physical Medicine & Rehabilitation*, 86, 397-403.
23. Kalichman, L., & Vulfsons, S. (2010). Dry needling in the management of musculoskeletal pain. *Journal of the American Board of Family Medicine*, 23(5), 640-646.
24. Kelley, L., Finnegan, M., & Dommerholt, J. (2013). Deep dry needling of the trunk muscles. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 119-132). London, England: Churchill Livingstone Elsevier.

25. Llamas-Ramos, R., Pecos-Martín, D., Gallego-Izquierdo, T., Llamas-Ramos, I., Plaza-Manzano, G., Ortega-Santiago, R., Cleland, J., & Fernández-de-las-Peñas, C. (2014). Comparison of the short-term outcomes between trigger point dry needling and trigger point manual therapy for the management of chronic mechanical neck pain: A randomized clinical trial. *Journal of Orthopaedic & Sports Physical Therapy*, 44(11), 852-861.
26. Ma, Y.T. *Biomedical acupuncture for sports and trauma rehabilitation: dry needling techniques*. St Louis, MO: Churchill Livingstone; 2011.
27. Mayoral-del-Moral, O., & Torres-Lacomba, M. (2013). Deep dry needling of the leg and foot muscles. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 151-165). London, England: Churchill Livingstone Elsevier.
28. McEvoy, J. (2013). Trigger point dry needling: Safety guidelines. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 39-58). London, England: Churchill Livingstone Elsevier.
29. Mejuto-Vázquez, M.J., Salom-Moreno, J., Ortega-Santiago, R., Truyols-Dominguez, S., & Fernández-de-las-Peñas, C. (2014). Short-term changes in neck pain, widespread pressure pain sensitivity, and cervical range of motion after the application of trigger point dry needling in patients with acute mechanical neck pain: A randomized clinical trial. *Journal of Orthopaedic & Sports Physical Therapy*, 44(4), 252-261.
30. Scandalici, D., & Dommerholt, J. (2013). Deep dry needling of the hip, pelvis and thigh muscles. In J. Dommerholt & C. Fernández-de-las-Peñas (Eds.), *Trigger point dry needling: An evidenced and clinical-based approach*. (pp. 133-150). London, England: Churchill Livingstone Elsevier.
31. Shah, J.P., Danoff, J.V., Desai, M.J., Parikh, S., Nadamura, L.Y., Phillips, T.M., & Gerber, L.H. (2008). Biochemicals associated with pain and inflammation are elevated in sites near to and remote from active myofascial trigger points. *Archives of Physical Medicine & Rehabilitation*, 89, 16-23.
32. Simons, D.G., Travell J.G., Simons, L.S. *Travell and Simons' myofascial pain and dysfunction: the trigger point manual. Volume 1. Upper half of body. 2nd ed.* Baltimore, MD: Williams & Wilkins; 1999.
33. Tsai, C.T., Hsieh, L.F., Kuan, T.S., Kao, M.J., Chou, L.W., & Hong, C.Z. (2009). Remote effects of dry needling on the irritability of the myofascial trigger point in the upper trapezius muscle. *American Journal of Physical Medicine & Rehabilitation*, 89, 133-140.
34. Travell J.G., Simons, D.G. *Volume 2. Travell and Simons' myofascial pain and dysfunction: the trigger point manual. The lower extremities.* Philadelphia, PA: Lippincott, Williams & Wilkins; 1993.
35. Weiss, J.M. (2000). Chronic pelvic pain and myofascial trigger points. *The Pain Clinic*, 2(6), 13-18.
36. www.kineticcore.com
37. www.myopainseminars.com

Appendix B

Draft Dry Needling-Specific Tasks and Knowledge Requirements

Table B1. Draft List of Dry Needling Tasks

PATIENT/CLIENT ASSESSMENT

Information Gathering & Synthesis

Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to...

1. ...identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements)
2. ...identify contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications)

INTERVENTIONS

Manual Therapy Techniques

Position the patient/client using supportive devices and equipment (e.g., pillows, rolls, cushions) to...

3. ...ensure the patient/client is comfortable and relaxed
4. ...enable ease of access to the tissue(s) being needled
5. ...reduce the risk of harm to the patient/client and/or therapist
6. Instruct the patient/client to limit movement during treatment
7. Perform palpation techniques to identify the area(s) to be needled
8. Apply sterile needle handling techniques (e.g., wash hands, wear gloves, avoid contact with needle shaft, use sterile plunger, minimize needle contact with skin)
9. Disinfect needle site using detergent, water, alcohol, or iodine solution
10. Perform dry needling techniques on muscles, tendons, ligaments, and other connective tissue to reduce pain and improve functional ability
11. Monitor patient/client's psychological and physiological response to dry needling
12. Apply pressure to the needle area to facilitate hemostasis
13. Dispose of medical waste (e.g., needles, gloves, swabs) in accordance with regulatory standards and local jurisdictional policies and procedures (e.g., sharps container)
14. Discuss post-treatment care with the patient/client or family/caregiver

NON-PROCEDURAL INTERVENTIONS

Education

15. Educate patient/client or family/caregiver about dry needling (e.g., purpose, technique, methods of action, tools and equipment)
16. Educate patient/client or family/caregiver about adverse effects associated with dry needling (e.g., fainting, bruising, soreness, fatigue)
17. Educate patient/client or family/caregiver about precautions and contraindications for dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications)

Emergency Procedures

18. Implement emergency response procedures to treat injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding)
19. Remove broken, bent, or stuck needles using clean, sanitized equipment (e.g., tweezers, pliers)

Environmental Safety

20. Prepare and maintain a safe and comfortable environment for performing dry needling (e.g., unobstructed walkways, areas for patient/client privacy)
21. Clean and disinfect surfaces and textiles using detergent, water, and bleach
22. Stock dry needling tools and equipment in close proximity to treatment area
23. Stock infection control tools and equipment in close proximity to treatment area

Infection Control

24. Implement infection control procedures to mitigate the effects of needle stick injuries
25. Clean and disinfect blood and bodily fluids spills using detergent, water, and chlorine-generating

disinfectant

26. Replace surfaces that cannot be cleaned

Professional Responsibilities

27. Determine own ability to perform dry needling safely and effectively

Table B2. Draft List of Dry Needling Knowledge Requirements

Anatomy and Physiology

1. Anatomical features of the external body, including form, proportion, and projection of surface landmarks and their correspondence with underlying tissues, organs, and other structures

Emergency Preparedness and Response

Emergency preparedness and response procedures related to secondary effects or complications from:

- 2. ...perforation of underlying organs (e.g., pneumothorax)
- 3. ...perforation of blood vessels and arteries (e.g., bleeding, bruising)
- 4. ...trauma to the skin (e.g., cellulitis)
- 5. ...trauma to nerves (e.g., neuropraxia, axonotmesis, neurotmesis)
- 6. ...skeletal punctures (e.g., broken/bent needle)
- 7. Emergency preparedness and response procedures related to secondary psychological effects or complications (e.g., shock, claustrophobia, depression, drowsiness)

Safety and Protection

- 8. Clean needle techniques (e.g., needle site disinfection, hand hygiene, application of single-use needles, needle reinsertion guidelines, grasping and positioning needles, needle re-sheathing)
- 9. Draping techniques
- 10. Equipment sterilization procedures
- 11. Environment sterilization procedures
- 12. Personal protection procedures and techniques (e.g., positioning to access treatment area, use of personal protective equipment)
- 13. Patient positioning techniques (e.g., side-lying, prone, supine) and their effect on anatomy and physiology
- 14. Local laws and regulations regarding the disposal of needles and medical waste
- 15. Federal laws and regulations regarding infection prevention (e.g., Occupational Safety and Health Administration Standards)

Theory and Technique

- 16. Theoretical basis for dry needling interventions, including applications for rehabilitation, health promotion, and performance according to current best evidence
- 17. Theoretical basis for combining dry needling with other manual techniques and modalities
- 18. Theoretical basis for pain, including pathways, physiology, pathophysiology, and relation to movement impairment
- 19. Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications)
- 20. Tissue palpation techniques, including pressure, duration, and hand placement
- 21. Needle insertion techniques, including depth, direction, velocity, manipulation, and duration
- 22. Targeted physiological responses to dry needling
- 23. Targeted psychological responses to dry needling

Equipment and Devices

- 24. Solid filament needles, including type, dimensions, and applications
- 25. Hollow filament, beveled needles, including type, dimensions, and applications
- 26. Diagnostic equipment and devices (e.g., magnetic resonance imaging devices, ultrasound elastographic devices, and intramuscular electromyographic devices)
- 27. Supportive devices and equipment (e.g., pillows, cushions, wedges)

Appendix C Task Force Members

Joe Donnelly, PT, DHS, OCS

Sean Flannagan, PT, DPT, Cert. SMT, Cert. DN

Michelle Layton, DPT, OCS, MTC, CMTPT, FAAOMPT, CCTT

Keri Maywhort, PT, DPT

JJ Thomas, MPT, CMTPT

Sumesh Thomas, PT, DPT

Edo Zylstra, PT, DPT, MS, OCS, IMSp

Appendix D

Physical Therapy Tasks Required for the Competent Performance of Dry Needling

ID#	Tasks
PATIENT/CLIENT ASSESSMENT	
Information Gathering & Synthesis	
	Interview patients/clients, caregivers, and family to obtain patient/client history and current information (e.g., medical, surgical, medications, social, cultural, economic) to...
1.	...establish prior and current level of function
2.	...establish general health status (e.g., fatigue, fever, malaise, unexplained weight change)
3.	...identify risk factors and needs for preventative measures
4.	...identify patient/client's, family/caregiver's goals
5.	...determine if patient/client is appropriate for PT
6.	...identify prior experience with and tolerance for dry needling (e.g., needle phobia, response to treatment, ability to comply with treatment requirements)
7.	...identify contraindications and precautions related to dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
8.	Review medical records (e.g., lab values, diagnostic tests, specialty reports, narrative, consults)
9.	Gather information/discuss client/patient's current health status with interprofessional/interdisciplinary team members (e.g., teacher, physician, rehabilitation member)
Systems Review	
	Perform screen of the...
10.	...patient/client's current affect, cognition, communication, and learning style (e.g., ability to make needs known, consciousness, orientation, expected emotional/behavioral responses, learning preferences)
11.	...patient/client's quality of speech, hearing, vision (e.g., dysarthria, pitch/tone, use corrective lenses, use of hearing aids)
12.	...vestibular system (e.g., dizziness, vertigo)
13.	...gastrointestinal system (e.g., difficulty swallowing, heartburn, indigestion, change in appetite/diet)
14.	...genitourinary system (e.g., frequency, volume, urgency, incontinent episodes)
15.	...genital reproductive system (e.g., sexual and/or menstrual dysfunction)
16.	...cardiovascular/pulmonary system (e.g., blood pressure, heart rate)
17.	...integumentary system (e.g., presence of scar formation, skin integrity, edema)
18.	...musculoskeletal system (e.g., gross symmetry, strength, weight, height, range of motion)
19.	...neuromuscular system (e.g., gross coordinated movements, motor function, locomotion)
Tests & Measures	
Cardiovascular and Pulmonary	
	Select and perform tests and measures of...
20.	...cardiovascular function (e.g., blood pressure, heart rate, heart sounds)
21.	...pulmonary function (e.g., respiratory rate, oxygen saturation, breathing patterns, breath sounds, chest excursion)
22.	...peripheral circulation (e.g., peripheral pulses, capillary refill, blood pressure in upper versus lower extremities)
23.	...physiological responses to position change (e.g., orthostatic hypotension, skin color, blood pressure, heart rate)
Anthropomorphic	
24.	Quantify edema (e.g., palpation, volume test, circumference)
Arousal, Attention, & Cognition	
	Select and perform tests and measures of...

ID#	Tasks
25.	...attention and cognition (e.g., ability to process commands)
26.	...patient's/client's ability to communicate (e.g., expressive and receptive skills, following instructions)
27.	...arousal and orientation to time, person, place, and situation
28.	...recall (including memory and retention)
<i>Nerve Integrity</i>	
	Select and perform tests and measures of...
29.	...neural provocation (e.g., tapping, tension/stretch)
30.	...cranial nerve integrity (e.g., facial asymmetry, oculomotor function, hearing)
31.	...peripheral nerve integrity (e.g. sensation, strength)
32.	...spinal nerve integrity (e.g., dermatome, myotome)
<i>Ergonomics and Body Mechanics</i>	
	Select and perform tests and measures of...
33.	...postural alignment and position (static and dynamic)
<i>Functional Mobility, Balance, & Vestibular</i>	
	Select and perform tests and measures of...
34.	...balance (dynamic and static) with or without the use of specialized equipment
35.	...gait and locomotion (e.g., ambulation, wheelchair mobility) with or without the use of specialized equipment
36.	...mobility during functional activities and transitional movements (e.g., transfers, bed mobility)
<i>Integumentary Integrity</i>	
37.	Assess skin characteristics (e.g., blistering, continuity of skin color, dermatitis, hair growth, mobility, nail growth, sensation, temperature, texture, and turgor)
38.	Assess scar tissue characteristics (e.g., banding, pliability, sensation, and texture)
<i>Joint Integrity & Range of Motion</i>	
	Select and perform tests and measures of...
39.	...spinal and peripheral joint stability (e.g., ligamentous integrity, joint structure)
40.	...spinal and peripheral joint mobility (e.g., glide, end feel)
41.	...range of motion (e.g., functional and physiological)
42.	...active and passive joint range of motion (e.g., goniometry)
43.	...flexibility (e.g., muscle length, soft tissue extensibility)
<i>Muscle Performance & Motor Function</i>	
	Select and perform tests and measures of...
44.	...muscle strength, power, and endurance (e.g., manual muscle test, isokinetic testing, dynamic testing)
45.	...muscle tone (e.g., hypertonicity, hypotonicity, dystonia)
46.	...patient's need for assistance (e.g. during transfers, in the application of devices)
<i>Reflex Integrity</i>	
	Select and perform tests and measures of...
47.	...deep tendon/muscle stretch reflexes (e.g., quadriceps, biceps)
48.	...superficial reflexes and reactions (e.g., cremasteric reflex, abdominal reflexes)
49.	...upper motor neuron integrity (e.g., Babinski reflex, Hoffman sign)
<i>Pain & Sensory Integrity</i>	
	Select and perform tests and measures of...
50.	...pain (e.g., location, intensity, characteristics, frequency)
51.	...deep sensation (e.g., proprioception, kinesthesia, pressure)
52.	...superficial sensation (e.g., touch, temperature discrimination)

Evaluation & Diagnosis

ID#	Tasks
	Interpret each of the following types of data to determine the need for intervention or the response to intervention:
53.	Cardiovascular/pulmonary system
54.	Lymphatic system
55.	Neuromuscular system
56.	Vestibular system
57.	Musculoskeletal system
58.	Integumentary system
59.	Anthropomorphic
60.	Genitourinary
61.	Pain
62.	Imaging, lab values, medications
63.	Develop physical therapy diagnosis by integrating system and non-system data
Development of Prognosis, Plan of Care, & Goals	
64.	Establish PT prognosis based on information gathered during the examination process
65.	Develop plan of care based on data gathered during the examination process, incorporating information from the patient/client, caregiver, payers, family members, and other professionals
66.	Revise treatment intervention plan based on treatment outcomes, change in patient/client's health status, and ongoing evaluation
67.	Develop goals based on information gathered during the examination process, incorporating information from the patient/client, caregiver, payers, family members, and other professionals
68.	Select interventions based on information gathered during the examination process, incorporating information from the patient/client, caregiver, payers, family members, and other professionals
69.	Sequence dry needling with other procedural interventions and techniques (e.g., therapeutic exercises, neuromuscular reeducation, manual therapy, physical modalities) to augment therapeutic effects and minimize risk due to adverse outcomes and/or contraindications.
INTERVENTIONS	
Manual Therapy Techniques	
	Position the patient/client to...
70.	...expose the area(s) to be needed
71.	...reduce the risk of harm to the patient/client and/or therapist
72.	Educate the patient/client on the impact of movement during treatment
73.	Perform palpation techniques to identify the area(s) to be needed
74.	Apply needle handling techniques that ensure compliance with relevant and current professional standards (e.g., wash hands, wear gloves, minimize needle contamination)
75.	Apply draping materials (e.g., linens, towels) to minimize unnecessary exposure and respect patient privacy
76.	Perform dry needling techniques consistent with treatment plan (e.g., place, manipulate, and remove needles)
77.	Manage needle removal complications (e.g., stuck needle, bent needle)
78.	Monitor patient/client's emotional and physiological response to dry needling
79.	Facilitate hemostasis as necessary
80.	Dispose of medical waste (e.g., needles, gloves, swabs) in accordance with regulatory standards and local jurisdictional policies and procedures (e.g., sharps container)
81.	Discuss post-treatment expectations with the patient/client or family/caregiver
Non-procedural Interventions	
Communication	
82.	Discuss physical therapy evaluation, interventions, goals, prognosis, discharge planning, and plan of care with interprofessional/interdisciplinary team members (e.g., teacher, physician, rehabilitation member)

ID#	Tasks
83.	Discuss physical therapy evaluation, interventions, goals, prognosis, discharge planning, and plan of care with patient/client and caregivers
84.	Provide written and oral information to the patient/client and/or caregiver
Documentation	
85.	Document examination results
86.	Document evaluation to include diagnosis, goals, and prognosis
87.	Document intervention(s) and patient/client response(s) to intervention
88.	Document patient/client and caregiver education
89.	Document outcomes (e.g., discharge summary, reassessments)
90.	Document communication related to the patient/client's care (e.g. with the doctor, teacher, case manager)
91.	Assign billing codes for physical therapy diagnosis and treatment provided
92.	Document disclosure and consent (e.g., disclosure of medical information, consent for treatment)
93.	Document letter of medical necessity (e.g., wheelchair, assistive equipment, continued therapy)
Education	
94.	Educate patient/client about current condition and health status (e.g., treatment outcomes, plan of care, risk and benefit factors)
95.	Educate caregivers about patient/client's current condition and health status (e.g., treatment outcomes, plan of care, risk and benefit factors)
96.	Educate healthcare team about role of the physical therapist in patient/client management
97.	Educate patient/client and caregiver on lifestyle and behavioral changes to promote wellness (e.g., nutrition interventions, physical activity, tobacco cessation)
98.	Educate patient/client or family/caregiver about dry needling (e.g., purpose, technique, methods of action, benefits, tools and equipment)
99.	Educate patient/client or family/caregiver about potential adverse effects associated with dry needling (e.g., fainting, bruising, soreness, fatigue)
100.	Educate patient/client or family/caregiver about precautions and contraindications for dry needling (e.g., age, allergies/sensitivities, diseases/conditions, implants, areas of acute inflammation, acute systemic infections, medications)
Patient/client & Staff Safety	
Emergency Procedures	
101.	Implement emergency life support procedures
102.	Perform first aid
103.	Implement emergency response procedures to treat patient/client injuries sustained during dry needling (e.g., perforation of hollow organs, heavy bleeding, broken needles)
104.	Implement emergency response procedures to treat practitioner injuries sustained during dry needling (e.g., needle stick)
Environmental Safety	
105.	Perform regular equipment inspections (e.g., modalities, assistive devices)
106.	Prepare and maintain a safe and comfortable environment for performing dry needling (e.g., unobstructed walkways, areas for patient/client privacy)
107.	Perform regular equipment inspections (e.g., modalities, needle expiration, sharps containers)
108.	Stock dry needling supplies and equipment in safe proximity during treatment
Infection Control	
109.	Perform activities using appropriate infection control practices (e.g., universal precautions, hand hygiene, isolation, airborne precautions)
110.	Create and maintain an aseptic environment for patient/client interaction
111.	Implement infection control procedures to mitigate the effects of needle stick injuries
112.	Clean and disinfect blood and bodily fluids spills in accordance with regulatory standards and local jurisdictional policies and procedures
113.	Replace surfaces that cannot be cleaned

ID#	Tasks
Research & Evidence-Based Practice	
114.	Integrate current best evidence, clinical experience, and patient values in clinical practice (e.g., clinical prediction rules, patient preference)
Professional Responsibilities	
115.	Discuss ongoing patient care with the interprofessional/interdisciplinary team members
116.	Refer patient/client to specialists or other healthcare providers when necessary
117.	Disclose financial interest in recommended products or services to patient/client
118.	Provide notice and information about alternative care when the physical therapist terminates provider relationship with the patient/client
119.	Document transfer of patient/client care to another physical therapist (therapist of record)
120.	Determine own need for professional development (i.e., continued competence)
121.	Participate in learning and/or development activities to maintain the currency of knowledge, skills, and abilities
122.	Practice within the jurisdiction regulations and professional standards.
123.	Determine own ability to perform dry needling safely and effectively

Appendix E

Tasks NOT Related to Competency in Dry Needling

ID#	Tasks
PATIENT/CLIENT ASSESSMENT	
Tests & Measures	
Cardiovascular and Pulmonary	
	Select and perform tests and measures of...
1.	...perfusion and gas exchange (e.g., airway protection, pulse oximetry)
2.	...critical limb ischemia (e.g., skin perfusion pressure, pulse volume recordings)
3.	...aerobic capacity under maximal and submaximal conditions (e.g., gait speed, treadmill testing, cadence, numbers of stairs climbed, metabolic equivalents)
Anthropomorphic	
	Select and perform tests and measures of...
4.	...body composition (e.g., percent body fat, lean muscle mass, BMI, hip-to-waist ratio)
5.	...body dimensions (e.g., height, weight, girth, limb length, head circumference/shape)
Muscle Performance	
	Select and perform tests and measures of...
6.	...electrophysiological function using surface electrodes (e.g., surface EMG)
7.	...electrophysiological function using needle insertion (e.g., nerve conduction)
8.	...muscle integrity (e.g., ultrasound imaging)
Environmental & Community Integration/Reintegration (Home, Work, Job, School, Play, & Leisure)	
9.	Assess activities of daily living (ADL) (e.g., bed mobility, transfers, household mobility, dressing, self-care)
10.	Assess instrumental activities of daily living (IADL) (e.g., household chores, hobbies, money management)
11.	Assess ability to perform skills needed for integration or reintegration into the community, work, or school
12.	Assess barriers (e.g., social, economic, physical, environmental, work conditions and activities) to community, work, or school integration/reintegration
13.	Assess ability to participate in activities with or without the use of devices or equipment
Ergonomics and Body Mechanics	
14.	Select and perform tests of safety in work environments
	Select and perform tests and measures of...
15.	...specific work conditions or activities
16.	...tools, devices, equipment, and workstations related to work actions, tasks, or activities
17.	...ergonomics and body mechanics during self-care, home, management, work, community, or leisure actions, tasks, or activities (e.g., how patient moves, whether patient aggravates the injury)
Functional Mobility, Balance, & Vestibular	
	Select and perform tests and measures of...
18.	...vestibular function (e.g., peripheral dysfunction, central dysfunction)
Integumentary Integrity	
19.	Assess activities, positioning, and postures that may produce or relieve trauma to the skin
20.	Assess devices and equipment that may produce or relieve trauma to the skin

ID#	Tasks
21.	Assess wound characteristics (e.g., tissue involvement, depth, tunneling, burn degree)
Muscle Performance & Motor Function	
22.	Select and perform tests and measures of...
23.	...dexterity, coordination, and agility (e.g., rapid alternating movement, finger to nose)
24.	...ability to initiate, modify and control movement patterns and postures (e.g., catching a ball, gait)
25.	...ability to change movement performance with practice (e.g., motor learning)
Neuromotor Development & Sensory Integration	
26.	Select and perform tests and measures of...
27.	...acquisition and evolution of motor skills
28.	...sensorimotor integration
29.	...developmental reflexes and reactions (e.g., asymmetrical tonic neck reflex, righting reactions)
Evaluation & Diagnosis	
	Interpret each of the following types of data to determine the need for intervention or the response to intervention:
30.	assistive and adaptive device
31.	environmental, home, and work/job/school/play barriers
32.	ergonomics and body mechanics
33.	gait, locomotion, and balance
34.	orthotic, protective, and supportive device
35.	prosthetic requirements
36.	ADLs and home management
37.	Evaluate patient/client's ability to assume or resume work/job/school/play, community, and leisure activities
Development of Prognosis, Plan of Care, & Goals	
INTERVENTIONS	
Procedural Interventions	
Therapeutic Exercise/Therapeutic Activities	
38.	Train in aerobic capacity/endurance conditioning
39.	Train in strength, power, and endurance exercises
40.	Train in balance, coordination, and agility activities
41.	Train in body mechanics and postural stabilization techniques
42.	Perform flexibility techniques
43.	Train in flexibility techniques
44.	Train in neuromotor techniques (e.g., movement pattern training, neuromuscular education or reeducation)
45.	Perform desensitization techniques (e.g., brushing, tapping, uses of textures)
46.	Train in desensitization techniques (e.g., brushing, tapping, uses of textures)
47.	Perform mechanical repositioning for vestibular dysfunction
48.	Train in habituation/adaptation exercises for vestibular dysfunction (e.g., vestibuloocular reflex, position changes)
49.	Train in relaxation techniques
50.	Train in genitourinary management (e.g., pelvic floor exercises, bladder strategies)
51.	Train in gastrointestinal management (e.g., bowel strategies, positioning to avoid reflux)

ID#	Tasks
<i>Pulmonary Interventions</i>	
52.	Administer prescribed oxygen during interventions
53.	Perform manual/mechanical airway clearance techniques (e.g., assistive cough, percussion, vibration, shaking)
54.	Train in manual/mechanical airway clearance techniques (e.g., assistive devices, assistive cough, incentive spirometer, flutter valve, percussion/postural drainage)
55.	Perform techniques to maximize ventilation and perfusion (e.g., assistive cough, positioning)
56.	Train in breathing strategies (e.g., active cycle breathing, autogenic drainage, paced breathing, pursed lip breathing) and techniques to maximize ventilation and perfusion (e.g., assistive cough, positioning, pursed-lip breathing)
<i>Functional Training</i>	
57.	Recommend barrier accommodations or modifications (e.g., ramps, grab bars, raised toilet, environmental control units)
58.	Train in the use of barrier accommodations or modifications (e.g., ramps, grab bars, raised toilet, environmental control units)
59.	Train in Activities of Daily Living (ADL) (e.g., bed mobility, transfers, household mobility, dressing, self-care)
60.	Instruct in community and leisure integration or reintegration (e.g., work/school/play)
61.	Train in Instrumental Activities of Daily Living (IADL) (e.g., household chores, hobbies, money management)
62.	Train in mobility techniques (e.g., crawling, walking, running)
63.	Train in fall prevention and fall recovery strategies
64.	Train in behavior modification and cognitive strategies
<i>Manual Therapy Techniques</i>	
65.	Perform manual lymphatic drainage
66.	Perform spinal and peripheral manual traction
67.	Perform soft tissue mobilization (e.g., connective tissue massage, therapeutic massage)
68.	Perform peripheral mobilization /manipulation (thrust/non-thrust)
69.	Perform spinal mobilization (non-thrust)
70.	Perform cervical spinal manipulation (thrust)
71.	Perform thoracic and lumbar spinal manipulation (thrust)
<i>Devices & Equipment</i>	
	Apply, adjust, and/or fabricate...
72.	...adaptive devices (e.g., utensils, seating and positioning devices, steering wheel devices)
73.	...protective devices (e.g., braces, cushions, helmets, protective taping)
74.	...supportive devices (e.g., compression garments, corsets, elastic wraps, neck collars, serial casts)
75.	...orthotic devices (e.g., braces, casts, shoe inserts, splints)
	Apply and/or adjust...
76.	...assistive devices (e.g., canes, crutches, walkers, wheelchairs, tilt tables, standing frames)
77.	...prosthetic devices (e.g., lower extremity and upper-extremity)
78.	...mechanical neuromuscular reeducation devices (e.g., weighted vests, therapeutic suits, body weight supported treadmill, proprioceptive taping)
	Train in use of...
79.	...adaptive devices (e.g., utensils, seating and positioning devices, steering wheel devices)
80.	...assistive devices (e.g., canes, crutches, walkers, wheelchairs, tilt tables, standing frames)
81.	...orthotic devices (e.g., braces, casts, shoe inserts, splints)

ID#	Tasks
82.	...prosthetic devices (e.g., lower extremity and upper-extremity)
83.	...protective devices (e.g., braces, cushions, helmets, protective taping)
84.	...supportive devices (e.g., compression garments, corsets, elastic wraps, neck collars, serial casts)
85.	...mechanical neuromuscular re-education devices (e.g., weighted vests, therapeutic suits, body weight supported treadmill, proprioceptive taping)
Integumentary Repair	
86.	Perform debridement (e.g., nonselective, enzymatic or autolytic, or sharp)
87.	Apply topical agents (e.g., cleansers, creams, moisturizers, ointments, sealants) and dressings (e.g., hydrogels, negative pressure wound therapy, wound coverings)
88.	Recommend topical agents (e.g., pharmacological to physician, over-the-counter to patient) and dressings (e.g., hydrogels, negative pressure wound therapy, wound coverings)
Therapeutic Modalities	
89.	Perform biofeedback therapy (e.g., relaxation techniques, muscle reeducation, EMG)
90.	Perform iontophoresis
91.	Perform phonophoresis
92.	Perform electrical stimulation therapy (e.g., electrical muscle stimulation (EMS), TENS, functional electrical stimulation (FES))
93.	Perform cryotherapy procedures (e.g., cold pack, ice massage, vapocoolant spray)
94.	Train in cryotherapy procedures
95.	Perform hydrotherapy procedures using contrast baths/pools
96.	Train in hydrotherapy procedures using contrast baths/pools
97.	Perform ultrasound procedures
98.	Perform hot pack thermotherapy procedures
99.	Train in hot pack thermotherapy procedures
100.	Perform paraffin bath thermotherapy procedures
Mechanical Modalities	
101.	Apply intermittent pneumatic compression
102.	Apply continuous passive motion (CPM) devices
103.	Train in continuous passive motion (CPM) devices
104.	Apply mechanical spinal traction
105.	Train in mechanical spinal traction
Documentation	
106.	Document intervention/plan of care for specialized services and settings (e.g., individual education plan, individual family service plan, vocational transition plan)
Education	
107.	Educate community groups on lifestyle and behavioral changes to promote wellness (e.g., nutrition interventions, physical activity, tobacco cessation)
108.	Participate in the development of curriculum for the clinical education of students
Patient/client & Staff Safety	
Emergency Procedures	
109.	Implement disaster response procedures
Environmental Safety	
110.	Perform risk assessment of the physical environment (e.g., barrier-free environment, outlets, windows, floors, lighting)

ID#	Tasks
<i>Infection Control</i>	
<i>Research & Evidence-Based Practice</i>	
111.	Search the literature for current best evidence
112.	Evaluate the quality of published data
113.	Participate in research activities
114.	Compare intervention outcomes with published data
<i>Professional Responsibilities</i>	
115.	Supervise physical therapist assistant(s) and support personnel (licensed/unlicensed)
116.	Assign tasks to other personnel (licensed/unlicensed) to assist with patient/client care
117.	Report health care providers that are suspected to not perform their professional responsibilities with reasonable skill and safety to the appropriate authorities
118.	Report suspected cases of abuse involving children or vulnerable adults to the appropriate authority
119.	Report suspected illegal or unethical acts performed by health care professionals to the relevant authority
120.	Advocate for public access to physical therapy and other healthcare services
121.	Read and evaluate the quality of professional journals, magazines, and publications to maintain currency of knowledge
122.	Participate in professional organizations
123.	Perform community based screenings (e.g., posture, musculoskeletal, flexibility, sports-specific)

Appendix F

Knowledge Requirements Related to Competency in Dry Needling

ID#	Knowledge
CARDIOVASCULAR/PULMONARY & LYMPHATIC SYSTEMS	
<i>Physical Therapy Examination</i>	
1.	Cardiovascular/pulmonary systems tests/measures, including outcome measures, and their applications according to current best evidence
2.	Anatomy and physiology of the cardiovascular/pulmonary systems as related to tests/measures
3.	Movement analysis as related to the cardiovascular/pulmonary systems (e.g., rib cage excursion)
<i>Foundations for Evaluation, Differential Diagnosis, & Prognosis</i>	
4.	Cardiovascular/pulmonary systems diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
5.	Nonpharmacological medical management of the cardiovascular/pulmonary systems (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
6.	Pharmacological management of the cardiovascular/pulmonary systems
7.	Differential diagnoses related to diseases/conditions of the cardiovascular/pulmonary systems
8.	Lymphatic system diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
9.	Nonpharmacological medical management of the lymphatic system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
10.	Differential diagnoses related to diseases/conditions of the lymphatic system
<i>Interventions</i>	
11.	Anatomy and physiology of the cardiovascular/pulmonary systems as related to physical therapy interventions, daily activities, and environmental factors
12.	Secondary effects or complications from physical therapy and medical interventions on the cardiovascular/pulmonary systems
13.	Secondary effects or complications on the cardiovascular/pulmonary systems from physical therapy and medical interventions used on other systems
14.	Anatomy and physiology of the lymphatic system as related to physical therapy interventions, daily activities, and environmental factors
15.	Secondary effects or complications from physical therapy and medical interventions on the lymphatic system
16.	Secondary effects or complications on the lymphatic system from physical therapy and medical interventions used on other systems
MUSCULOSKELETAL SYSTEM	
<i>Physical Therapy Examination</i>	
17.	Musculoskeletal system tests/measures, including outcome measures, and their applications according to current best evidence
18.	Anatomy and physiology of the musculoskeletal system as related to tests/measures
19.	Movement analysis as related to the musculoskeletal system
20.	Joint biomechanics and their applications
<i>Foundations for Evaluation, Differential Diagnosis, & Prognosis</i>	
21.	Muscular and skeletal diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
22.	Nonpharmacological medical management of the musculoskeletal system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
23.	Pharmacological management of the musculoskeletal system
24.	Differential diagnoses related to diseases/conditions of the muscular and skeletal systems
25.	Connective tissue diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis

ID#	Knowledge
26.	Differential diagnoses related to diseases/conditions of the connective tissue
27.	Musculoskeletal system physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
28.	Anatomy and physiology of the musculoskeletal system as related to physical therapy interventions, daily activities, and environmental factors
29.	Secondary effects or complications from physical therapy and medical interventions on the musculoskeletal system
30.	Secondary effects or complications on the musculoskeletal system from physical therapy and medical interventions used on other systems

NEUROMUSCULAR & NERVOUS SYSTEMS

Physical Therapy Examination

31.	Neuromuscular/nervous systems tests/measures, including outcome measures, and their applications according to current best evidence
32.	Anatomy and physiology of the neuromuscular/nervous systems as related to tests/measures
33.	Movement analysis as related to the neuromuscular/nervous systems

Foundations for Evaluation, Differential Diagnosis, & Prognosis

34.	Neuromuscular/nervous system (CNS, PNS, ANS) diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
35.	Nonpharmacological medical management of the neuromuscular/nervous systems (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
36.	Pharmacological management of the neuromuscular/nervous systems
37.	Differential diagnoses related to diseases/conditions of the neuromuscular/nervous system (CNS, PNS, ANS)

Interventions

38.	Neuromuscular/nervous systems physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
39.	Anatomy and physiology of the neuromuscular/nervous systems as related to physical therapy interventions, daily activities, and environmental factors
40.	Secondary effects or complications from physical therapy and medical interventions on the neuromuscular/nervous systems
41.	Secondary effects or complications on the neuromuscular/nervous systems from physical therapy and medical interventions used on other systems
42.	Motor control as related to neuromuscular/nervous systems physical therapy interventions
43.	Motor learning as related to neuromuscular/nervous systems physical therapy interventions

INTEGUMENTARY SYSTEM

Physical Therapy Examination

44.	Integumentary system tests/measures, including outcome measures, and their applications according to current best evidence
45.	Anatomy and physiology of the integumentary system as related to tests/measures
46.	Movement analysis as related to the integumentary system (e.g., friction, shear, pressure, and scar mobility)

Foundations for Evaluation, Differential Diagnosis, & Prognosis

47.	Integumentary system diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
48.	Nonpharmacological medical management of the integumentary system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
49.	Pharmacological management of the integumentary system
50.	Differential diagnoses related to diseases/conditions of the integumentary system

ID# Knowledge

Interventions

51. Anatomy and physiology of the integumentary system as related to physical therapy interventions, daily activities, and environmental factors
 52. Secondary effects or complications from physical therapy and medical interventions on the integumentary system
 53. Secondary effects or complications on the integumentary system from physical therapy and medical interventions used on other systems
-

METABOLIC & ENDOCRINE SYSTEMS
Foundations for Evaluation, Differential Diagnosis, & Prognosis

54. Metabolic and endocrine systems diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
 55. Nonpharmacological medical management of the metabolic and endocrine systems (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
 56. Pharmacological management of the metabolic and endocrine systems
 57. Differential diagnoses related to diseases/conditions of the metabolic and endocrine systems
-

Interventions

58. Anatomy and physiology of the metabolic and endocrine systems as related to physical therapy interventions, daily activities, and environmental factors
 59. Secondary effects or complications from physical therapy and medical interventions on the metabolic and endocrine systems
 60. Secondary effects or complications on the metabolic and endocrine systems from physical therapy and medical interventions used on other systems
-

GASTROINTESTINAL SYSTEM
Foundations for Evaluation, Differential Diagnosis, & Prognosis

61. Gastrointestinal system diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
 62. Nonpharmacological medical management of the gastrointestinal system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
 63. Differential diagnoses related to diseases/conditions of the gastrointestinal system
-

Interventions

64. Anatomy and physiology of the gastrointestinal system as related to physical therapy interventions, daily activities, and environmental factors
 65. Secondary effects or complications from physical therapy and medical interventions on the gastrointestinal system
 66. Secondary effects or complications on the gastrointestinal system from physical therapy and medical interventions used on other systems
-

GENITOURINARY SYSTEM
Physical Therapy Examination

67. Genitourinary system tests/measures, including outcome measures, and their applications according to current best evidence
 68. Anatomy and physiology of the genitourinary system as related to tests/measures
 69. Physiological response of the genitourinary system to various types of tests/measures
-

Foundations for Evaluation, Differential Diagnosis, & Prognosis

70. Genitourinary system diseases/conditions and their pathophysiology to establish and carry out a plan of care, including prognosis
 71. Nonpharmacological medical management of the genitourinary system (e.g., diagnostic imaging, laboratory test values, other medical tests, surgical procedures)
-

ID#	Knowledge
72.	Pharmacological management of the genitourinary system
73.	Differential diagnoses related to diseases/conditions of the genitourinary system

Interventions

74.	Genitourinary system physical therapy interventions and their applications for rehabilitation and health promotion according to current best evidence (e.g., bladder programs, biofeedback, pelvic floor retraining)
75.	Anatomy and physiology of the genitourinary system as related to physical therapy interventions, daily activities, and environmental factors
76.	Secondary effects or complications from physical therapy and medical interventions on the genitourinary system
77.	Secondary effects or complications on the genitourinary system from physical therapy and medical interventions used on other systems

SYSTEM INTERACTIONS

Foundations for Evaluation, Differential Diagnosis, & Prognosis

78.	Diseases/conditions where the primary impact is on more than one system to establish and carry out a plan of care, including prognosis
79.	Nonpharmacological medical management of multiple systems (e.g., diagnostic imaging and other medical tests, surgical procedures)
80.	Pharmacological management of multiple systems, including polypharmacy
81.	Differential diagnoses related to diseases/conditions where the primary impact is on more than one system
82.	Impact of comorbidities/coexisting conditions on patient/client management (e.g., diabetes and hypertension, obesity and arthritis, hip fracture and dementia)
83.	Psychological and psychiatric conditions that impact patient/client management (e.g., depression, schizophrenia)

THERAPEUTIC MODALITIES

84.	Thermal modalities
85.	Electrotherapy modalities, excluding iontophoresis
86.	Pneumatic compression modalities

SAFETY & PROTECTION

87.	Factors influencing safety and injury prevention
88.	Patient positioning techniques (e.g., side-lying, prone, supine) and their effect on anatomy and physiology
89.	Draping techniques
90.	Infection control procedures (e.g., standard/universal precautions, isolation techniques, sterile technique)
91.	Environment cleaning and sanitization procedures
92.	Equipment cleaning and sanitization procedures (not including needles)
93.	Local laws and regulations regarding the disposal of needles and medical waste
94.	Regulations and standards regarding infection prevention (e.g., Occupational Safety and Health Administration Standards)
95.	Medical waste disposal equipment
96.	Signs/symptoms of physical, sexual, and psychological abuse and neglect

PROFESSIONAL RESPONSIBILITIES

97.	Standards of documentation
98.	Patient/client rights (e.g., ADA, IDEA, HIPAA)
99.	Human resource legal issues (e.g., OSHA, sexual harassment)

ID#	Knowledge
100.	Roles and responsibilities of physical therapist assistants in relation to physical therapists and other health-care professionals
101.	Roles and responsibilities of other health-care professionals and support staff
DRY NEEDLING-SPECIFIC KNOWLEDGE	
<i>Anatomy and Physiology</i>	
102.	Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks
<i>Emergency Preparedness and Response</i>	
103.	Emergency preparedness (e.g., CPR, first aid, disaster response)
104.	Emergency preparedness and/or response procedures related to secondary physiological effects or complications associated with dry needling (e.g., shock, vasovagal)
105.	Emergency preparedness and/or response procedures related to secondary emotional effects or complications associated with dry needling (e.g., claustrophobia, anxiety, agitation)
106.	Standards for needle handling (e.g., hand hygiene, application of single-use needles)
<i>Safety & Protection</i>	
107.	Personal protection procedures and techniques as related to dry needling (e.g., positioning self to access treatment area, use of personal protective equipment)
108.	Theoretical basis for dry needling (e.g., applications for rehabilitation, health promotion, fitness and wellness, performance)
109.	Theoretical basis for combining dry needling with other interventions
110.	Secondary effects or complications associated with dry needling on other systems (e.g., gastrointestinal, cardiovascular/pulmonary, musculoskeletal)
111.	Theoretical basis of pain sciences, including anatomy, physiology, pathophysiology, and relation to body structures and function
112.	Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions)
113.	Palpation techniques as related to dry needling
114.	Needle insertion techniques
115.	Needle manipulation techniques
116.	Physiological responses to dry needling
117.	Solid filament needles (e.g., physical characteristics)

Appendix G

Knowledge Requirements NOT Related to Competency in Dry Needling

ID#	Knowledge Requirement
CARDIOVASCULAR/PULMONARY & LYMPHATIC SYSTEMS	
Interventions	
1.	Cardiovascular/pulmonary systems physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
2.	Lymphatic system physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
MUSCULOSKELETAL SYSTEM	
Interventions	
3.	Physical therapy ultrasound imaging of the musculoskeletal system
INTEGUMENTARY SYSTEM	
Interventions	
4.	Integumentary system physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
METABOLIC & ENDOCRINE SYSTEMS	
Physical Therapy Examination	
5.	Metabolic and endocrine systems physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
GASTROINTESTINAL SYSTEM	
Interventions	
6.	Pharmacological management of the gastrointestinal system
7.	Gastrointestinal system physical therapy interventions and their applications for rehabilitation and health promotion according to current best evidence (e.g., positioning for reflux prevention, bowel programs)
EQUIPMENT & DEVICES	
Interventions	
8.	Assistive and adaptive devices
9.	Prosthetic devices
10.	Protective, supportive, and orthotic devices
THERAPEUTIC MODALITIES	
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
11.	Iontophoresis
12.	Phonophoresis
13.	Ultrasound modalities, excluding phonophoresis
14.	Mechanical modalities (e.g., mechanical motion devices, traction devices)
15.	Biofeedback
16.	Electromagnetic radiation (e.g., diathermy)
SAFETY & PROTECTION	
Foundations for Evaluation, Differential Diagnosis, & Prognosis	
17.	Function, implications, and precautions related to intravenous lines, tubes, catheters, and monitoring devices

ID#	Knowledge Requirement
RESEARCH & EVIDENCE-BASED PRACTICE	
18.	Research design and interpretation (e.g., qualitative, quantitative, hierarchy of evidence)
19.	Data collection techniques (e.g., surveys, direct observation)
20.	Measurement science (e.g., reliability, validity)
21.	Statistics (e.g., t-test, chi-square, correlation coefficient, ANOVA, likelihood ratio)
Dry Needling-specific Knowledge	
	Emergency preparedness and response procedures related to secondary effects or complications from:
	...perforation of underlying organs (e.g., pneumothorax)
22.	...perforation of blood vessels and arteries (e.g., bleeding, bruising)
23.	...trauma to the skin (e.g., cellulitis)
24.	...trauma to nerves (e.g., neuropraxia, axonotmesis, neurotmesis)
25.	...skeletal punctures (e.g., broken/bent needle)
26.	Emergency preparedness and response procedures related to secondary psychological effects or complications (e.g., shock, claustrophobia, depression, drowsiness)
27.	Clean needle techniques (e.g., needle site disinfection, hand hygiene, application of single-use needles, needle reinsertion guidelines, grasping and positioning needles, needle re-sheathing)
28.	Equipment sterilization procedures
29.	Environment sterilization procedures
30.	Personal protection procedures and techniques (e.g., positioning to access treatment area, use of personal protective equipment)
31.	Federal laws and regulations regarding infection prevention (e.g., Occupational Safety and Health Administration Standards)
32.	Theoretical basis for dry needling interventions, including applications for rehabilitation, health promotion, and performance according to current best evidence
33.	Theoretical basis for combining dry needling with other manual techniques and modalities
34.	Theoretical basis for pain, including pathways, physiology, pathophysiology, and relation to movement impairment
35.	Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/conditions, implants, pregnancy, areas of acute inflammation, acute systemic infections, medications)
36.	Tissue palpation techniques, including pressure, duration, and hand placement
37.	Needle insertion techniques, including depth, direction, velocity, manipulation, and duration
38.	Targeted physiological responses to dry needling
39.	Targeted psychological responses to dry needling
40.	Solid filament needles, including type, dimensions, and applications
41.	Hollow filament, beveled needles, including type, dimensions, and applications
42.	Diagnostic equipment and devices (e.g., magnetic resonance imaging devices, ultrasound elastographic devices, and intramuscular electromyographic devices)
43.	Supportive devices and equipment (e.g., pillows, cushions, wedges)

Appendix H

Skills and Abilities Needed for the Competent Performance of Dry Needling

Skill/Ability	O*NET Definition
Communicating with patients	
1. Active Listening	Giving full attention to what other people are saying, taking time to understand the points being made, asking questions as appropriate, and not interrupting at inappropriate times.
2. Reading Comprehension	Understanding written sentences and paragraphs in work related documents.
3. Writing	Communicating effectively in writing as appropriate for the needs of the audience.
4. Speaking	Talking to others to convey information effectively.
5. Active Learning	Understanding the implications of new information for both current and future problem-solving and decision-making.
6. Critical Thinking	Using logic and reasoning to identify the strengths and weaknesses of alternative solutions, conclusions or approaches to problems.
Adapting behavior or treatment to accommodate patient's needs/preferences	
7. Coordination	Adjusting actions in relation to others' actions.
8. Social Perceptiveness	Being aware of others' reactions and understanding why they react as they do.
Reflecting on and evaluating own competence to perform dry needling	
9. Judgment and Decision Making	Considering the relative costs and benefits of potential actions to choose the most appropriate one.
Abiding by professional and ethical standards	
10. Judgment and Decision Making	Considering the relative costs and benefits of potential actions to choose the most appropriate one.
Handling and controlling needles and palpating tissues	
1. Arm-Hand Steadiness	The ability to keep your hand and arm steady while moving your arm or while holding your arm and hand in one position.
2. Finger Dexterity	The ability to make precisely coordinated movements of the fingers of one or both hands to grasp, manipulate, or assemble very small objects.
3. Gross Body Coordination	The ability to coordinate the movement of your arms, legs, and torso together when the whole body is in motion.
4. Gross Body Equilibrium	The ability to keep or regain your body balance or stay upright when in an unstable position.
5. Manual Dexterity	The ability to quickly move your hand, your hand together with your arm, or your two hands to grasp, manipulate, or assemble objects.
6. Speed of Limb Movement	The ability to quickly move the arms and legs.
7. Wrist-Finger Speed	The ability to make fast, simple, repeated movements of the fingers, hands, and wrists.



FSBPT Addendum to Report

Selection of HumRRO

HumRRO was selected from an RFP process from among five qualified vendors. All of the proposals were deemed acceptable but HumRRO's proposal had the best understanding of the needs of the licensing jurisdictions.

The Human Resources Research Organization (HumRRO) is a non-profit, applied research and consulting company with a rich, 64-year history of providing services related to the development, validation, and implementation of assessments for credentialing and employment selection purposes. HumRRO employs 80 professional staff members, many of whom have advanced training in measurement fields, including Industrial-Organizational (I-O) Psychology, Education, Psychometrics, and Statistics. HumRRO's staff includes nationally recognized experts in the field of I-O Psychology who have an established history of collaborating with private- and public-sector organizations to develop scientifically robust, legally-defensible high-stakes assessment processes and programs.

HumRRO has conducted hundreds of job analyses to develop test blueprints, performance assessments, job descriptions, and training curricula for professions, specialty areas within and across professions, and entire workforces within an organization. Although there are some fairly uniform best practices, HumRRO designs each method according to the purpose for which it is performed and the available data sources.

To maintain the highest quality, HumRRO uses a multi-level quality assurance process to ensure rigorous standards of technical performance. The first level involves the project staff. Everyone who is involved in a project has the responsibility of maintaining product quality. At the next level, project directors communicate a standard of quality to the project team and conduct quality checks at critical times in the development of each deliverable. This process includes checks for both technical quality and clarity. Our Quality Management Liaison, a senior researcher, consults with all project directors at project outset and periodically thereafter to identify and monitor opportunities to ensure high quality. Finally, before a product is delivered, it receives additional review by other team members for quality, appearance, and suitability to the prospective user, with final approval coming from the project director. As an additional quality measure, the Research Division Directors conduct periodic quality checks both during development and at project completion. These checks involve reviews of technical accuracy, substance, completeness, coherence, clarity, and usefulness.



November 13, 2012

Mr. Justin Elliott
Associate Director, State Government Affairs
American Physical Therapy Association
1111 Fairfax Street
Alexandria, VA 22314-1488

RE: Dry Needling Professional Liability Claims

Dear Mr. Elliott,

CNA has been the underwriting company for the APTA-endorsed physical therapy professional liability insurance plan, offered by Healthcare Providers Service Organization, since 1992, and is responsible for managing reported claims.

After reviewing the CNA claim database, which includes approximately 5,800 closed physical therapist claims, there were no trends relative to dry needling identified that would indicate this procedure presents a significant risk factor. The data indicates there are six closed claims arising from the practice of dry needling with a total indemnity paid for all claims of \$79,000.

At this time, CNA does not foresee the practice of dry needling by a licensed physical therapist as having any immediate claim or rate impact. As with any emerging modality, we plan to monitor the type and severity of injuries that may arise from dry needling, and reserve the right to make any appropriate underwriting adjustments that may be indicated at that time.

Please note that all findings stated herein are based solely upon CNA specific claim data. If I can be of any further assistance, please let me know.

Sincerely,

Michael Loughran
President, Healthcare

CC: Michael A. Scott/CNA HealthPro
Heather Ingledue/HPSO

May 25, 2016

Angela Shuman
Director, State Government Affairs
American Physical Therapy Association
1111 N. Fairfax Street
Alexandria, VA 22314

Dear Ms. Shuman:

RE: Physical Therapists performing dry needling

The Federation of State Boards of Physical Therapy (FSBPT or Federation) is an organization made up of the 53 physical therapy licensing jurisdictions within the United States. The mission of the FSBPT is to protect the public by providing service and leadership that promote safe and competent physical therapy practice. To support its mission of public protection, the Federation administers and maintains the Examination, Licensure, and Disciplinary Database (ELDD).

The main purpose of the Federation's ELDD is to serve as an alert mechanism for physical therapy licensing boards. If a physical therapist or physical therapist assistant has been disciplined in a jurisdiction, as soon as FSBPT is aware of the action, the ELDD automatically pushes an alert to all other jurisdictions in which the therapist holds a license. FSBPT regularly receives reports from many of our member jurisdictions regarding disciplinary actions taken. Some jurisdictions experience barriers to reporting disciplinary actions to the Federation. Thus, we cannot guarantee that every disciplinary action from all 53 jurisdictions taken against physical therapists and physical therapist assistants is contained in the ELDD. However, FSBPT also independently searches out public records and databases to maintain the most complete record of disciplinary actions against licensed PTs and PTAs possible.

You asked if FSBPT is aware of any disciplinary actions taken against physical therapists involved in the performance of dry needling. In 2015, one instance of disciplinary action was taken against a physical therapist regarding dry needling. Of the total 257 initial basis for disciplinary actions entered into the ELDD between January 1, 2014-December 31, 2014, two were for incidents involving dry needling performed by physical therapists. Neither of the two instances describes any harm to the patient, however the therapists were disciplined for failing to meet appropriate standards of patient care in the performance of dry needling. One additional record exists in the ELDD referencing dry needling. In 2013, an action was taken against a PT for performing dry needling without the appropriate training and failure to document the procedure. Prior to 2013, there are no disciplinary actions involving dry needling recorded in the ELDD. For the five year period (2010-2015) 0.2% of the 1,987 disciplinary actions reported in the ELDD pertained to issues with performance of dry needling.

Should you have any further question related to the ELDD or other regulatory issues regarding physical therapists, please do not hesitate to contact me.

Sincerely,


Leslie Adrian, PT, DPT, MPA
Director of Professional Standards
Federation of State Boards of Physical Therapy



Steven R. Goodman, MD
Board Certified in Physical Medicine
& Rehabilitation and Neurophysiology

Mark S. Gordon, MD
Board Certified in Physical Medicine
& Neurophysiology and in
Neurology

Vivian Moise, MD
Board Certified in Physical Medicine
& Neurophysiology and in
Neurology

Robert K. Schwartz, MD
Board Certified in Physical Medicine
& Neurophysiology

St. Luke's Rehabilitation Institute
715 S. Cowley, Suite 224
Spokane, WA 99202
phone: 509.473.6706
fax: 509.473.6704

October 1, 2014

Why Trigger Point Dry Needling is Not Acupuncture

Steven R. Goodman, M.D.

There is an effort underway by the National Center for Acupuncture Safety and Integrity and other various acupuncture entities to redefine the scope of practice for physical therapists to exclude the practice of trigger point dry needling. Those who are attempting to do so are claiming that dry needling and acupuncture are synonymous, and as such dry needling is outside the physical therapy scope of practice. It is simply not true that trigger point dry needling is indistinguishable from acupuncture.

I am a board certified physical medicine and rehabilitation physician and have sub-specialized in the treatment of chronic pain for over 25 years. Chronic pain is a national epidemic that not only creates immeasurable suffering, impairment, disability and addiction but also is a major contributor to health care expenditures. It is increasingly recognized in the medical community that the type of pain that dry needling treats, 'trigger point' or 'myofascial pain', is a highly prevalent source of under-diagnosed pain in patients seen not only by primary care providers but also by specialists like myself at chronic pain clinics. As such the epidemic of chronic pain that drains our health care systems will never be reversed until trigger point myofascial pain is recognized and treated early and properly.

I learned the Intramuscular Stimulation (IMS) model of trigger point dry needling in 1993 from the physician who developed it, C. C. Gunn, M.D., Clinical Assistant Professor at the University of Washington Pain Center. Dr. Gunn has been recognized internationally by the medical community and has been awarded the Order of Canada for his contributions to the understanding and treatment of chronic pain. Upon Dr. Gunn's recommendation I was appointed to the faculty at the University of Washington Pain Center where I taught the IMS dry needling to other physicians

from 2001-2003. Working with a physical therapist, I recently co-authored a chapter on the IMS form of dry needling in the 2013 published textbook 'Trigger Point Dry Needling: An Evidenced and Clinical-Based Approach'. The editors of this textbook were physical therapists and 23 out of 24 contributors to this textbook were either M.D.s or P.T.s. I have never studied acupuncture.

Numerous clinical trials have been published in the peer review medical literature over the past 30 years (see references below) demonstrating the safety and efficacy of dry needling for trigger point myofascial pain. These articles have been authored by M.D.s and/or P.T.s without any reference to acupuncture principles, points or treatment techniques. IMS trigger point dry needling is currently provided and taught by both medical doctors and physical therapists at both the University of Washington and the University of British Columbia, as well as at other medical institutions and clinics in Europe, the Middle East and South America.

The suggestion that dry needling is acupuncture is wrong. Acupuncture has a long and reputable history, originating in the orient and based on a system of 'energy flow' along what are called meridians throughout the body. Dry needling is a much more recent approach, about 40 years old, and based on an understanding of neuro-anatomy and neurophysiology. Proper practice of dry needling requires a neuro-musculoskeletal physical examination which forms the basis for treatment. Dr. Gunn's neuropathic-myofascial model of chronic pain is based on the widely recognized work of the eminent physiologist Walter Cannon, M.D. (1871-1945), who in addition to his research on denervation was the first investigator to research the 'fight or flight' response of the autonomic nervous system. IMS dry needling is very definitely grounded on western scientific neuroanatomic and neurophysiological principles and evidence.

While dry needling uses a similar monofilament needle as acupuncture, "why" the patient is sick, "what" to look for on physical examination and as such "where" and "how" to treat the patient are entirely different from acupuncture. To say that dry needling and acupuncture are the same because they use the same tool would be like saying that drawing a patient's blood to measure blood chemistries is the same as blood letting. Similarly it would be like saying that Mozart and Bluegrass are the same because they are both played on a violin. Ultrasound is used by a wide variety of health care practitioners including physical therapists for heating soft tissue, by ultrasonographers to visualize the viscera or musculoskeletal structures and by cardiologists to measure blood flow. Thus it is not the tool that defines the model and treatment results but how it is understood to be effective and applied. It is in all of these respects that dry needling shares little in common with acupuncture while much with physical therapy treatment of neuro-musculoskeletal pain.

In addition to treating many different types of pain, the American Academy of Medical Acupuncture lists *all of the following conditions as potentially benefiting from acupuncture: insomnia, anorexia, allergic sinusitis, persistent hiccups, dermatological conditions, diarrhea, severe hyperthermia and urinary incontinence, to name just a few.*

Indeed, in lists of over 40 medical conditions that can be treated with acupuncture 'trigger point' or 'myofascial pain' are not even mentioned once:

<http://www.medicalacupuncture.org/FAQ.aspx>

(<http://www.medicalacupuncture.org/ForPatients/GeneralInformation/HealthConditions.aspx>)

While I do not dispute the utility of acupuncture for any of these conditions, trigger point dry needling practitioners make no similar claims. Because dry needling is based on specific principles of anatomy and neurophysiology whose effects can be demonstrated using electrophysiological and electromyographic techniques, the condition for which it is useful is limited to exactly one: myofascial trigger point pain. *It does not even claim to treat ALL types of pain*, i.e. the pain caused by an acute injury like an ankle sprain or the pain of inflammation from arthritis. It has *one and only one* specific pathology that it targets: myofascial trigger point pain.

Over the course of my career I have worked closely with all of the various therapies available to treat persistent pain and I can state with confidence that the *only* health profession that can provide this service safely, properly and effectively to the largest number of patients who would benefit from it is physical therapy. Physical therapists have the proper education in the biomedical sciences, are already treating neuromusculoskeletal injuries and conditions associated with trigger point myofascial pain, and significantly, can provide these patients with the proper exercise and functional rehabilitation programs they also require. Indeed physical therapists are the ideal practitioners to provide dry needling to the truly enormous numbers of people who could benefit from it. I know they can learn to safely and effectively provide this treatment with proper training because they have been doing so for over 10 years in Canada and more recently in numerous U.S. states.

Having worked in an orthopedic surgery practice for many years I am familiar with the treatment algorithm-flow chart for patients with musculoskeletal pain: most of the patients that fail to respond to physical therapy do not typically then go to an acupuncturist; many of them go on to have surgery. If their problem is myofascial trigger point pain surgery will not help the patient, and so if physical therapists do not have the option of offering their patients dry needling many of these patients will go on to lives of chronic pain, opioid dependence, vocational impairment and disability.

Unfortunately to date acupuncture has not stemmed the tsunami of chronic pain and preventing physical therapists from dry needling certainly will not change that. Alternatively, allowing physical therapists to offer dry needling when indicated will I believe have a very positive effect on treatment of neuromusculoskeletal pain and actually NO effect on acupuncture practice. To state it again: patients who don't have the option of receiving trigger point dry needling from a physical therapist will NOT receive acupuncture, but often surgery. With a growing national epidemic of chronic pain one can only wonder why the acupuncture community is so intent on obstructing what should be recognized as a major step towards improving the treatment of patients with chronic pain.

Dry needling is a safe, effective, low cost and low tech treatment that can save large numbers of patients from chronic pain, unnecessary suffering, opioid dependence and disability. From reducing the need for prolonged physical therapy to avoiding unnecessary radiographic studies, lessening medication use and the need for surgery, over time the availability of dry needling will also provide substantial financial savings in the treatment of these conditions. With proper training physical therapists are increasingly offering dry needling as a therapeutic option to their patients, a development I wholeheartedly support.



Steven R. Goodman, M.D.
Spokane, Washington

REFERENCES

Annaswamy TM, De Luigi AJ, O'Neill BJ, Keole N, Berbrayer D. Emerging concepts in the treatment of myofascial pain: a review of medications, modalities, and needle-based interventions. *PM R*. 2011 Oct;3(10):940-61

Couto C, de Souza ICC, Torres ILS, Fregni F, Caumo W. Paraspinal stimulation combined with trigger point needling and needle rotation for the treatment of myofascial pain: a randomized sham-controlled clinical trial. *Clin J Pain* 2014 Mar 30 (3): 214-223

Furlan AD, van Tulder MW, Cherkin D, Tsukayama H, Lao L, Koes BW, Berman BM. Acupuncture and dry-needling for low back pain. *Cochrane Database of Systematic Reviews* 2005, Issue 1, Art. No.: CD001351. DOI: 10.1002/14651858.CD001351.pub2

Ga H, Koh HJ, Choi JH, Kim CH. Intramuscular and nerve root stimulation vs lidocaine injection of trigger points in myofascial pain syndrome. *J Rehabil Med* 2007 39: 374-378

Ga H, Choi JH, Park CH, Yoon HJ. Dry needling of trigger points with and without paraspinal needling in myofascial pain syndromes in elderly patients. *J Altern Complement Med* 2007 13: 617-624

Goodman SR, Choma, C. Intramuscular Stimulation. *Trigger Point Dry Needling: An Evidenced and Clinical-Based Approach*. Dommerholt & Fernandez-de-las-Penas, eds. Churchill Livingstone Elsevier, 2013 Ch.14

Gunn CC. The Gunn approach to the treatment of chronic pain-Intramuscular stimulation for myofascial pain of radiculopathic origin. London: Churchill Livingstone. 2nd ed. 1996

Gunn CC, Milbrandt WE, Little AS, Mason KE. Dry needling of muscle motor points for chronic low-back pain: A randomized clinical trial with long-term follow-up. *Spine* 1980 5: 279-291

Kietrys DM, Palombaro KM, Azzaretto A, Hubler R, Schaller B, Schlusser JM, Tucker M. Effectiveness of Dry Needling for Upper-Quarter Myofascial Pain: A systematic Review and Meta-analysis. *Jrnl Ortho Sports Phys Therapy* 2013 43(9):620-634
Mayoral de Moral, O. Dry needling treatments for myofascial trigger points. *J Musculoskel Pain* 2010 18(4):411-416

Kim HK, Kim SH, Kim MJ, Lim JA, Kang PS, Woo NS, Lee YC. Intramuscular stimulation in chronic pain patients. *J Korean Pain Soc* 2002 15:139-145.

Kim JK, Lim KJ, Kim C, Kim HS. Intramuscular stimulation therapy in failed back surgery syndrome patients. *J Korean Pain Soc* 2003 16:60-67.

Kim TH, Lee CR, Choi TY, Lee MS. Intramuscular stimulation therapy for healthcare: a systematic review of randomized controlled trials. *Acupunct Med* 2012 30:286-90

EDITORIAL

On the Impossibility of Trigger Point–Acupoint Equivalence: A Commentary on Peter Dorsher’s Analysis

STEPHEN BIRCH, Ph.D., Lic.Ac.(U.S.), M.B.Ac.C.(U.K.)

Six (6) years after Melzack, Stillwell, and Fox¹ published their landmark article claiming to have demonstrated that acupuncture points and trigger points correlate and are essentially the same thing, the parents of trigger point therapy, Travell and Simons,² wrote the first text on trigger points. They analyzed the Melzack et al. study and concluded: “[A]cupuncture points and trigger points are derived from vastly different concepts. The fact that a number of pain points overlap does not change that basic difference. The two terms should not be used interchangeably” (page 21).

I would like to thank Dr. Dorsher for his interesting paper (pp. 353–359). He has done a good job documenting that the needling of trigger points may be useful in the treatment of pain. He has also shown the superficial similarities of the needling of trigger points and acupuncture points, but he has failed to provide any convincing evidence that acupuncture points are correlated with trigger points. I do not deny that trigger point needling is an effective therapy for pain (though I suspect its clinical trial evidence is worse or at least no better than that for acupuncture). Nor do I deny that since the 1970s, a new form of acupuncture has developed and spread that involves the needling of trigger points. The field of acupuncture is a large field with a complicated history. Many forms of acupuncture have developed over the centuries in multiple countries, under the pressure of many different social and cultural factors as part of how it has been acculturated everywhere.³ Trigger point acupuncture is now an established part of this field.⁴ But what social forces have pushed medical specialists such as Dr. Dorsher to want to lay claim to be doing acupuncture rather than trigger point therapy? I suspect that there are complex social issues that create this desire among medical practitioners. I leave it for others more suitably qualified to explore these sociologic, anthropologic considerations. Instead I raise the related question of why it was deemed important in the 1970s to find an association between acupuncture points and trigger points. Surely acupuncture and trigger point therapy could have simply coexisted as different therapies? However, in

the 1970s if the medical community was to start using acupuncture, it was important to establish a clear link between known anatomically based medical knowledge and the less well known and not accepted East Asian origin acupuncture knowledge. The principal reason for the 1977 Melzack et al.¹ study was to show that one does not need to talk about the less well known and less acceptable East Asian origin ideas about acupuncture because in showing a “correlation” to the known biomedical entities called “trigger points,” one can thus replace the older unacceptable ideas with the more acceptable modern ideas.^{1,5} This allows physicians to address political restraints on the practice of acupuncture and at the same time provide plausible-sounding mechanistic explanations of acupuncture’s effects that are acceptable within mainstream medical institutions.

In other words, the importance of the study lies in its attempts at replacing traditional ideas and explanations of the nature of acupuncture points and mechanisms by which they work with modern anatomico-physiologically acceptable explanations. Unfortunately, Dorsher’s analysis has missed this point and thus the methods I used in 2003⁵ to examine the 1977 study in light of this issue. Because he has misunderstood this, he has both missed key requirements in an analysis of the claims of the 1977 study and has distorted or misunderstood some of my analyses.

The principal and unquestionable issue in any claim to have shown an equivalence of acupuncture points and trigger points is that they must necessarily show the same characteristics of each other. It is not enough that some of the acupuncture points are used the same way as some of the trigger points, or that they lie in the same areas as each other; we must first examine their underlying defining characteristics. By definition a trigger point must exhibit pressure pain for it to be a trigger point; thus by definition, if there is an equivalence of acupuncture points and trigger points, acupuncture points *must* exhibit pressure pain. Here, only the class of extra, nonchannel points, the *ashi* points, exhibit this quality as a defining feature. Other acupoints, in particular the main points of acupuncture that Dorsher and the

Stichting Foundation for the Study of Traditional East Asian Medicine, Amsterdam, The Netherlands.

1977 study claim a correspondence to, may exhibit pressure pain as a result of clinical changes, but this is *not* a defining property of these acupoints; they still exist whether they exhibit pressure pain or not. In fact, *ashi* points are the only candidates for a potential correspondence to trigger points because they must exhibit pressure pain to be an *ashi* point and are also associated with the system of *jing-jin* or channel sinews (see Birch⁵ for references), which have as associated symptoms muscle pain, muscle spasms, joint pain⁶—the principal symptoms associated with trigger points. In other words *trigger points could only ever correlate to ashi points* despite the fact that other classes of acupoints can exhibit pressure pain.

I could stop this here and end with QED—end of story, Travell and Simons² were correct in their 1983 discussion of this topic. This fundamental issue overrides any other issue about an apparent correlation or superficial similarity between acupoints and trigger points, but Dorsher has made a number of mistakes and questionable statements, which it would be unwise to ignore. Although I do not have space to dissect all of his mistakes, I will highlight the more important ones here.

Dorsher quotes the Deadman et al.⁷ text with regards finding pressure pain at the acupoints, but this relates to clinical treatment—find local sore points. *This has nothing to do with the defining nature of the points.* He has confused clinical uses with more fundamental discussions about the nature of the acupoints. Similarly, he cites the O'Connor and Bensky text⁸ about finding pressure pain points. The quote suggests that points may show sensitivity in relation to the symptom. This is basically correct and a common perspective in the Japanese traditions,⁹ but many of these points lie very distant to the location of the pain and thus could not be trigger points. Here a complex trap exists for the unwary researcher. In general, trigger points have another defining feature: they occur and are used proximate to the site of pain or within a referred pain region. One would not use the pressure pain point at LU-6 near the elbow for hemorrhoids or the pressure pain points at BL-60 or BL-62 near the external ankles for neck pain and be able to call those points trigger points. Yet these are commonly found reactions at acupoints in relation to the mentioned symptoms. This usage lies outside the defined nature of trigger points. However Melzack and colleagues¹ and Dorsher try to argue that these are just distant points that utilize similar neurologic mechanisms. In my 2003 study,⁵ I showed that approximately 35% of the points used for treatment of pain in the texts I analyzed lie distant to the pain; these by accepted definition are not trigger points. Nor could the suggestion that these distant points may use similar neurologic mechanisms ever prove that these points are trigger points; instead, it rather raises questions about the nature of trigger points for pain. If these supposedly similar mechanisms can be accessed at nontrigger points, what is it that defines trigger points?

There is also the unacceptable assumption that both Dorsher and the 1977 study make: Because they are *trying*

to talk only about the use of acupuncture points in the treatment of pain to attempt a correlation between trigger points and acupoints, they assume that they can conveniently ignore the much more frequent uses of acupuncture points for nonpain conditions.^{2,5} This is simply unacceptable as the issue in the study is an equivalence of one class of objects for another. One cannot simply ignore the main features of one of the classes of object in such a comparison because it suits one's limited claim. Dorsher himself accepts that acupoints are more frequently mentioned for the treatment of nonpain conditions: In his paper he states this to be 70% of indications. Not only is this unacceptable methodologically, rather, it lends support to the opposite conclusion: Because trigger points are not used for this much larger class of nonpain uses, then trigger points could not correspond to acupuncture points. One cannot claim to be talking about something while one conveniently discusses only those aspects of that thing that may be suitable to one's point of view. This is a form of investigator bias.

In his "reanalysis" of my 2003 article,⁵ Dorsher has missed completely the nature of the analysis I attempted. I have always accepted that almost all acupoints are given indications of use for treatment of local pain conditions. The question is whether this reflects *recommended* clinical usage or not. There are literally dozens of acupoints with the indication of "low-back pain"; the more important question is out of all those, which are actually listed in the treatment sections of the texts as being recommended for the low-back pain? When I looked at the 1977 study, I noticed and then demonstrated in my 2003 review that many of the supposedly corresponded acupoints, such as BL-42, BL-45, SP-17, SP-19, ST-13, ST-15, KI-24, are never indicated for the treatment of pain and hardly ever for the treatment of anything else either.⁵ But Dorsher has conveniently only examined the local indications of acupoints rather than their actual *recommended* use in the texts he has reviewed. He has thus not reanalyzed my 2003 study; rather he has demonstrated an irrelevant superficial similarity of the points to trigger points, a point that Travell and Simons raised in their commentaries on the original 1977 study.² His table detailing this is irrelevant to any reexamination of the analysis I made in 2003.

Early Chinese claims to a lineage for acupuncture dates it back 5000 years to the time of the Yellow Emperor. However, these claims were discredited by 20th-century scholars. The Yellow Emperor is a mythical figure; the earliest texts describing acupuncture date from around 200–300 BC, *not*, as Dorsher claims, 2700 BC.^{3,10–12} In fact, the systems of acupoints were not present at all in the very earliest sources; instead the system of the channels were described with no acupoints.^{5,10,13} At present, it looks as though theories of the channels predated the first descriptions of acupoints and that the system of acupoints emerged out of channel theory and an emerging *qi* circulation model. This may explain why one of the earliest and most important characterizations of the nature of the acupoints said (Ling Shu^{14–16})

“The acupuncture point at the joint is where shen *qi* (vital energy) comes and goes. It is not (of) the skin, flesh, muscles, bones.” (The *Ling Shu*, circa 200 BC, is a pivotal text for the early development of acupuncture; quote is from: Kosodo and Hameda.¹⁴ See also Sunu and Lee¹⁵ and Wu.¹⁶) The very nature of the acupoints according to this important early description is to do with movement and circulation of *qi* and *not* the underlying anatomic structures. Thus any valid investigation of the nature of the acupuncture points must take these descriptions into account.

Unfortunately, Dr. Dorsher’s study has failed to provide any new or convincing evidence that acupuncture points and trigger points are basically the same thing. He has not taken into account the documented historical literature about the nature and development of the acupoints and has misrepresented a number of important issues. I stand by my analysis of Melzack et al.’s article¹ that the 1977 analysis was incorrect. These 2 entities do not appear to show a correlation.⁵ I also agree with Travell and Simons² statement that these 2 concepts are irreconcilably different and they could never be equivalent.

What if the earliest descriptions of trigger points in the 20th century arose out of a modern encounter with acupuncture? Certainly the earliest uses of acupuncture in the West were almost exclusively limited to treatment of pain, and as early as 1798, speculations had begun on the possible neurologic basis of acupuncture’s analgesic effects.^{3,11} Although limited and inaccurate, this early Western literature on acupuncture was available at the time the idea of trigger points was developing. Maybe the concept of trigger points arose as a kind of adaptation of ancient Chinese ideas to a modern Western system as part of the process of acculturation of acupuncture in the West—define the culturally new concept in terms of existing accepted concepts. Although this gives a superficial patina of acceptability, it does not constitute a scientific proof. Perhaps medical historians can figure this history out more precisely, but it certainly seems similar to other social processes that acupuncture has been subjected to in the West.^{3,17}

Thank you for the opportunity to respond and clarify.

REFERENCES

1. Melzack R, Stillwell DM, Fox EJ. Trigger points and acupuncture points for pain: correlations and implications. *Pain* 1977;3:3–23.

2. Travell JG, Simons DG. *Myofascial Pain and Dysfunction: The Trigger Point Manual*. Baltimore: Williams and Wilkins, 1983.
3. Birch S, Felt R. *Understanding Acupuncture*. Edinburgh: Churchill Livingstone, 1989.
4. Baldry PE. *Acupuncture, Trigger Points and Musculoskeletal Pain*. Edinburgh: Churchill Livingstone, 1989.
5. Birch S. Trigger point—acupuncture point correlations revisited. *J Altern Complement Med* 2003;9:91–103.
6. Manaka Y, Itaya K, Birch S. *Chasing the Dragon’s Tail*. Brookline: Paradigm Publications, 1995.
7. Deadman P, Al-Khafaji M, Baker K. *A Manual of Acupuncture*. Hove: Journal of Chinese Medicine Publications, 1998.
8. O’Connor J, Bensky D. *Acupuncture: A Comprehensive Text*. Seattle: Eastland Press, 1981.
9. Birch S, Ida J. *Japanese Acupuncture*. Brookline: Paradigm Publications, 1998.
10. Harper D. *Early Chinese Medical Literature*. London: Kegan Paul International, 1998.
11. Lu GD, Needham J. *Celestial Lancets*. Cambridge: Cambridge University Press, 1980.
12. Unschuld PU. *Medicine in China: A History of Ideas*. Berkeley, CA: University of California Press, 1985.
13. Engelhardt U. New archaeological findings of the meridian therapy [in German]. *Chin Med* 1998;13:93–100.
14. Kosodo T, Hamada Y. *Ishaku Kotei Daikei Reisu—Explanation of the Huang Di Nei Jing Ling Shu*. Tokyo: Tsukijishokan K.K., 1972.
15. Sunu K, Lee Y. *The Canon of Acupuncture: Huang Ti Nei Ching Ling Shu*. Seoul, Korea: Acupuncture Society, 1985.
16. Wu JN. *The Spiritual Pivot*. Honolulu: University of Hawaii Press, 1993.
17. Wolpe PR. The maintenance of professional authority: acupuncture and the American physician. *Soc Probl* 1985;32:409–424.

Address reprint requests to:

*Stephen Birch, Ph.D., Lic.Ac.(U.S.), M.B.Ac.C.(U.K.)
Stichting Foundation for the Study of
Traditional East Asian Medicine
W.G. Plein 330
1054 SG Amsterdam
The Netherlands*

E-mail: sjbirch@gmail.com

MEMORANDUM

TO: APTA Component Leaders, State Legislative Chairs, Component Executives, and Chapter Lobbyists

FROM: Paul Rockar, Jr. PT, MS, DPT
President, American Physical Therapy Association

DATE: January 6, 2014

RE: Letter from National Center for Acupuncture Safety and Integrity (NCASI)

APTA is aware that a number of state regulatory boards are in receipt of a November 13, 2013, letter from the National Center for Acupuncture Safety and Integrity (NCASI) alleging, among other things, that physical therapists' (PT) use of acupuncture needles in "trigger point dry needling" (TPDN) procedures, and various state boards' determination that TPDN is within the physical therapist scope of practice, are inconsistent with the requirements for acupuncture needles under the Federal Food, Drug, and Cosmetic Act (FDC Act), 21 U.S.C. § 301 et seq., and U.S. Food and Drug Administration (FDA) implementing regulations. APTA commissioned a legal analysis from the law firm of Hogan Lovells US LLP to investigate whether NCASI's allegation against physical therapists and the physical therapy licensing boards has merit.

Based on the legal analysis, we believe the conclusions of the NCASI letter are without merit. FDA regulates acupuncture needles as class II medical devices. When the FDA down-classified acupuncture needles and promulgated 21 C.F.R. § 880.5580, the FDA stated that acupuncture needles are for use by qualified practitioners as determined by the states. We believe that the FDA, in doing this, was clearly signaling that it would not involve itself in determining who is a qualified practitioner to use acupuncture needles, leaving it to the states to decide. The regulations require that acupuncture needles comply with the following special controls: (1) "labeling for single use only and conformance to the requirements for prescription devices set out in 21 C.F.R. § 801.109" ("prescription device regulation"), (2) "material biocompatibility," and (3) "sterility." *Id.* § 880.5580(b). This regulation does not designate acupuncture needles as restricted devices but rather categorizes them as prescription devices requiring compliance with 21 C.F.R. § 801.109.

To comply with the prescription device regulation special control generally, according to 21 C.F.R. § 801.109(b)(1), prescription devices must bear the following statement:

“Caution: Federal law restricts this device to sale by or on the order of a _____”, the blank to be filled with the word “physician”, “dentist”, “veterinarian”, or with the description designation of *any other practitioner licensed by the law of the State in which he practices to use or order the use of the device.*” (emphasis added)

Together, the FDA regulations at 21 C.F.R. §§ 880.5580 and 801.109 make clear that the determination of who is authorized to use acupuncture needles is a matter left to the states.

This approach is consistent with the principle behind § 1006 of the FDC Act, 21 U.S.C. § 396, which says that nothing in the FDC Act limits the authority of a health care practitioner to administer a legally marketed device for any condition within a legitimate practitioner-patient relationship. The legislative history for this provision indicates that Congress intended to emphasize that FDA should not interfere in the practice of medicine.

I hope this information is helpful. If you need any further information or have any questions, please contact Justin Elliott, Director, State Affairs at justinelliott@apta.org or 703-706-8533. Thank you for your service to the profession.

PR/je



Sunrise Review – Adding Dry Needling to Physical Therapist Scope of Practice
Follow-Up Questions to Applicant Report
July 19, 2016

1. Should dry needling (DN) be performed on vulnerable patients, such as infants, toddlers, pregnant women, or medically-compromised seniors? Is there a population of clients who should not receive dry needling?

The decision on whether to perform dry needling on a particular patient is based upon a thorough physical examination that takes into account the patient's age, cognitive level, patient values and beliefs about healthcare, patient's desired treatment plan, etc. Therapists must rely on their clinical training in examination, **as they do with all interventions**, to determine an appropriate plan of care for each patient. Dry needling continuing education does provide additional considerations when deciding whether dry needling is appropriate for patients with certain conditions and comorbidities.

Informed consent: The therapist must assess whether the patient communicates in a way that demonstrates understanding of the procedure, risks, benefits, etc., and can the patient communicate a change in status effectively? Obviously this question would take into consideration a population of patients who are very young (infants), very old (with either memory or dementia complications), and/or those with neurological disturbances that may limit that patient's ability to understand and/or communicate. However, while these factors must be considered, they are not an absolute contraindication.

Populations with special considerations:

- Is the patient under the age of 18? Dry needling, in general, is not suitable for children under 12 (girls) to 15 (boys). Infants, toddlers and other young children are not able to tolerate dry needling other than perhaps superficial dry needling. In general, non-invasive treatment options are preferable for children but there may be exceptions as evidence emerges. Recently, dry needling has been used in the treatment of pain and limitations in range of motion due to spasticity and hypertonicity in people after stroke, which may mean that there are potential benefits for other conditions such as the treatment of children with cerebral palsy. Informed consent would need to be obtained from a parent in this situation and the response carefully assessed to determine whether to proceed. These patients surely require special attention. However, to negate them from receiving this helpful tool would be to deny them the potential benefits.
- Is the patient medically compromised? Medically-compromised seniors need to be evaluated like any other patient and it needs to be determined whether dry needling

should be utilized. In principle, there are no convincing reasons why DN would be contra-indicated, except in individuals with a significantly compromised immune system. This is a definite consideration of how and if to proceed with dry needling, but it is not a blanket contraindication. The main issue with an impaired immune system is the potential of neutropenia and thrombocytopenia, as frequently seen during chemotherapy and radiation therapy. DN is contraindicated in these cases. There are no reported cases of infection secondary to dry needling, but in the presence of neutropenia and thrombocytopenia it is conceivable that DN may not be well tolerated. Clinically, a therapist will often communicate with the physicians who have an active role in the care of these patients before proceeding. Many of them are receiving other medical injections (which is a much larger needle with a cutting edge and essentially has a larger effect on the immune system) and they more easily tolerate a smaller filament needle and appropriate dosing of the treatments. Again, risk/reward ratio needs to be taken into consideration. A trained therapist needs to weigh the risk of using a minimally invasive tool on a patient who is immunocompromised.

- Does the patient have memory or cognitive dysfunction? Other relevant issues include the patient's ability to provide informed consent to dry needling treatment. Patients with dementia may not be able to provide informed consent and therefore, physical therapists must use their best judgment in determining whether DN should be applied.
- Does the patient have active cancer? While most DN continuing education courses teach this as a contraindication, there is not currently clear research to describe the effects dry needling has on an individual with cancer (from the progression of the disease standpoint). The effects are unknown, and therefore it is generally not practiced on these individuals. This is true for many other physical therapy interventions (for example ultrasound).
- Does the patient have a bleeding disorder that will affect their ability to respond appropriately from a hematological sense to the insertion of a filament needle? Patients with bleeding disorders may need special consideration. Both poor clotting and excessive clotting disorders need to be considered in this population. This again is not a contraindication, but practitioners must proceed with caution. Muscles where hemostasis is not possible due to anatomical considerations should not be needled, such as the lateral pterygoid muscle given the close proximity to the maxillary artery, or the iliacus, psoas, and subscapularis muscles, among others.
- Is the patient pregnant? Evidence shows that pregnancy is not a reason not to be treated with dry needling. However, as a precaution, continuing education courses recommend caution with dry needling during the first trimester mostly because of the increased rate of spontaneous miscarriage during the first trimester. The recommendation against DN during the first trimester is to avoid being inadvertently linked to any possible complications of pregnancy. Similar caution is taught in entry level physical therapy education with other interventions such as ultrasound and neuromuscular electrical stimulation. There is absolutely no scientific evidence

linking DN to adverse events of pregnancy. As outlined in the review, the paper by Carr and others provide ample evidence that DN during pregnancy is safe. See for example:

- Carr, DJ, 2015. The safety of obstetric acupuncture: forbidden points revisited. *Acupuncture in Medicine*; 33:413-419.
- Betts, D & Budd, S, 2011. 'Forbidden points' in pregnancy: historical wisdom? *Acupuncture in Medicine*; 29:137-139.
- Cummings, M, 2011. 'Forbidden points' in pregnancy: no plausible mechanism for risk. *Acupuncture in medicine*; 29:140-142.

As with all therapeutic interventions, therapists must use best available evidence to make decisions about patient populations that would benefit from particular interventions, as well as known and potential contraindications. The decision must be made based on the individual patient's physical examination, history, comorbidities, patient values and goals.

2. Please provide more detail on the appropriate clinical setting for performing dry needling, including maintenance of environment safety and infection control measures.

Any physical therapy clinical setting is in principle appropriate for the practice of dry needling. Clinicians must comply with best practice hygiene practices and any other additional requirements of their employer or other local workplace policies. This may include waste disposal rules, and requirements and guidelines for needles or bodily fluids. All physical therapists have been thoroughly educated in standard blood borne precautions as part of the basic physical therapy education as described by OSHA Blood Borne Pathogens protocol (Standards - 29 CFR). Physical therapists must comply with best practice requirements for the management of needle stick accidents and adverse reactions. Individual clinic policy and procedure documents can incorporate these guidelines.

3. The applicant report states that pneumothorax is a very rare but serious complication associated with dry needling. Is a physical therapist trained to recognize the signs of pneumothorax or other potential serious complications?

Entry level physical therapy students receive considerable education in differential diagnosis, which includes recognition of and response to potential pneumothorax. PTs are trained to assess patients in both the hospital and outpatient clinical setting for spontaneous and iatrogenic pneumothorax. Therapists who attend continuing education courses on dry needling also receive extensive training in the prevention, recognition and management of pneumothorax.

How would a physical therapist respond to such complications?

Dry needling practitioners and continuing education courses take the risk of pneumothorax very seriously and, aside from teaching very safe techniques to avoid the lung field, courses also:

- A. Encourage all participants to educate their patients on the risks of pneumothorax and what to do in case they suspect they have suffered a pneumothorax.
- B. If one of their patients is exhibiting symptoms of a pneumothorax, they advise that patient to go to be evaluated by their doctor, go to an ER, walk-in clinic, or somewhere that they can be seen quickly for a chest x-ray. The symptoms of pneumothorax may not even show up until a day after a treatment, so it is not likely that they will even be in the office when they experience the symptoms. As with all "red flags" that might happen when treating a patient (dry needling related or not), the urgency of the situation needs to be identified. A phone conversation with that patient will easily help the therapist make a good judgement on the situation (assessing ability to talk, breath, pain, etc.), so, as with anything, the therapist would use their discretion as to how emergent it is.

4. The applicant report lists objectives of available continuing education courses on dry needling, stating that the average length of these courses is 54 hours and satisfies the task force's recommendations, however:

- *The objectives listed for the above do not demonstrate the courses meet the 16 knowledge requirements that require advanced/specialized training for competency in dry needling identified in the HumRRO report (Table 2, page 12);*
- *Please provide more detail to demonstrate that the 16 recommended knowledge requirements are met through the available post-graduate/continuing education training programs.*

Please see the accompanying table of continuing education courses with details to answer this question.

5. How much of the specialized training is didactic and how much experiential?

Course	Total Hours	**Didactic	**Experiential
Myopain Seminars	100 hours	40%	60%
Kinetacore	54 hours	34%	66%
Spinal Manipulation Institute	54 hours	30%	70%
Integrative Dry Needling Institute	54 hours	15%	85%
Institute of Advanced Musculoskeletal Treatments	54 hours	8% lecture in Level I 4% lecture in Level II	92-96%

***These numbers are estimates as the didactic learning is integrated into the lab work. Many courses utilize case studies and didactic learning to guide the hands-on lab. Most courses require pre-course study outside of the hours of the course.*

6. Please provide more details on the physical therapist disciplinary cases related to dry needling described on page 20 of the applicant report, particularly the nature of the complaints. Were there other complaints involving physical therapist dry needling that resulted in action other than discipline (e.g., agreed orders, probation, etc.); if yes provide details.

Please see the accompanying letter from the Federation of State Boards of Physical Therapy.

The objectives listed in the applicant report were a general representation of of the current courses available in the US with the greatest enrollment. However, to distinctly identify the fulfillment of these knowledge criteria, we must look at each course series individually. Each course highlights a unique list of learning objectives and therefore the knowledge criteria may fall under a slightly different objective or multiple objectives. The table below compares the learning objectives from 4/5 continuing education providers with the knowledge criteria identified by the FSBPT task force. The 5th continuing education provider (Myopian Seminars) gave a direct response to explain how each knowledge requirement is met in their courses. To give the best representation of the current standard, the continuing education companies used in the table are the ones with the highest enrollment in the US for dry needling education. We have also provided the objectives from each course for your reference.

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
<p>Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks</p>	<ul style="list-style-type: none"> • Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1. This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy, proper therapist and patient positioning, identification of possible contraindications and precautions, proper needle selection , compliance with clean needle technique as described in the course to follow OSHA standards, proper hand placement for safe application, safe application of functional dry needling 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. • Master the psychomotor skills necessary to evaluate and treat neuromusculoskeletal dysfunctions related to neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder pain, TMJ, and carpal tunnel syndrome with dry needling 	<ul style="list-style-type: none"> • Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions. • Participants will demonstrate the knowledge and clinical skills necessary to evaluate and treat myofascial pain and soft tissue dysfunctions by the end of the course • Participants will be able to identify and compare/ contrast homeostatic, paravertebral and symptomatic trigger points with an accuracy rate of 90% by the end of the course. 	<ul style="list-style-type: none"> • Locate specific muscle groups, peripheral nerves and vascular structures through clinical palpation • Locate active myofascial trigger points in the muscles based on the work of Travel and Simons technique 	<p>Surface anatomy and deep anatomy are covered in detail for every needling location. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Emergency preparedness and/or response procedures related to secondary physiological effects or complications	<ul style="list-style-type: none"> Identify and acknowledge the possible risks associated with dry needling, including precautions, contraindications to dry needling, possible adverse effects, and how to manage adverse effects, in both emergent and non-emergent situations. 	<ul style="list-style-type: none"> Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. 	<ul style="list-style-type: none"> Participants will demonstrate the ability to provide safe and effective needling treatment, including preventing and managing adverse responses to needling, blood borne pathogens and clean needling technique based on OSHA standards with 100% accuracy by the end of the seminar. 	<ul style="list-style-type: none"> Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice. Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments. 	<p>The most common “emergency responses” include autonomic responses often due to anxiety; pneumothorax and other organ puncture. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
<p>Emergency preparedness and/or response procedures related to secondary emotional effects or complications associated with dry needling (e.g., claustrophobia, anxiety, agitation)</p>	<ul style="list-style-type: none"> • Demonstrate understanding of the underlying physiological, biomechanical and chemical mechanisms that can occur with the application of dry needling to the neuromusculoskeletal system. • Identify and acknowledge the possible risks associated with dry needling, including precautions, contraindications to dry needling, possible adverse effects, and how to manage adverse effects, in both emergent and non-emergent situations. • Demonstrate knowledge of the biomechanical and physiological effects dry needling can have on all of the systems in the body, and understand how to integrate this knowledge into a safe and effective treatment using dry needling. 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. • Verbalize 3 indications and contraindications associated with dry needling of neuromusculoskeletal structures in the thorax, neck, shoulder, upper extremity, and craniofacial region. 	<ul style="list-style-type: none"> • Participants will demonstrate the ability to provide safe and effective needling treatment, including preventing and managing adverse responses to needling, blood borne pathogens and clean needling technique based on OSHA standards with 100% accuracy by the end of the seminar. 	<ul style="list-style-type: none"> • Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice. • Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments. 	<p>Claustrophobia is not a common effect or complication of dry needling. Anxiety and other psychological response patterns are covered in details throughout the courses. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Standards for needle handling (e.g., hand hygiene, application of single-use needles)	<ul style="list-style-type: none"> • Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1. This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy, proper therapist and patient positioning, identification of possible contraindications and precautions, proper needle selection , compliance with clean needle technique as described in the course to follow OSHA standards, proper hand placement for safe application, safe application of functional dry needling 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. • Master the psychomotor skills necessary to evaluate and treat neuromusculoskeletal dysfunctions related to neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder headaches, shoulder pain, TMJ, and carpal tunnel syndrome with dry needling 	<ul style="list-style-type: none"> • Participants will demonstrate the ability to provide safe and effective needling treatment, including preventing and managing adverse responses to needling, blood borne pathogens and clean needling technique based on OSHA standards with 100% accuracy by the end of the seminar. • 	<ul style="list-style-type: none"> • Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist. 	<p>Much attention is paid to needle handling, hygiene and use of single use needles. In the Myopain Seminars courses we use physiotherapy needles, specifically designed for DN. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Factors influencing safety and injury prevention	<ul style="list-style-type: none"> • Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1. This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy, proper therapist and patient positioning, identification of possible contraindications and precautions, proper needle selection , compliance with clean needle technique as described in the course to follow OSHA standards, proper hand placement for safe application, safe application of functional dry needling • Identify and acknowledge the possible risks associated with dry needling, including precautions, contraindications to dry needling, possible adverse effects, and how to manage adverse effects, in both emergent and non-emergent situations. 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. • Verbalize 3 indications and contraindications associated with dry needling of neuromusculoskeletal structures in the thorax, neck, shoulder, upper extremity, and craniofacial region. 	<ul style="list-style-type: none"> • Participants will demonstrate the ability to provide safe and effective needling treatment, including preventing and managing adverse responses to needling, blood borne pathogens and clean needling technique based on OSHA standards with 100% accuracy by the end of the seminar. • Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions • Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice 	<ul style="list-style-type: none"> • Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist. • Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments. • Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice. • Locate specific muscle groups, peripheral nerves and vascular structures through clinical palpation. 	<p>DN is always anatomy-driven. We maintain that there are no “dangerous muscles” as long as a clinician is aware of three-dimensional anatomy. In the Myopain Seminars courses, detailed reviews of anatomy are included for every needling procedure, guaranteeing safe needling and injury prevention. Indications and precautions are covered in detail for every needling procedure. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
<p>Personal protection procedures and techniques as related to dry needling (e.g., positioning self to access treatment area, use of personal protective equipment)</p>	<p>Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1. This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy, proper therapist and patient positioning, identification of possible contraindications and precautions, proper needle selection , compliance with clean needle technique as described in the course to follow OSHA standards, proper hand placement for safe application, safe application of functional dry needling</p>	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. 	<ul style="list-style-type: none"> • Participants will demonstrate the ability to provide safe and effective needling treatment, including preventing and managing adverse responses to needling, blood borne pathogens and clean needling technique based on OSHA standards with 100% accuracy by the end of the seminar. 	<ul style="list-style-type: none"> • Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist.. • Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice. • Apply dry needling technique to treat pain, tendinopathy, muscle dysfunctions and other musculoskeletal dysfunctions associated with active myofascial trigger points in the upper and lower quadrant muscles. 	<p>During the Myopain Seminars courses, all participants are required to wear nitrile gloves for personal protection. Much attention is paid to the positioning of subjects and practitioners. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Theoretical basis for dry needling (e.g., applications for rehabilitation, health promotion, fitness and wellness, performance)	<ul style="list-style-type: none"> • Synthesize foundational and clinical sciences of myofascial pain, trigger points, pain patterns, movement dysfunction and functional dry needling to impact those findings clinical setting • Clearly define and describe dry needling for the treatment of neuromusculoskeletal dysfunction, movement impairments and pain associated with that dysfunction and impairment. • Demonstrate understanding of the underlying physiological, biomechanical and chemical mechanisms that can occur with the application of dry needling to the neuromusculoskeletal system. 	<ul style="list-style-type: none"> • Verbalize 3 indications and contraindications associated with dry needling of neuromusculoskeletal structures in the thorax, neck, shoulder, upper extremity, and craniofacial region • Justify the use of dry needling techniques by describing at least at one study from the literature for each of the following conditions: neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder pain, TMJ, and carpal tunnel syndrome • Explain at least one of the proposed mechanisms [mechanical, hypoalgesic (central, segmental and/or peripheral), neurophysiologic, chemical and/or hormonal] for how dry needling results in a reduction in pain and disability. 	<ul style="list-style-type: none"> • Participants will demonstrate the knowledge and clinical skills necessary to evaluate and treat myofascial pain and soft tissue dysfunctions by the end of the course. • Participants will be able to accurately describe the neuroanatomy and physiology of trigger points, and the unique concepts of the IDN system during the case study portion of the course. • Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions. 	<ul style="list-style-type: none"> • Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments. • Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments. • Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice 	The Myopain Seminars courses include 5 hours of theoretical lectures establishing the theoretical basis of DN and the applications of DN in many settings. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
<p>Theoretical basis for combining dry needling with other interventions</p>	<ul style="list-style-type: none"> • Synthesize foundational and clinical sciences of myofascial pain, trigger points, pain patterns, movement dysfunction and functional dry needling to impact those findings clinical setting • Demonstrate knowledge of the biomechanical and physiological effects dry needling can have on all of the systems in the body, and understand how to integrate this knowledge into a safe and effective treatment using dry needling. 	<ul style="list-style-type: none"> • Verbalize how best to incorporate dry needling into conventional physical therapy practice 	<ul style="list-style-type: none"> • Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions • Participants will demonstrate the knowledge and clinical skills necessary to evaluate and treat myofascial pain and soft tissue dysfunctions by the end of the course • Participants will be able to accurately describe the neuroanatomy and physiology of trigger points, and the unique concepts of the IDN system during the case study portion of the course. 	<ul style="list-style-type: none"> • Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments. • Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments. • Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice 	<p>DN is always part of a more comprehensive treatment approach, and this is covered in detail throughout the courses.</p>

Knowledge Criteria as outlined by FSBPT task force	Kineticore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
<p>Secondary effects or complications associated with dry needling on other systems (e.g., gastrointestinal, cardiovascular/pulmonary, musculoskeletal)</p>	<ul style="list-style-type: none"> • Demonstrate knowledge of the biomechanical and physiological effects dry needling can have on all of the systems in the body, and understand how to integrate this knowledge into a safe and effective treatment using dry needling. 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. • Explain at least one of the proposed mechanisms [mechanical, hypoalgesic (central, segmental and/or peripheral), neurophysiologic, chemical and/or hormonal] for how dry needling results in a reduction in pain and disability. 	<ul style="list-style-type: none"> • Participants will demonstrate the ability to provide safe and effective needling treatment, including preventing and managing adverse responses to needling, blood borne pathogens and clean needling technique based on OSHA standards with 100% accuracy by the end of the seminar. 	<ul style="list-style-type: none"> • Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments. • Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice. • Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments. 	<p>There are few secondary effects or complications associated with DN, but these are covered in detail in the Myopain Seminars DN courses. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
<p>Theoretical basis of pain sciences, including anatomy, physiology, pathophysiology, and relation to body structures and function</p>	<ul style="list-style-type: none"> • Synthesize foundational and clinical sciences of myofascial pain, trigger points, pain patterns, movement dysfunction and functional dry needling to impact those findings clinical setting 	<ul style="list-style-type: none"> • Explain at least one of the proposed mechanisms [mechanical, hypoalgesic (central, segmental and/or peripheral), neurophysiologic, chemical and/or hormonal] for how dry needling results in a reduction in pain and disability. • Justify the use of dry needling techniques by describing at least at one study from the literature for each of the following conditions: neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder pain, TMJ, and carpal tunnel syndrome • Explain at least one of the proposed mechanisms [mechanical, hypoalgesic (central, segmental and/or peripheral), neurophysiologic, chemical and/or hormonal] for how dry needling results in a reduction in pain and disability 	<ul style="list-style-type: none"> • Participants will be able to accurately describe the neuroanatomy and physiology of trigger points, and the unique concepts of the IDN system during the case study portion of the course. • Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions 	<ul style="list-style-type: none"> • Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments. • Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments. 	<p>Covered in detail. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/ conditions)	<ul style="list-style-type: none"> • Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1. This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy, proper therapist and patient positioning, identification of possible contraindications and precautions, proper needle selection , compliance with clean needle technique as described in the course to follow OSHA standards, proper hand placement for safe application, safe application of functional dry needling • Identify and acknowledge the possible risks associated with dry needling, including precautions, contraindications to dry needling, possible adverse effects, and how to manage adverse effects, in both emergent and non-emergent situations. 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. • Verbalize 3 indications and contraindications associated with dry needling of neuromusculoskeletal structures in the thorax, neck, shoulder, upper extremity, and craniofacial region 	<ul style="list-style-type: none"> • Participants will demonstrate the ability to provide safe and effective needling treatment, including preventing and managing adverse responses to needling, blood borne pathogens and clean needling technique based on OSHA standards with 100% accuracy by the end of the seminar. • Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions • Participants will demonstrate the knowledge and clinical skills necessary to evaluate and treat myofascial pain and soft tissue dysfunctions by the end of the course 	<ul style="list-style-type: none"> • Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice 	<p>Covered in detail. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Palpation techniques as related to dry needling	<ul style="list-style-type: none"> • Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1. This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy, proper therapist and patient positioning, identification of possible contraindications and precautions, proper needle selection , compliance with clean needle technique as described in the course to follow OSHA standards, proper hand placement for safe application, safe application of functional dry needling 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. • Master the psychomotor skills necessary to evaluate and treat neuromusculoskeletal dysfunctions related to neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder pain, TMJ, and carpal tunnel syndrome with dry needling 	<ul style="list-style-type: none"> • Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions • Participants will demonstrate the knowledge and clinical skills necessary to evaluate and treat myofascial pain and soft tissue dysfunctions by the end of the course. • Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice 	<ul style="list-style-type: none"> • Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments. • Locate specific muscle groups, peripheral nerves and vascular structures through clinical palpation • Locate active myofascial trigger points in the muscles based on the work of Travel and Simons technique 	Covered in detail for every muscle, scar tissue, fascia. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Needle insertion techniques	<ul style="list-style-type: none"> • Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1. This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy, proper therapist and patient positioning, identification of possible contraindications and precautions, proper needle selection , compliance with clean needle technique as described in the course to follow OSHA standards, proper hand placement for safe application, safe application of functional dry needling 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. • Master the psychomotor skills necessary to evaluate and treat neuromusculoskeletal dysfunctions related to neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder pain, TMJ, and carpal tunnel syndrome with dry needling. 	<ul style="list-style-type: none"> • Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions • Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice 	<ul style="list-style-type: none"> • Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist. 	<p>Covered in detail for every muscle, scar tissue, fascia. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Needle manipulation techniques	<ul style="list-style-type: none"> • Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1. This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy, proper therapist and patient positioning, identification of possible contraindications and precautions, proper needle selection , compliance with clean needle technique as described in the course to follow OSHA standards, proper hand placement for safe application, safe application of functional dry needling 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region • Master the psychomotor skills necessary to evaluate and treat neuromusculoskeletal dysfunctions related to neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder pain, TMJ, and carpal tunnel syndrome. 	<ul style="list-style-type: none"> • Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions • Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice 	<ul style="list-style-type: none"> • Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist. 	<p>Covered in detail for every muscle, scar tissue, fascia. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.</p>

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Physiological responses to dry needling	<ul style="list-style-type: none"> • Demonstrate knowledge of the biomechanical and physiological effects dry needling can have on all of the systems in the body, and understand how to integrate this knowledge into a safe and effective treatment using dry needling. • Demonstrate understanding of the underlying physiological, biomechanical and chemical mechanisms that can occur with the application of dry needling to the neuromusculoskeletal system. 	<ul style="list-style-type: none"> • Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region. • Explain at least one of the proposed mechanisms [mechanical, hypoalgesic (central, segmental and/or peripheral), neurophysiologic, chemical and/or hormonal] for how dry needling results in a reduction in pain and disability. 	<ul style="list-style-type: none"> • Participants will demonstrate the ability to provide safe and effective needling treatment, including preventing and managing adverse responses to needling, blood borne pathogens and clean needling technique based on OSHA standards with 100% accuracy by the end of the seminar. • Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions 	<ul style="list-style-type: none"> • Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments. • Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice. • Apply dry needling technique to treat pain, tendinopathy, muscle dysfunctions and other musculoskeletal dysfunctions associated with active myofascial trigger points in the upper and lower quadrant muscles. 	Covered in detail. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.

Knowledge Criteria as outlined by FSBPT task force	Kinetacore	Spinal Manipulation Institute	Integrative Dry Needling	Institute of Advanced Musculoskeletal Treatments	Myopain Seminars
Solid filament needles (e.g., physical characteristics)	<ul style="list-style-type: none"> Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1. This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy, proper therapist and patient positioning, identification of possible contraindications and precautions, proper needle selection , compliance with clean needle technique as described in the course to follow OSHA standards, proper hand placement for safe application, safe application of functional dry needling 	<ul style="list-style-type: none"> Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region 	<ul style="list-style-type: none"> Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice 	<ul style="list-style-type: none"> Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist. 	Covered in detail for every muscle,scar tissue, fascia. All courses include practical and theoretical competency testing. The 3-course series is concluded with challenging theoretical and practical examinations.

Kinetacore

After completing Functional Dry Needling, participants will be able to:

- Clearly define and describe dry needling for the treatment of neuromusculoskeletal dysfunction, movement impairments and pain associated with that dysfunction and impairment.
- Demonstrate understanding of the underlying physiological, biomechanical and chemical mechanisms that can occur with the application of dry needling to the neuromusculoskeletal system.
- Identify and acknowledge the possible risks associated with dry needling, including precautions, contraindications to dry needling, possible adverse effects, and how to manage adverse effects, in both emergent and non-emergent situations.
- Synthesize foundational and clinical sciences of myofascial pain, trigger points, pain patterns, movement dysfunction and functional dry needling to impact those findings clinical setting.
- Demonstrate knowledge of the biomechanical and physiological effects dry needling can have on all of the systems in the body, and understand how to integrate this knowledge into a safe and effective treatment using dry needling.
- Demonstrate appropriate knowledge and psychomotor skills necessary for safe and effective application of functional dry needling for musculature instructed in FDN Level 1.
 - This includes demonstration of competence in the knowledge of surface anatomy and 3 dimensional anatomy
 - proper therapist and patient positioning
 - identification of possible contraindications and precautions
 - proper needle selection
 - compliance with clean needle technique as described in the course to follow OSHA standards
 - proper hand placement for safe application
 - safe application of functional dry needling

Spinal Manipulation Institute

After completion of DN-1, participants will:

1. Verbalize 3 indications and contraindications associated with dry needling of neuromusculoskeletal structures in the thorax, neck, shoulder, upper extremity, and craniofacial region.
2. Justify the use of dry needling techniques by describing at least at one study from the literature for each of the following conditions: neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder pain, TMJ, and carpal tunnel syndrome.
3. Explain at least one of the proposed mechanisms [mechanical, hypoalgesic (central, segmental and/or peripheral), neurophysiologic, chemical and/or hormonal] for how dry needling results in a reduction in pain and disability.
4. Verbalize precautions and demonstrate safe, competent and proficient performance of dry needling techniques for neuromusculoskeletal structures associated with the thorax, neck, shoulder, upper extremity, and craniofacial region.
5. Integrate clinical reasoning skills and best available evidence to select appropriate dosage (i.e. frequency, intensity, and duration) for neuromusculoskeletal dysfunctions related to neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder pain, TMJ, and carpal tunnel syndrome.
6. Master the psychomotor skills necessary to evaluate and treat neuromusculoskeletal dysfunctions related to neck pain, cervical radiculopathy, epicondylitis, cervicogenic headaches, shoulder pain, TMJ, and carpal tunnel syndrome with dry needling.
7. Describe and incorporate 3, evidence-based distal points into a semi-standardized dry needling approach.
8. Verbalize how best to incorporate dry needling into conventional physical therapy practice.
9. Master an ability to perform semi-standardized dry needling protocols associated with the peri-neural needling of the medial, ulnar, and superficial radial nerve.

***as evidenced by successful completion of oral/practical check-off sheets

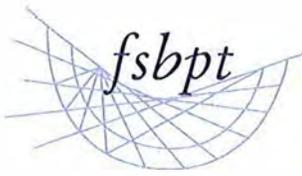
Integrative Dry Needling:

1. Participants will be able to identify and compare/contrast homeostatic, paravertebral and symptomatic trigger points with an accuracy rate of 90% by the end of the course.
2. Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions.
3. Participants will demonstrate the ability to provide safe and effective needling treatment, including preventing and managing adverse responses to needling, blood borne pathogens and clean needling technique based on OSHA standards with 100% accuracy by the end of the seminar.
4. Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions.
5. Participants will demonstrate the knowledge and clinical skills necessary to evaluate and treat myofascial pain and soft tissue dysfunctions by the end of the course.
6. Participants will be able to accurately describe the neuroanatomy and physiology of trigger points, and the unique concepts of the IDN system during the case study portion of the course.
7. Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice

Institute of Advanced Musculoskeletal Treatments

Objectives:

1. Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments.
2. Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments.
3. Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice.
4. Locate specific muscle groups, peripheral nerves and vascular structures through clinical palpation.
5. Locate active myofascial trigger points in the muscles based on the work of Travel and Simons technique
6. Apply dry needling technique to treat pain, tendonopathy, muscle dysfunctions and other musculoskeletal dysfunctions associated with active myofascial trigger points in the upper and lower quadrant muscles.
8. Discuss legal issues regarding use of dry needling by physical therapist
8. Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist.



July 13, 2016

Jackie Barry, CAE
Executive Director
Physical Therapy Association of Washington
208 Rogers St NW
Olympia, WA 98502

Dear Ms. Barry:

RE: Physical Therapists performing dry needling; Sunrise Review Washington

The Federation of State Boards of Physical Therapy (FSBPT or Federation) is an organization made up of the 53 physical therapy licensing jurisdictions within the United States. The mission of the FSBPT is to protect the public by providing service and leadership that promote safe and competent physical therapy practice. To support its mission of public protection, the Federation administers and maintains the Examination, Licensure, and Disciplinary Database (ELDD).

Thank you for contacting us with your request to answer the sunrise review query from the Washington State Department of Health for more detail regarding the incidents of discipline in the ELDD and physical therapists and dry needling. Below you will find additional details on the reports.

In October 2014, two PTs in Arizona were disciplined for substandard practice for performing dry needling through clothing. One of these therapists was additionally licensed in Ohio and an action to restrict the Ohio license was taken in January 2015 based on the disciplinary action from Arizona. (This is the 2015 action noted in the original letter).

In March 2013, a PT in Maryland was disciplined because he did not document the dry needling treatment he performed on a patient although other procedures during that treatment session were documented. The PT in question had not received training in dry needling and was found to be working outside of the individual's competency.

There are a total of three discreet incidents- 2 in Arizona and 1 in Maryland. The FSBPT ELDD has no additional records of any additional complaints that were found to have merit and require some action. Probation, consent orders, reprimands, etc. are considered forms of action (discipline) in the ELDD and thus would be noted. If other complaints were lodged but found to have no merit, no report would be made to the FSBPT ELDD or the National Practitioner Data Bank.

Should you have any further question related to the ELDD or other regulatory issues regarding physical therapists, please do not hesitate to contact me.

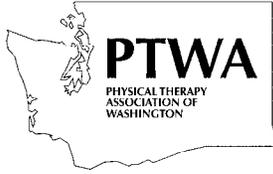
Sincerely,

Leslie Adrian, PT, DPT, MPA
Director of Professional Standards
Federation of State Boards of Physical Therapy

Federation of State Boards of Physical Therapy

124 West Street South; 3rd Floor, Alexandria, Virginia 22314 | 703.299.3100 Phone | 703.299.3110 Fax

www.fsbpt.org



August 16, 2016

Sherry Thomas, Policy Coordinator
Department of Health, Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850
sunrise@doh.wa.gov

Dear Sherry:

On behalf of the Physical Therapy Association of Washington (PTWA), please accept these additional comments supporting our applicant report on dry needling in physical therapist scope of practice. These comments seek to answer questions posed during the sunrise public hearing and to supplement our oral and written testimony.

Dry Needling and Physical Therapist Practice

Dry needling is used by physical therapists to augment a comprehensive treatment plan for neuromusculoskeletal pain and dysfunction. A publication by Ron Pavkovich, PT, DPT, Cert. DN, CIDN, in the International Journal of Sports Physical Therapy describes in detail the use of dry needling to address cervical pain. Being a case report, this study is presented only to provide a description of a physical therapist's evaluation and determination of appropriateness for dry needling intervention, not to demonstrate any generalizable results on efficacy. The primary outcomes assessed in this article were pain and disability, both of which were significantly improved in two sessions of dry needling. The author notes that the patient's range of motion and strength were not improved. This demonstrates the need for a comprehensive physical therapy treatment plan targeting the affected musculature to improve strength. In addition to being linked below, this article is provided in the appendix with permission of the author. (Pavkovich R. The use of Dry Needling for a Subject with Acute Onset of Neck Pain: A Case Report. *International Journal of Sports Physical Therapy*. 2015;10(1):104-13.)
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4325294/>

Document removed by the department due to lack of available space in report - link was retained.

A team of physical therapists, led by Raymond Butts at the American Academy of Manipulative Therapy, recently published an extensive review of the physiological effects specific to dry needling, a copy of which is included in our appendix. This literature review showed the analgesic effects of dry needling to be:

- A.** Acute or chronic injury stimulates local and biochemical tissue changes associated with extracellular increase in H⁺ (acidic environment) that inhibits acetylcholinesterase, the enzyme responsible for removing ACh from the motor endplate allowing for the sustained hypertonicity. The acidic environment also exaggerates the release of CGRP and further increases motor unit sensitivity and synthesis of receptors at neuromuscular junction, resulting in pain and dysfunction.
- B.** Dry needling causes a significant increase in endogenous anandamide in the periphery (endogenous form of THC) which is recognized by CB2R receptors on keratinocytes and macrophages and stimulates the production of opioids to be delivered to local tissue. The stimulation of endogenous anandamide also drives down the production of inflammatory cytokines and interleukin factors, minimizing and controlling the sustained inflammatory response often associated with chronic injuries.
- C.** Dry needling activates spinal-level, opioid-based pain reduction. Mediated by endogenous cannabinoids and the sympathetic nervous system, which work together to stimulate spinal opioid production and provide non-opioid relief via serotonin and norepinephrine from the brain stem.
- D.** Dry needling stimulates the neuroendocrine system through the hypothalamic-pituitary-adrenal axis centrally and the corticotropin releasing hormone-proopiomelanocortin-corticosteroid axis locally to inhibit the formation of inflammatory cytokines (cox-2 mechanisms),
- E.** Dry needling stimulates mechanotransductive effects of fibroblasts and peripheral nerves via intracellular calcium wave propagation, resulting in the subsequent activation of the nucleus accumbens. Inhibiting spinal pain transmission via glycinergic and opiodenergic interneurons. The increased ATP is metabolized to adenosine, which activates purinergic receptors, a key event in mechanical analgesia and rho-kinase based tissue remodeling.

Physical therapists have foundational knowledge of these physiological systems of analgesia and they are the reason for their routine use of modalities and manual techniques aimed to address neuro-musculoskeletal dysfunction:

- Joint/spine mobilization and manipulation
- Soft tissue mobilization – massage, myofascial release, trigger point release
- Instrument assisted soft tissue mobilization – ASTYM, Graston, IASTM, etc.

- Graded motor imagery
- Modalities – laser, electrical stimulation, ultrasound, etc.
- Exercise and therapeutic activities
- Dry needling

Health care providers, including physical therapists, have been consistently challenged since the mid-1980s to improve the reliability and validity of their pathological and movement pattern diagnosis. Although not an absolute for clinical practice, accurate and valid clinical pattern assessment and diagnosis has an essential role in determining the most effective treatment package for neuro-musculoskeletal conditions¹. When compared to diagnostic gold standard MRI, diagnostic accuracy of physical therapists was not significantly different than orthopedic surgeons for musculoskeletal diagnosis¹. However, several studies have noted some variability in clinical and pattern diagnosis among allied¹ and alternative² healthcare providers. Consistent clinical and movement pattern diagnosis by a physical therapist, allows them to select the most appropriate package of techniques and modalities to address deficits in neurological, connective, and musculoskeletal tissue to decrease pain and enhance functional abilities.

Physical therapy-related modalities and techniques have been shown to affect fascial, muscular, spinal and cortical systems differently depending on the type of stimulus applied. For example, myofascial trigger points have a unique electrical signal emitted from the extrafusal motor endplate³, that are not present in other tissue, including traditional acupoints.⁴ Myofascial trigger points have been shown to respond favorably when treated by physical therapists using techniques such as dry needling⁵, instrument assisted and traditional myofascial techniques and joint mobilization⁶.

Fascial layers of connective tissue also have a critical role in pain and dysfunction. Connective tissue fascia has firm connections to muscle spindles, that if constantly stretched could cause excessive acetylcholine release at focal adhesion points on muscle tissue⁷. Perpetuating the muscle trigger point response. Additionally, the lubricating effect hyaluronic acid provides for gliding of fascia over muscles and tendons, and is effected by the biochemical factors associated with injury⁷. Static adhesions between muscle and fascial tissue leads to increased thickness and disorganization of connective tissue layers, increasing tissue stiffness and decreasing ROM⁸. Physical therapy techniques such as myofascial release⁹, instrumented assisted soft tissue mobilization¹⁰, and dry needling¹¹ have all been shown to stimulate the blood flow, nitrous oxide, and connective tissue remodeling effects described by Butts et al.¹²

Physical therapy treatment techniques have demonstrated efficacy in addressing pain and dysfunction via spinal cord mediated effects¹³, primarily through modulation of A-beta fiber activity, stimulation of non-opioid inhibitory

mechanisms¹⁴, and opioid-based mechanisms¹². Common techniques in physical therapy practice, such as spinal manipulation¹⁵, spinal joint mobilization and dry needling¹⁶ have all been shown to stimulate spinal-based analgesia to varying degrees.

Physical therapists have the educational background and training in a variety of techniques and modalities, including dry needling, that have been shown to stimulate analgesia and healing for a variety of neuro-musculoskeletal tissues. It is reasonable to question, given the overlap in traditional acupoints and myofascial tender points¹⁷ reported in the literature, if traditional acupoints have a unique biochemical makeup that is responsible for the observed physiological effects. A high concentration of neurovascular bundles has been found in connective tissue underlying traditional acupoints¹⁸. It is possible that western-trained medical providers, including physical therapists, and traditional East Asian medical practitioners have identified through their unique diagnostic and clinical reasoning processes, a pathway into the body's spinal and cortical systems of pain control. However, recent evidence questions the necessity of specific point stimulation for the initiation of the desired treatment effects¹⁹. According to recent literature, there seems to be a consistent physiological response to needle stimulation, regardless of the specifically defined points¹⁹. An alternative hypothesis to point specificity has been proposed¹², suggesting that dry needling techniques stimulate mechanosensitive TPV1 receptors, initiating a cascade of events that triggers known local, spinal and supra-spinal effects within the segmental or cortical receptive field associated with the site of needle stimulation¹².

Dry needling is a unique treatment technique in physical therapy practice that allows for targeted stimulation of multiple physiological systems necessary for pain control and recovery. Not through the use of traditional concepts such as acupoints, channels, and meridians, all of which fall well outside the scope of physical therapy education and training, but rather the mechanical stimulation of tissue receptors that trigger both opioid and non-opioid systems of analgesia.

- 1 Moore J, Goss DL, Baxter RE, DeBerardino TM, Mansfield LT, Fellow DW, Taylor DC (2005) Clinical diagnostic accuracy and magnetic resonance imaging of patients referred by physical therapists, orthopaedic surgeons, and nonorthopaedic providers. *JOSPT* 35(2).
- 2 O'Brien K & Birch S (2009) A review of the reliability of traditional east asian medicine diagnosis. *Journal of Alternative and Complementary Medicine* 15: 353-366.
- 3 Ge HY, Fernandez-de-las-Penas C, Yue SW (2011). Myofascial trigger points: spontaneous electrical activity and its consequences for pain induction and propagation. *Chinese Medicine* 6:13.
- 4 Hong C (2000) Myofascial trigger points: pathophysiology and correlation with acupuncture points. *Acupunct Med* 18: 41-47
- 5 Pavkovich R (2015) The use of dry needling for a subject with acute onset of neck pain: a case report. *Int J of Sports Physical Therapy* 10(1).
- 6 Campa-Moran I et al. (2015) Comparison of dry needling versus orthopedic manual therapy in patients with myofascial chronic neck pain: a single blind, randomized pilot study. *Pain Research and Treatment* ID:327307
- 7 Stecco A, Gesi M, Stecco C, Stern R (2013) Fascial components of the myofascial pain syndrome. *Current Pain and Headache Reports* 17:352.
- 8 Langevin H, Napadow V, Park J, Schynner (2009) Resolving paradoxes in acupuncture research: a roundtable discussion. *Journal of Alternative and Complementary Medicine* 15(9): 1039-44.

- 9 Ajimsha M, Al-Mudahka N, Madzhar J (2015) Effectiveness of myofascial release: systematic review of randomized controlled trials. *Journal of Bodywork and Movement Therapies* 19(1): 102-12.
- 10 Loghmani M & Warden S (2009) Instrument assisted cross fiber massage accelerates knee ligament healing. *Journal of Orthopedic and Sports Physical Therapy* 39(7).
- 11 Chou L, Hsieh YL, Kuan TS, Hong C (2014) Needling therapy for myofascial pain: recommended techniques with multiple rapid needle insertion. *BioMedicine* 4(2):39-46.
- 12 Butts R et al. (2016) Peripheral and spinal mechanisms of pain and dry needling mediated analgesia: a clinical resource guide for health care professionals. *Int J Phys Med Rehabil* 4:2.
- 13 Boal R & Gillette R (2004) Central neuronal plasticity, low back pain and spinal manipulative therapy. *Journal of Manipulative and Physiological Therapeutics* 27(5): 314-26.
- 14 Hegedus E, Goode A, Butler R, Slaven E (2011) The neurophysiological effects of a single session of spinal joint mobilization: does the effect last? *Journal of Manual & Manipulative Therapy* 19(3):143-51.
- 15 George S, Bishop M, Bialosky J, Zeppieri G, Robinson M (2006) Immediate effects of spinal manipulation on thermal pain sensitivity: an experimental study. *BMC Musculoskeletal Disorders* 7:68.
- 16 Gerber L, Shah J, Rosenberger W, Armstrong K et al. (2015) Dry needling alters trigger points in the upper trapezius muscle and reduces pain in subjects with chronic myofascial pain. *Physical Medicine and Rehabilitation* <http://dx.doi.org/10.1016/j.pmrj.2015.01.020>
- 17 Dunning J, Butts R, Mourad F, Young I, Flannagan S, Perreault T (2014) Dry needling: a literature review with implications for clinical practice guidelines. *Physical Therapy Reviews* 19(4): 252-65.
- 18 Chou L, Kao MJ, Jaung-Geng L (2012) Probable mechanisms of needling therapies for myofascial pain control. *Evidence-Based Complementary and Alternative Medicine* ID: 705327
- 19 Chae Y, Chang DS, Lee SH, Jung WM et al. (2013) Inserting needles into the body: a meta-analysis of brain activity associated with acupuncture needle stimulation. *Journal of Pain* 3:215-22.

Dry Needling Education and Training Requirements in the United States

While most states that allow dry needling do so without restrictions, thirteen states have regulations that list quite varied hours of education and coursework that fulfill their state's requirement to practice dry needling. A chart of these state requirements can be found at the end of this document.

The Washington State Board of Physical Therapy (Board of PT) does not require that courses taken by licensees in Washington be preapproved and they're not planning to change that requirement, so preapproval of dry needling courses would be problematic in our state. Some states require preapproval of courses, including but not limited to dry needling courses. This preapproval is sometimes done by the state board, the state association, the American Physical Therapy Association (APTA), or through a program called ProCert (which is a product that the Federation of State Boards of Physical Therapy began offering a few years ago). APTA is certified by the International Association for Continuing Education and Training (IACET), the international body that accredits CE providers. While APTA does not independently certify or approve courses, any course sponsored by APTA must meet IACET CE standards and requirements. The Commission on the Accreditation of Physical Therapy Education (CAPTE) accredits post-graduate physical therapy education programs, not post-graduate education. Please see the attached chart. As the chart demonstrates, some states do delineate the curriculum required for this dry needling continuing education in lieu of approving the course.

Supervision in the Military

In general, competency assessment is required of all members of the military staff and is demonstrated by one's performance in a designated setting. Performance must meet established standards that are determined, in part, by the work setting

and the employee's designated role in that setting. To ensure the competence and skill of those providing health care and services to every category of Department of Defense (DoD) beneficiaries, all health care personnel are provided supervision of their clinical performance, as appropriate. Physician supervision of members of another discipline (for example, OTs, PTs, nurses, pharmacists) is not required for functions performed that are within the scope of practice authorized by the individual's license, registration, certification, or privileges. (Source: Joint Task Force National Capital Region Medical MANUAL. March 29, 2012.)

The military Focused Professional Practice Evaluation (FPPE) program is "a system to evaluate and document the professional current competency of all practitioners in order to assure the highest quality of patient care by the organization."

"Focused Professional Practice Evaluation provides each Privileging Authority an opportunity to evaluate the privilege specific competency of a practitioner who does not have documented evidence of competently performing the requested privilege at the privileging organization. FPPE is time-limited and takes into account the practitioner's education, training, board certification and years of professional practice experience..."

<http://hm.navyadvancement.org/NAVMED%20POLICY%2009-002.pdf>

This program also helps healthcare professionals obtain supplemental privileges in areas of specialty practice. This training is offered for other specialty practice areas of physical therapy, such as electroneuromyographic examination and early intervention with high-risk infants in the Neonatal ICU.

The army document that pertains to physical therapists performing dry needling is titled "Physical Therapists and the Performance of Dry Needling" (MEDCOM Reg 40-60). This document is included in the appendix. The regulation states that a qualified supervisor must be someone that is privileged to perform dry needling. The preceptor will provide oversight in the form of direct and/or indirect supervision, as deemed appropriate, based on the individual needs of the physical therapist under supervision. Indirect supervision is defined as performing a retrospective review of selected records. Direct supervision is defined as the supervisor being involved in the decision-making process. This may be further subdivided as follows: Verbal- the supervisor is contacted by telephone or informal consultation before implementing or changing a regimen of care; and Physically present- the supervisor is present physically through all or a portion of the care. The preceptor will perform a formal review of the 25 cases (patients). In person supervision is not always available, and therefore verbal or indirect supervision is often employed. Of note, this program would allow a physical therapist with one course (typically 24 hours) of training to practice dry needling within the scope of the education provided in that course.

Additionally, the Army states “Dry Needling is based on western medical concepts and includes a neuromusculoskeletal examination, assessment, identification of a neuroanatomical basis for needle site selection, and neurophysiologic rationale for treatment effects. Dry needling does not rely on traditional Chinese or Eastern medicine theories, the stimulation of auricular or meridian-based acupuncture points and terminology, or restoration of energy flow within the body.”

Supervision requirements for endorsements are practical when qualified supervisors can be identified and are available. If this strategy were to be legislated in Washington state there would need to be access to a qualified cohort of physical therapists who could serve as supervisors.

Post-Graduate Continuing Education Courses

Pasted in below is additional information regarding the most common courses offered to physical therapists on dry needling. Following initial anatomy review and education on clean needle technique, the majority of each course is in the lab environment, and generally equates to over 70 percent of the hours dedicated to needle handling and technique. Of the most common courses, the ratio of students to instructor is 1:10. The students are supervised throughout the lab portion of the course. Students must pass a written and practical examination and are required to repeat the course until they are able to demonstrate competency with the techniques.

Many courses are 24 hours for the level 1 course and, when allowable by state law, require the therapist to perform cases on the areas taught in the first course only, prior to moving on to a second course. In states where the law does not allow performance of dry needling on patients until the completion of 50 or more classroom hours, some courses offer an intermediate course that allows additional patient practice. However, this regulation limits the clinician’s ability to perform the technique on patients and develop further clinical competency before going on to advanced training.

	Kineticore	Integrative Dry Needling	IAMT	Myopain	Spinal Manipulation Institute
Hours of actual needle handling	Out of 54 hours of level I and II there is at least 40 hours of needle handling.	Level 1 - 17 hours Level 2- 22 hours	We begin needling a few hours into the first day, and continue needling through the level 1 and level 2 courses. In the level 1 (27 course hours) there is approximately 24 hours of needle handling. In the level 2 (27 course hours) there is approximately 25 hours of needle handling.	70% needling	DN-1 and DN-2 are each 27 contact hours in duration--i.e. 54 face-to-face hours in total of dry needling training is required to earn the Certification in Dry Needling (Cert. DN). Students receive a comprehensive lecture on safe/clean dry needling technique, major and minor adverse events and relative/absolute contraindications related to dry needling. Students then immediately begin handling needles and continue to do so during the practical components of both the DN-1 and DN-2 courses. All courses include are 30% didactic and 70% hands-on practical application (needle handling). During all lab practical sessions, the primary and assistant instructors assess participants for needling technique and safety.
Supervision in class	1:6 in level one, 1:8 in level two	Groups of 3, 10 tables, one student needling at a time. Limit of 30 students in course. In lab 1:10 students who are handling needles.	1:10	1:10	1:10 instructor to participant ratio.

	Kineticore	Integrative Dry Needling	IAMT	Myopain	Spinal Manipulation Institute
<p>Describe competency assessment</p>	<p>Theory test (70% pass, people do fail), practical testing on site. 1 instructor for every 3-4 participants. Need to pass safety standards or fail the course. People do fail and need to retake course. Supervision during 1-2 day to identify people who may not be ready to pass test/course. Safe muscles in level 1, practice and submit a log of 200 needling sessions prior to level 2.</p>	<p>I apologize I did not get this information from the courses contact.</p>	<p>Attendees have techniques on the muscle list "checked off" throughout the course of the weekend, where they demonstrate to the instructors they are safe and competent with each technique. We have a written exam covering topics like contraindications & precautions, anatomy & indications, history and models of treatment, definitions, OSHA & clean needle technique. We have a practical exam where participants perform at least 3 techniques and are rated on clean needle technique, safety, anatomical knowledge and technique/application. They are asked regional anatomical precautions, overall contraindications and are asked to perform techniques representative of important skills –over the spine, in the presence of neuro-vascular precautions and visceral precautions. The attendees must pass the written and practical exam to receive credit for the course.</p>	<p>Each course is concluded with a theoretical examination and a practical assessment of muscles covered in the course. At the end of the 3 courses, there is a difficult 80-question theoretical examination and two practical examinations. One muscle is on the chest wall to evaluate the student's ability to avoid adverse events.</p>	<p>After completing 27 hours of onsite face-to-face training in DN-1 and 27 hours for DN-2 (54 hours total), students must pass a comprehensive written exam consisting of 71 multiple choice questions (142 multiple choice questions total) on safe/clean dry needling technique and precautions/contraindications related to dry needling. Students must also be familiar with the findings of clinical trials that have investigated the use of dry needling to treat common neuromusculoskeletal conditions. More specifically, students completing DN-1 must be familiar with the use of dry needling in patients with whiplash associated disorder, cervicogenic headaches, tension type headaches, migraine headaches, rib syndromes, facet joint dysfunction, cervical radiculopathy, mechanical neck pain, carpal tunnel syndrome, shoulder impingement syndrome, lateral/medial epicondylalgia, and TMJ dysfunction. Students that have completed DN-2 must be familiar with dry needling literature related to mechanical low back pain, multifidus dysfunction, piriformis syndrome, lumbar radiculopathy (sciatica), hip dysfunction, joint osteoarthritis, patella femoral pain syndrome, medial collateral ligament injuries, shin splints, ankle sprains, Achilles tendonitis and plantar fasciitis. In addition, students must understand the mechanical, hypoalgesic (central, segmental and peripheral), neurophysiologic, chemical, and hormonal effects of dry needling.</p>

<p>What advanced training options do you have passed the 54 hours</p>	<p>Kinetacore A course is available that can be offered before taking level 2 so that they get practice. They have a level 3 also.</p>	<p>Integrative Dry Needling In process of designing third course.</p>	<p>IAMT We have a Level 3 Dry Needling course as well as a Dry Needling Refresher course. The Level 3 course requires successful completion of our level 1 and level 2 courses. The Refresher course is used for various purposes. It allows folks who have completed at least our level 1 course, but haven't needed in while, a chance to get reacquainted with needling. We also use this course with some of our clients for annual compliance testing. Some of our clients require that their PTs demonstrate their dry needling skills on an annual basis in order to continue dry needling.</p>	<p>Myopain Our first Foundations course is 34 hours (3.4 CEU), our second Foundations course is also 34 hours (3.4 CEU). We offer an advanced course with 32 hours (3.2 CEU). The certification examinations are immediately following the DN-3 course</p>	<p>Spinal Manipulation Institute We offer a DN-3 Advanced Dry Needling Course within the 12-month, APTA-accredited American Academy of Manipulative Therapy (AAMT) Fellowship in Orthopaedic Manual Physical Therapy. This course more fully explores the peripheral, spinal and supraspinal mechanisms related to dry needling mediated analgesia and tissue repair. DN-3 also explores the use of dry needling for the complex patient suffering from pain-related conditions and includes an oral written and practical examination. Within the APTA-accredited AAMT Fellowship, we also offer a course Neuroanatomical Anatomy Course with Cadavers, which explores anatomical precautions commonly encountered during dry needling procedures. This course also focuses on identifying anatomical structures that are common targets of dry needling treatments.</p>
<p>Do you use acupuncture texts and if so, why</p>	<p>Only reference acupuncture texts to demonstrate that it is different.</p>	<p>Biomedical Acupuncture for Sports and Sports Rehabilitation: Dry Needling Techniques, Yun-tao Ma, Elsevier, 2010. IDN states that this title was used by the publisher due to lack of familiarity by the medical community at the time of publication. Their upcoming edition, which will be independently published, does not contain any reference to the word acupuncture.</p>	<p>NO! Absolutely not.</p>	<p>We do not as we are not teaching acupuncture.</p>	<p>We do not use acupuncture textbooks. During DN-1 and DN-2, dry needling is taught within the framework of Western/biomedical musculoskeletal diagnoses, not within the theoretical framework of traditional Chinese acupuncture or Oriental medicine, and not for the purpose of altering the flow of Qi or energy along traditional Chinese acupuncture meridians.</p>

Of note, even professions that commonly use needles in practice do not require a specific number of hours of training in needle handling. The Commission on Collegiate Nursing Education (CNNE) states that they do require clinical practice as a whole, but they do not prescribe the number of hours. Rather, the onus is on the program to be able to demonstrate that upon graduation, students have achieved the appropriate degree level competencies. In other words, there are no specific hours required as part of nursing education but rather it is incumbent upon the educational programs to ensure competency in the skill. We attempted to gather information from educational programs in Washington state on the hours of needle handling lab provided in entry level RN education, however we did not receive a response by the deadline. We believe it to be far less than the amount acquired in a level 1 Dry needling course (based on anecdotal surveys of recent RN graduates).

Common Procedural Terminology (CPT)

The concern has been raised about the lack of a specific CPT code for dry needling. The CPT code set provides uniform language that accurately describes medical, surgical and diagnostic services, and thereby serves as an effective means for reliable communication among physicians, qualified health care professionals, patients, and third parties. CPT coding is meant to describe practice, not dictate what acceptable interventions are.

The criteria by AMA on whether to add a CPT code for a Category I procedure is as follows (<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/applying-cpt-codes.page?>):

- All devices and drugs necessary for performance of the procedure or service have received FDA clearance or approval when such is required for performance of the procedure or service.
- The procedure or service is performed by *many* (emphasis added) physicians or other qualified health care professionals across the United States.
- The procedure or service is performed with frequency consistent with the intended clinical use (i.e. a service for a common condition should have high volume, whereas a service commonly performed for a rare condition may have low volume).
- The procedure or service is consistent with current medical practice.
- The clinical efficacy of the procedure or service is documented-in-literature that meets the requirement set forth in the CPT code change application.

While there is no way to confirm the reason for there not being a current CPT code, it is likely that despite its practice throughout the United States by physicians and physical therapists, it is not being performed by “many” clinicians.

CPT coding is not specific to any profession and therefore is not a determination of a physical therapist’s ability to perform any particular technique. Any provider may use almost any code, assuming that they are qualified and adequately trained.

APTA recommends that physical therapists check with individual insurance companies to determine which code should be used if that insurer covers dry needling. In general, if no specific CPT code exists to describe the services provided, then physical therapists should use the appropriate unlisted physical medicine/rehabilitation service or procedure code 97799. Payment would be determined based on review of the medical record and each individual insurer policy.

Furthermore, the presence of a specific CPT code does not ensure payment by any particular payer. <http://www.apta.org/Payment/Coding/AboutCPTProcess/> There have been many instances when the Editorial Panel has approved a new CPT code but a payer has determined that it will not pay for that service or procedure. Successful code development and valuing does not guarantee payment. For example, Medicare had a non-payment policy for the Negative Pressure Wound Therapy Codes (97605-97606) even though they were developed and successfully valued by the RUC process. Medicare ultimately reversed this policy after APTA asked for reconsideration. Private payers also have non-coverage policies for some procedures and services described by CPT. Therefore; it should not be assumed that lack of a code precludes payment, nor that having a code would guarantee payment.

Effectiveness of Dry Needling in physical therapy treatment.

Our initial applicant report cited several articles that show improvements in patient function as a result of dry needling.

A 2014 article by Casanueva showed improvements in pain, fatigue, global subjective improvement in patients with fibromyalgia six weeks after dry needling treatments, when compared with usual care.

The Gunn article from 1980 randomized 56 patients with chronic low back pain that had not improved with 8 weeks of standard care that included PT, OT, and exercise. The patients who underwent dry needling did so for 1- 2 times per week for an average total of 7.9 treatments. The group that had been treated with needling was found to be clearly and significantly better than the control group ($P > 0.005$, $N = 53$) with regard to status at discharge, status at 12 week follow-up, and status at final follow-up. At final follow-up, 18 of the 29 study subjects had returned to their original or equivalent jobs and 10 had returned to lighter employment. In the control group, only 4 had returned to their original work and 14 to lighter employment; 9 were still disabled.

A study by Edwards demonstrated that dry needling followed by active stretching was more effective than active stretching alone (Edwards 2003). This demonstrates that dry needling can enhance a physical therapy exercise program to address myofascial pain.

Cost effectiveness in physical therapy would be based on measuring the change in a patient’s health and function following intervention (Burge). Total cost of healthcare must take into account the expense of the intervention when compared with the impact of no treatment. Cost-effectiveness of physical therapy has been shown for several musculoskeletal conditions, such as neck pain, chronic low back pain, knee osteoarthritis, hip osteoarthritis, and patellofemoral pain syndrome. This is a relevant result, as the prevalence of musculoskeletal conditions is high.

Physical therapists provide low cost and low volume treatment plans for patients with musculoskeletal conditions. Physical therapists tend to have fewer numbers of visits for musculoskeletal conditions than other providers. In a study of Medicare beneficiaries analyzing 1,840 episodes of physical therapy care, physical therapists tend to treat patients on average 6.8 visits (Fritz). This is significantly lower than other healthcare providers who treat similar conditions.

Table 1. Participation Rates of Random Samples of Licensed Acupuncturists, Chiropractors, Massage Therapists, and Naturopathic Physicians by State.

Profession and State	Eligible Practitioners Interviewed		Eligible Practitioners Providing Visit Data		Patient Visits Reported‡	
	No.	Percent*	No.	Percent†	Total	Mean per Practitioner
Acupuncture						
Massachusetts	101	91.0	67	75.3	1,298	19.4
Washington	116	88.6	66	81.5	1,263	19.1
Chiropractic						
Arizona	104	61.2	62	68.1	1,201	19.4
Massachusetts	101	85.6	68	76.4	1,349	19.8
Massage Therapy						
Connecticut	114	85.7	61	65.6	965	15.8
Washington	112	83.6	65	69.9	1,040	16.0
Naturopathy						
Connecticut	59	93.6	34	61.8	631	18.6
Washington	111	78.2	65	69.9	1,186	18.2

*Denominator is licensed practitioners who see patients and for whom a telephone number could be identified.

†Denominator is interviewed practitioners who saw a minimum number of patients per week (varied by profession—see Methods section of text).

‡Each practitioner was asked to provide descriptive information on 20 consecutive patient visits.

Physical therapy plans of care are based on specific goals related to function, therefore improvements in pain and function will inherently lead to a reduction of visits if goals are met, as well as a reduced cost to society through disability and time loss from employment and life duties. Unfortunately there is not literature at this time that specifically attempt to measure whether dry needling reduces the overall number of treatment visits since most studies follow a protocol for specific number of dry needling treatments with a goal of showing efficacy and improved outcomes rather than a reduction in visits. More research is needed in this area.

Bürge E, Monnin D, Berchtold A, Allet L. Cost-effectiveness of physical therapy only and of usual care for various health conditions: systematic review. *Phys Ther*. 2016;96:774–786.

Casanueva, B., Rivas, P., Rodero, B. et al. Short-term improvement following dry needle stimulation of tender points in fibromyalgia. *Rheumatol Int* (2014) 34: 861-866.

https://www.kinetacore.com/physical-therapy/assets/files/Prep_Materials/Level_1_FDNDry_needling_of_muscle_motor_points_for_chronic_low_back_pain.pdf

Cherkin DC et al. Characteristics of visits to licensed acupuncturists, chiropractors, massage therapists, and naturopathic physicians. *J Am Board Fam Pract*. 2002 Nov-Dec;15(6):463-72.

<http://www.jabfm.org/content/15/6/463.long>

Edwards J, Knowles N. Superficial dry needling and active stretching in the treatment of myofascial pain – a randomised controlled trial . *Acupunct Med* 2003 21: 80-86.

Fritz, J. M., Hunter, S. J., Tracy, D. M., & Brennan, G. P. (2011). Utilization and Clinical Outcomes of Outpatient Physical Therapy for Medicare Beneficiaries With Musculoskeletal Conditions. *Physical Therapy*, 91(3), 330-345. Accessed August 10, 2016. <http://dx.doi.org/10.2522/ptj.20090290>.

Gunn CC, Milbrandt WE 1980 Dry needling of muscle motor points for chronic low back pain. A randomized clinical trial with long-term follow-up. *Spine* 5: 3.

Is Dry Needling Acupuncture?

Our applicant report thoroughly describes the description of trigger points and the origins of the practice of dry needling. As early as 1977, Melzack et al noted high correspondence between myofascial trigger points and Ah-Shi acupuncture points. Melzack concluded, “Trigger points and acupuncture points for pain, although discovered independently and labeled differently, represent the same phenomena.” However, this concept has been studied and our knowledge has evolved over the past 40 years. Stephen Birch, PhD, Lic Ac, stated, “In the 1970s if the medical community was to start using acupuncture, it was important to establish a clear link between known anatomically based medical knowledge and the less well known and not accepted East Asian origin acupuncture knowledge. In other words, the importance of the study lies in its attempts at replacing traditional ideas and explanations of the nature of acupuncture points and mechanisms by which they work with modern anatomico-physiologically acceptable explanations.”

Birch (2008) went on to state that traditional acupoints do not exhibit the defining characteristics physiologically or clinically of myofascial trigger points (tenderness, taut band, and familiar pain). Only the class of extra, nonchannel points known as ashi points exhibit similar qualities as a feature. Birch looked at this landmark study

by Melzack again in 2003 to determine whether the initial correlations between acupuncture points and ashii points were accurate.

“There are literally dozens of acupoints with the indication of “low-back pain”; the more important question is out of all those, which are actually listed in the treatment sections of the texts as being recommended for the low-back pain? When I looked at the 1977 study, I noticed and then demonstrated in my 2003 review that many of the supposedly corresponded acupoints, such as BL-42, BL-45, SP-17, SP-19, ST-13, ST-15, KI-24, are never indicated for the treatment of pain and hardly ever for the treatment of anything else either.”

Birch states that of the 50 acupuncture points examined by Melzack, 60.4 percent are not recommended at all for the treatment of pain in acupuncture. Only 18.8 percent of these points are recommended for pain in the acupuncture literature. Additionally, of the 50 acupuncture points addressed in the original study, only 19.6 percent are used in general acupuncture treatments and 44.4 percent are not recommended at all. Furthermore 35 percent of the acupuncture points for the treatment of pain lie distal to the site of pain, meaning that the mechanism of directly treating the trigger point could not apply. He concluded: “However, it is probable that there is some overlap in the location of acupuncture points and trigger points, but it is unlikely to be more than chance, and such similarity of location does not imply a correlation.”

Literature continues to emerge showing highly variable levels of correlation. In the end, this argument is a philosophical one that will likely not be resolved by us. The confusion over these two concepts is perpetuated by the medical community’s ongoing use of the two terms interchangeably in the literature, making it difficult to draw comparisons or distinctions. Regardless, no one profession owns a particular body part, dysfunction or disease. Trigger points are treated by physical therapists, occupational therapists, massage therapists, physicians, chiropractors, and many others with varying techniques and strategies based on their foundational knowledge and practice framework.

Melzak, R. Trigger points and Acupuncture Points for Pain: Correlations and Implications. *Pain*, 3(1977) 3-23. <http://www.skypig.info/pdf/trigger/5.pdf>

Birch, S. Trigger Point–Acupuncture Point Correlations Revisited. *The Journal of Alternative and Complementary Medicine*. 9 (2003) 91-103.

Birch, S. On the Impossibility of Trigger Point- Acupoint Equivalence: A Commentary on Peter Dorsher’s Analysis. *The Journal of Alternative and Complementary Medicine*. 14 (2008) 343-345.

Conclusion

Thank you for the opportunity to provide additional comments to the Department of Health to supplement our applicant report and public hearing testimony. We have provided additional information on key points of the issue of dry needling by physical therapists, including how dry needling fits into a physical therapist's treatment plan; continuing education on dry needling for physical therapists throughout the country; dry needling performed by physical therapists in the military; the cost effectiveness of dry needling in physical therapist practice; and the ongoing debate of dry needling vs. acupuncture.

Our applicant report, public testimony and these additional comments support the conclusion that dry needling is a safe, effective and appropriate tool for physical therapists to use in treating patients with musculoskeletal impairments. Physical therapists in the majority of the United States and our armed forces are using dry needling as one of the tools available to help get patients better, quicker. Therefore, PTWA urges DOH to recommend that dry needling be added to the physical therapy scope of practice in Washington.

Dry Needling Education & Training Requirements in the States

APTA State Affairs - April 2016

Arizona	<p>A PT must complete a minimum of 24 contact hours of education and provided documented proof of compliance within 30 days of completing the course or within 30 days of initial licensure. Course content shall be approved by one or more of the following entities prior to the course being completed:</p> <ul style="list-style-type: none"> • Commission on Accreditation in Physical Therapy Education (CAPTE) • APTA • State chapters or specialty groups of the APTA • Federation of State Boards of Physical Therapy (FSBPT) <p>Course content shall include the following components of education and training, and shall include passage of both a written and practical exam before completion of the course content; examination shall be done in person:</p> <ul style="list-style-type: none"> - Sterile needle procedure to include one of the following standards: <ul style="list-style-type: none"> • The U.S. Centers for Disease control and Prevention, OR • The U.S. Occupational Safety & Health Administration - Anatomical Review - Blood Borne Pathogens - Contraindication and Indication for Dry Needling. <p>Dry Needling shall not be delegated to assistive personnel.</p>
Colorado	<ul style="list-style-type: none"> • 2 years of clinical practice as a licensed PT. • 46 hours of in-person dry needling education & training.



	<ul style="list-style-type: none"> • The course instructor of the dry needling course must also have met the same pre-requisites and have two years of experience.
DC	<ul style="list-style-type: none"> • Documented proof of sufficient education and training to ensure competent practice. • Self-study and online courses in dry needling are not acceptable.
Delaware	<ul style="list-style-type: none"> • The program shall be a minimum of 54 hours, which shall be completed within no more than two years. The Physical Therapist shall successfully complete the minimum passing criteria for the dry needling program. • Physical Therapists who are performing dry needling at the time of enactment of this regulation, and who have completed 25 hours of dry needling education, may continue to practice dry needling, upon submission of proof of experience and education to the Board. Such Physical Therapists shall complete the required 54 hours of education within two years after enactment of this regulation. • A dry needling training program shall include the following to be eligible for Board approval: <p>Shall require each trainee to demonstrate successful psychomotor and cognitive performance through practical and written examination.</p> <p>Attended in person, shall not be attended online or through any other means of distance learning and shall not be a self-study program.</p> <p>The program curriculum shall include the following: History and current literature review of dry needling and evidence based practice; Pertinent anatomy and physiology; Choice and operation of supplies and equipment; Knowledge of technique including</p>



	<p>indications and contraindications and precautions for use; Proper technique of tissue penetration; Knowledge of hazards and complications; Safe practice guidelines and generally accepted standards of practice including clean needle techniques and OSHA's blood-borne pathogen standards; Post intervention care, including an adverse response or emergency; Documentation of successful completion of psychomotor and cognitive performance through practical and written examination.</p> <ul style="list-style-type: none"> • The dry needling program, including the required supervised training, shall be taught by a Physical Therapist who meets the qualifications of Regulation 15.4.
Illinois	Board regulations in process – not yet adopted
Louisiana	<ul style="list-style-type: none"> • 2 years of experience as a licensed PT. • 50 hours of education & training in dry needling. • Online and distance learning are not acceptable. • Course instructor must be a licensed healthcare provider with minimum 2 years of experience in dry needling.
Maryland	Board regulations in process – not yet adopted.
Montana	Board regulations in process – not yet adopted.
Mississippi	<ul style="list-style-type: none"> • 3 years of experience as a licensed PT. • 50 hours of education & training. • Online coursework not acceptable. • Course provide must meet same pre-requisites.
Tennessee	<p>Must be performed by PT, cannot be delegated to a PTA or support personnel.</p> <p>50 hours of instruction, to include instruction in each of the following areas, which are generally satisfied during the normal course of study in physical therapy school:</p> <ul style="list-style-type: none"> • Musculoskeletal and neuromuscular systems;



	<ul style="list-style-type: none">• Anatomical basis of pain mechanism, chronic pain, and referred pain;• Trigger points;• Universal Precautions <p>24 hours of dry needling specific instruction that includes instruction in each of the following 6 areas:</p> <ul style="list-style-type: none">• Dry needling technique;• Dry needling indications and contraindications;• Document of dry needling;• Management of adverse effects;• Practical psychomotor competency, and• Occupational Safety and Health Administration's Bloodborne Pathogen Protocols. <p>Each instructional course must specify what anatomical regions are included in the instruction and describe whether the course offers introductory or advanced instruction in dry needling. Must be obtained in person, cannot be obtained via online learning. Course be approved or pre-approved by the TN licensure board.</p> <p>PT must have one year of experience unless they can demonstrate compliance with the 24 hours of specific dry needling instruction through pre-licensure educational coursework.</p> <p>A physical therapist practicing dry needling must supply written documentation, upon request by the Board that substantiates training.</p> <p>All physical therapy patients receiving dry needling shall be provided with information from the patient's physical therapist that includes a definition and description of the practice of dry needling, and a description of any risk benefits and potential side effects of dry needling.</p>
--	---



Utah	<ul style="list-style-type: none"> • Complete a course of study in dry needling of 300 hours that includes at least 54 hours of in-person instruction and 250 supervised treatment sessions.
Virginia	Board regulations in process – not yet adopted Former VA PT Board policy recommended 54 hours.
Wyoming	<p>Licensed physical therapists shall demonstrate that they have received training in dry needling in a course approved by state boards of physical therapy, the American Physical Therapy Association or individual chapters of the American Physical Therapy Association, the Federation of State Boards of Physical Therapy, or the International Association for Continuing Education Training.</p> <ul style="list-style-type: none"> • The course shall include but not be limited to training in indications, contraindications, potential risks, proper hygiene, proper use and disposal of needles, and appropriate selection of clients. • The course shall include a minimum of twenty-seven (27) hours of live face-to-face instruction. Online courses are not appropriate training in dry needling. • The physical therapist shall supply written documentation, upon request by the Board, that substantiates appropriate training as required by this rule. Failure to provide written documentation may result in disciplinary action taken by the Board. <p>Dry needling may not be performed by a PTA or a physical therapy aide.</p>



Appendix C

Public Hearing Summary

Dry Needling Sunrise Review
Public Hearing Summary
August 2, 2016

The hearing began at 1:00 PM. Andy Fernando, Rules and Legislative Implementation Manager in the Health Systems Quality Assurance Division, provided instructions for the hearing and introduced staff and panel members. This hearing was for the sunrise review of a proposal to add dry needling to the physical therapy scope of practice.

Introductions:

- Sherry Thomas is the Sunrise Review Coordinator
- Brandy Ragsdale and Jennifer Bush assisted with the hearing

The panel members' role was to ask questions and make sure the department has all the information necessary to make a sound recommendation. Panel Members:

- Katie Wolt is a policy analyst in the Health Systems Quality Assurance Division of the Department of Health. Katie facilitates and consults on legislative and policy issues within the division, and has previously held communication and health education positions within the Department. Katie holds a master's degree from the Evergreen State College in Environmental Studies.
- Maggie Pagel is a staff attorney in our Office of Legal Services. She has her bachelor of arts in political science and a JD degree.
- Jennifer Coiteux is the operations manager in our office of customer service. She holds a bachelor of science in exercise science, a bachelor of arts in psychology and a master's degree in public administration. Jennifer has held various positions in the department including legislative analyst and program manager.
- Julie Tomaro is the program manager for the hospitals and residential treatment facility programs and a school nurse for a rural school district. She has her Bachelor of Science degree in nursing and a master's degree in public health. Julie began her nursing career in the emergency room before transition into government public health.

Mr. Fernando explained that the purpose of the hearing was for the proponents to make their presentation and for opponents and other interested parties to comment on the proposal. The panel members and department staff would be asking questions of the proponent and public members who testified. He reminded participants to please keep in mind during their presentations and written submissions that the sunrise review process has statutorily mandated criteria. We try to stick to those as much as possible. As this was not a legislative hearing, he stated that political arguments or other factors not included in the criteria the legislature has given us would not help or hurt the proposal being reviewed. It is the legislature's job to take those into account; they specifically have asked us to look only at certain criteria. He told participants that it would be his job to try to keep them within the time limits as well as the limits of the review.

Applicant Presentation

Jan Dommerholt

Good afternoon. My name is Dr. Jan Dommerholt. I am a physical therapist, researcher and educator specialized in dry needling from Bethesda, MD. Thank you for the opportunity to share some thoughts about dry needling with you. In 1997, I taught the first dry needling course in the United States. I am the main editor of the only scientific textbook on dry needling and author and co-author of many scientific papers and research studies on myofascial pain and dry needling. I direct a post-graduate continuing education company and we conduct over 100 dry needling courses annually throughout the United States and in many countries around the world. I am a guest lecturer at several universities in the US and abroad.

Dry needling is a technique to alleviate pain and improve function and movement. The technique is performed with a thin filiform needle that most commonly is inserted into myofascial trigger points. In addition, physical therapists use dry needling to treat adhesions in scar tissue, fascia and connective tissue. Dry needling is nearly always a small part of a comprehensive physical therapy management plan and the technique is used primarily by

orthopedic and sports physical therapists. For example, I have trained the physical therapists of the Association of Tennis Professionals (ATP), the Women's Tennis Association (WTA), and several professional sports teams. Practically, every professional sports team in the United States employs physical therapists performing dry needling on their athletes! More recently, dry needling is being used to reduce spasticity, for example, in people who suffered a stroke or other neurological ailment.

In the United States, the Maryland Board of Physical Therapy Examiners was the first physical therapy state board to approve the technique of dry needling in 1984 (!) in close cooperation and coordination with the Maryland Acupuncture Society. Since 1984, the majority of state physical therapy boards have approved dry needling to be within the scope of physical therapy. However, the dry needling technique is also in the scope of many other professions, such as dentistry, medicine, veterinary medicine, acupuncture, and in some states chiropractic, occupational therapy and athletic training. I teach dry needling courses for veterinarians, which are accredited by RICE, the major accreditation agency for veterinary physicians in the US. I have also taught several dry needling courses for dentists both in Europe and in the US. In the US, those courses were approved by the American Academy of Orofacial Pain.

Several State Attorney Generals concluded that such an overlap in scope of practice is not only desirable, it is a prerequisite for a functional healthcare system, a view that is consistent with the Pew Health Commission Taskforce on Health Care Workforce Regulation and the Federation of State Medical Boards of the United States. Suggesting that the needle is a tool that is reserved to only one particular discipline, is like saying that only a cardiologist would be allowed to use a stethoscope. Do we really want a healthcare system where one profession claims exclusive rights over a tool? When I use a stethoscope in my physical therapy practice, I do not suggest that I am a cardiologist.

Along these lines, you may hear testimony suggesting that the Food and Drug Administration (FDA) would agree with the exclusive use of a filiform needle by one profession only, however, let us take a look at the facts. When the FDA down-classified acupuncture needles and promulgated 21 C.F.R. § 880.5580, the FDA stated that acupuncture needles are for use by qualified practitioners as determined by the states. To comply with the prescription device regulation special control generally, according to 21 C.F.R. § 801.109(b)(1), prescription devices must bear the following statement:

“Caution: Federal law restricts this device to sale by or on the order of a _____”, the blank to be filled with the word “physician”, “dentist”, “veterinarian”, or with the description designation of any other practitioner licensed by the law of the State in which he practices to use or order the use of the device.”

Together, the FDA regulations at 21 C.F.R. §§ 880.5580 and 801.109 make clear that the determination of who is authorized to use acupuncture needles is a matter left to the states.

In addition, the FDA has approved specific “Dry Needling Needles” also referred to as “physiotherapy needles” for the use of dry needling by physical therapists in the United States.

You will likely hear testimony later this afternoon, that dry needling by physical therapists would constitute a severe threat to public health. You will be told that physical therapists can learn dry needling in a few weekend courses, while acupuncturists complete a two-year master's degree in acupuncture. Therefore, as will be suggested, dry needling by physical therapists must be unsafe and a danger to the public.

I would like to review the facts with you rather than rely on random and unsupported statements. I find it personally hard to believe that all those state boards across the entire United States would jeopardize public safety when they approved dry needling. In fact, since the Maryland Board approved dry needling 32 years ago, the board has not received any major complaints questioning the safety of dry needling or evidence of severe adverse events. If dry needling would endanger the public, would you not expect, that physical therapists would be brought to court by injured patients? Once again, quite to the contrary! The major liability or malpractice insurance for physical therapists has issued statements that dry needling does not pose an increased risk. Do we really believe that when an insurance company is confident that physical therapists performing dry needling with the highest possible standards, that dry needling would still be a threat to public health? The Federation of State Boards of Physical Therapy maintains a Disciplinary Database of all actions taken by physical therapy state boards in the country and the database does not contain a single citation describing harm or injury from dry needling

by physical therapists. Similarly, would professional football, baseball, and basketball teams employ physical therapists to use dry needling on their professional athletes, if dry needling by physical therapists would pose such a risk?

Dry needling is not just widely practiced by physical therapists in the US. Dry needling is in the scope of physical therapy practice in every province of Canada. Again, are we assuming that the Canadian state authorities were irresponsible when they approved dry needling? Did Canada experience a sudden increase in accidents and other adverse events caused by physical therapists? Of course, the answer is no. Fact is that physical therapists from Canada to Chile, from Australia to Abu Dhabi, and from Denmark to Dubai and many other countries such as the United Kingdom, Ireland, Sweden, Norway, Switzerland, Spain, and South Africa, Belgium and the Netherlands, Peru and Ecuador are using dry needling in their daily work. There is no evidence whatsoever, that dry needling would not be safe. Why do you think all branches of the United States Military have approved dry needling by physical therapists? Is it a coincidence that the Physical Therapist to the President of the United States is certified in dry needling?

But if you think that this still does not provide enough support for allowing physical therapists in Washington State to utilize dry needling, let us take a look at the scientific literature. There are literally hundreds of scientific studies of dry needling and many of those are conducted by physical therapists. In 2014, I was one of the authors of an adverse events study of dry needling by physical therapists. We prospectively evaluated nearly 8,000 (!) physical therapy treatments with dry needling and we found that the risk of a significant adverse event, such as a pneumothorax or collapsed lung, was less than 0.04%.

I think you will agree that the risk is indeed very small. In this context, are you aware that several studies have shown that physical therapists have the most advanced knowledge of the musculoskeletal system compared to all other medical disciplines except orthopedic surgeons? The level of education of physical therapists in the United States makes physical therapists uniquely qualified to perform dry needling.

Therefore, to suggest that physical therapists would not be capable of learning dry needling in a relatively short time as a complimentary technique to their already wide musculoskeletal knowledge base and skill set is simplistic and not based on the facts. Furthermore, The Washington State Legislature has already determined that the physical therapist scope of practice includes other tissue penetrating procedures such as sharps debridement and needle electromyography, which are far more complicated than dry needling.

You may also hear testimony that dry needling would be particularly dangerous for pregnant women as physical therapists may not be familiar with so-called forbidden points. In some acupuncture circles, there is a lingering belief that needling such points could lead to triggering a spontaneous abortion. Once again, let us look at the facts. The scientific acupuncture literature has repeatedly refuted the concept of these forbidden points. In one study, nearly 6,000 pregnant women were purposely needled in these points during all stages of pregnancy and nothing happened. Other studies in the scientific acupuncture literature have refuted the existence of these points.

Finally, let us talk about the benefits of dry needling. I already mentioned the widespread use of dry needling among professional athletes, but dry needling is also very suitable to patients with low back and neck pain, migraines and tension- type headaches, tennis elbow, and other musculoskeletal problems within the scope and expertise of physical therapists. Is dry needling for everyone? The answer is no. Physical therapists are qualified to determine for which patient populations dry needling may not be indicated, such as patients with compromised immune systems or patients with advanced dementia. By adding dry needling to the scope of physical therapy in Washington State, physical therapists will have more and better options to treat patients and avoid unnecessary surgery or a prolonged dependence on opioid prescriptions. Studies have shown that adding dry needling to other evidence-based therapies will speed up recovery and reduce pain medication intake. Even in complex pain problems, such as complex regional pain syndrome, dry needling caused objective changes in the muscles and an improved return to function.

The American Physical Therapy Association considers dry needling to be part of the practice of manual physical therapy and I hope you will come to the same conclusion as so many states and countries have done before you.

Thank you for your attention and I am available to answer any question you may have.

Dan Anton

I'm Dr. Dan Anton a professor of orthopedics and chair of the Department of Physical Therapy at Eastern Washington University. I'm a physical therapist and have a PhD in Rehabilitation Sciences from the University of Iowa where I was previously a faculty member in the College of Public Health. Before that, I was in outpatient orthopedic private practice for 16 years. I'm here to talk to you today about entry level Doctor of Physical Therapy education and how it pertains to dry needling.

Entry level physical therapy education in the United States takes place at the post baccalaureate level. Entrance into physical therapy school is highly competitive. This last year alone Eastern Washington University had over 600 qualified applicants for 38 slots, and this is not unique to Eastern. Applicants must have an undergraduate degree and an excellent science GPA. The average science GPA of our last few new classes averaged 3.8 on a 4 point scale.

A typical Doctor of Physical Therapy, or DPT, program is three years long, comprising over 9000 hours of post baccalaureate education. The first year covers basic sciences that a DPT must know, such as medical physiology, pathokinesiology, pathology, neuroscience, and two quarters of gross anatomy as well as neuroanatomy. In gross anatomy, groups of 4 to 5 students share one cadaver and dissect the entire body. To our knowledge, no other health science curriculum requires as much anatomy as a DPT program. In fact, students have 160 hours of anatomy coursework compared to the UW medical students who have about 120 hours. Our anatomist, Dr. Kimberly Cleary, is also a physical therapist. Therefore, students learn anatomy with a clinical emphasis, as is taught in most physical therapy schools.

Also during the first year, students begin to learn clinical sciences such as differential diagnosis, physical examination, and surface anatomy which supplements gross anatomy. It is during the first year that students begin to learn important anatomical relationships such as locations and depth of tissues, which are important concepts regardless if dry needling, joint mobilization or physical examination techniques are conducted. Specific to dry needling, students learn the anatomy of the vascular system to avoid puncturing major blood vessels or otherwise impeding their flow. Students also learn and dissect all internal organs. For example, they learn the location of the kidneys and lungs to avoid puncturing these organs with needles. Although excellent 3-D apps to learn anatomy are available, we believe cadaver anatomy is superior to learning these anatomical relationships.

Students focus on clinical sciences during the second year of the DPT program. For example, they take the year-long musculoskeletal systems courses that I teach as well as a year of neuromuscular systems, cardiovascular systems, among others. The main emphasis during the second year is the development of clinical reasoning skills regardless of patient, diagnosis, or anticipated treatment. Students are taught to examine and treat the patient as a whole rather than just someone with back pain, or someone with a stroke, or heart disease. In other words, a patient where dry needling might be indicated would be examined and treated the same as if a strengthening program were indicated. It is important to note that entry level DPT students are taught to develop a comprehensive treatment plan instead of relying on a certain type of treatment such as dry needling. DPT students also have several internships including the entire third year of the curriculum. Since they are required to have at least one internship in an acute care hospital and one in a rehabilitation environment, they will likely be exposed to other tissue penetrating procedures in the physical therapy scope of practice other such as sharps debridement and needle electromyography.

So how does this training pertain to dry needling? First, we do not consider dry needling an entry level technique, similar to electrodiagnostic testing such as fine wire electromyography. In Washington, graduates who wish to practice electrodiagnostic testing must complete the requisite continuing medical education and apply for an endorsement to their license. Although dry needling is not specifically included in entry-level education for physical therapists, some programs have begun including it in their curriculum. Additionally, it's an intervention listed in the Guide to Physical Therapist Practice. This is a document published by the American Physical Therapy Association, which describes Physical Therapist practice, including examination, clinical decision making, and intervention selections based on impairments which are treated by Physical Therapists.

In summary, DPT education provides the student with a rigorous clinical and practical training that prepares the student for physical therapy practice. This education and training includes the foundational knowledge to perform dry needling. Thank you for your time.

JJ Thomas

Good afternoon, my name is JJ Thomas. I am a physical therapist who practices in DE and PA, and I am a specialist in dry needling both clinically and as an educator. I have participated in legislative issues regarding dry needling in physical therapy nationally, and was one of 7 experts chosen by the Federation of State Boards of Physical Therapy (FSBPT) to participate in the practice analysis study designed to examine what Physical Therapists must know and be able to do to perform dry needling safely and effectively. The intent of this independent study was to provide professionally-developed guidance and objective data to assist jurisdictions with questions they may have related to the safe practice of dry needling.

Having been selected to participate in this study, I would like to begin by highlighting a few key elements of it that are pertinent to our purposes today:

It was commissioned by the FSBPT, whose sole mission is to protect the public. The Federation is not a professional association; it is comprised of the 53 jurisdictional licensure boards that regulate physical therapy in the U.S. to ensure public protection. Direct quotes from their mission statement demonstrate this: Their mission statement is “to protect the public by providing service and leadership that promote safe and competent physical therapy practice.”

The Federation prioritizes the public’s best interest, and in line with this, they commissioned an outside independent entity to design, implement, and conduct the study. The Federation selected HumRRO, a Human Resource Research Organization. HumRRO is respected for utilizing the science and practice of education research, evaluation, and measurement to give data that can improve educational outcomes and inform education policy.

There were 2 main objectives of the research. The first objective was to define Dry Needling Competencies by physical therapists, and the second objective was to evaluate factors that impact safe and effective dry needling.

To achieve these goals, HumRRO first performed a practice analysis. The practice analysis studies the work itself in order to identify the tasks clinicians perform on the job. Then HumRRO investigated the knowledge, skills, and abilities needed to perform those tasks. Additional information was collected to identify criteria for evaluating the quality of performance on a task. HumRRO was able to organize the results into a list of the knowledge, skills and ability requirements for competent performance of dry needling. And finally, HumRRO compared the knowledge, skills, and ability requirements needed to perform dry needling with the knowledge, skills, and ability requirements obtained through baseline Physical Therapy education (currently doctoral programs).

The implementation of the Study had 3 main parts; a background review, a practitioner survey, and a task force meeting.

The background review yielded information from text publications, periodicals, peer reviewed research journals, instructional curricula and testing materials related to the National Physical Therapy licensure Exam. The purpose of the background review was to obtain theoretical, procedural, and descriptive information on dry needling and translate it into a preliminary set of competencies for physical therapists.

The Practitioner Survey was performed to identify entry-level physical therapy tasks and knowledge (required at the time of licensure) that are also required for dry needling. Over 350 physical therapists from a variety of practice settings participated in the study. The survey gave baseline insight into what entry level tasks and knowledge criteria are relevant or not relevant to competency in dry needling. The information identified from the survey was incorporated into the draft list of tasks and competencies developed during the background review. These lists were later analyzed by the Task Force.

The Task Force consisted of 7 dry needling experts, and our primary objective was to identify knowledge, skills, and abilities that are specifically needed for competency in dry needling. We also evaluated what entry level knowledge is required for state licensure that is also relevant for competence in dry needling. Additionally, we identified tasks and knowledge that are specifically needed for performing the dry needling technique.

HumRRO content analyzed the data collected from all three components of the study, and what they found was pretty remarkable. Of the 200+ job tasks identified as necessary for licensure as an entry level PT, nearly 1/2 of them were relevant to dry needling. The study also revealed that 86% (more than 4/5) of what physical therapists need to know to be competent in dry needling is acquired during their entry level clinical education. The other 14% (16 specific

knowledge criteria) need advanced or specialized training, and these criteria are almost solely related to the dry needling technique itself.

What this shows is that while some post-graduate training specific to dry needling should be completed by physical therapists, the calls by our opponents for 300+ hours are unfounded.

In considering this sunrise application we ask that you please consider the facts and data. We believe that the results of the study conducted by HumRRO, a respected organization dedicated to improving educational outcomes and inform education policy, should be given greater weight than opinions expressed by individuals who have no expertise in physical therapy education or practice.

Panel Questions

Q: I have a question specifically about the needle. You talked about a physiotherapy needle. How is that different than a filiform needle?

R: The needles look exactly the same. The process of making the needle is different than the process to make acupuncture needles. The last step of the process of making the needles, they are heated to an extreme temperature which changes the molecular structure of the needle. That makes it more suitable for dry needling. But if you look at it, it looks just like an acupuncture needle. The FDA has recognized it is different by granting permission for it to be marketed and sold, and the individual packaging says both the terms dry needling needle and physiotherapy needles are used.

Q: I have some follow up questions about the training for PTs, specifically around the hands-on supervised training. Is that with cadavers and clean needle technique? Can you tell me about any of the aspects of that training?

R: Training related to cadavers in the 54-hour training? Yes, four students get one cadaver and they dissect the entire cadaver.

Q: The way I understood that was that it was in the general PT training?

R: Yes, that's in doctoral PT training.

Q: For dry needling training, are cadavers used?

R: No, they would not be used and that wouldn't make sense, in all respect because physical therapists already have the knowledge about cadavers and 3-D anatomy. There's no reason to repeat that. We offer a post-dry needling anatomy course on cadavers so people can really verify and hone skills, but there is no prerequisite to do that. Regarding clean needle technique, all physical therapists are trained to meet OSHA standards, which by far exceed the clean needle techniques that acupuncturists use in their training. There are several things in the clean needle technique that acupuncturists use, you may argue they are inconsistent with OSHA. For example, not wearing gloves while the skin is being penetrated.

Q: Are needles used in physical therapy school in the doctoral program, and what is taught?

R: Depending on the school, they are taught dry needling. We don't teach it here in Washington but it is taught in other physical therapy programs throughout the country, and as I understand, internationally.

Q: On page 11 of the application, it states patients with myofascial pain are referred to physical therapists. In your experience, what percentage of the PT patient population would benefit from dry needling?

R: The way the physical therapist uses dry needling is, again, based on our foundation of neuromusculoskeletal anatomy as it relates to movement and function. When we do an evaluation, we're doing the same evaluation we would do if someone came in and said they couldn't reach the upper cabinet because my shoulder hurts and I've lost range. We would do a full evaluation that includes their history, background, past medical history, and from there we would put them through a whole slew of movement tests that include active motion, passive motion, strength testing. Then we would check to see if they are limited because their joint is restricted or because their soft tissue is limiting them. All these factors would come into play, and from that we would decide if they are dry needling appropriate. I personally find that dry needling is very appropriate for the right person when they have a soft tissue component. That's probably the most often when I use the technique, when there is a musculoskeletal component. There are plenty of other applications as well.

Q: About how many of your patients have a soft tissue component?

R: That's a trickier question because as a dry needling specialist, often people come to me because they have learned or have been referred specifically for dry needling. Probably 90 percent of my patients get dry needling, but I don't think

that's the norm.

Q: On page 19 of the report, it says that results from acupuncture studies cannot be applied because it's different in both location and depth of needle insertion. Can you explain how it's different than acupuncture? I don't think I have a clear understanding of how dry needling is not acupuncture and what the differences are.

R: That's a good question and not one to which we have an easy answer because you can argue any side of it. When we talk about acupuncture, we have to realize there are many different schools of acupuncture. I live in Maryland and the school in Maryland has a very different training program than the school in New York City, for example. In China alone, there are over 80 different schools of acupuncture. The schools in the United States are all slightly different. When you talk about acupuncture, the question is, what type of acupuncture are you referring to, traditional Chinese, Japanese, Vietnamese, French Vietnamese, Maryland, etc. There are so many variabilities, it's almost like you guessing what kind of car I drive without me telling you. The argument will be made by acupuncturists that dry needling has already been practiced for thousands of years, by needling *ashi* points, using lift and thrust techniques, which is true. There is no question that acupuncturists can do this and it is in their scope. The issue is whether it is exclusive to acupuncturists or whether opening up the scope is necessary. At the same time, in my teaching program we have acupuncturists in every single course. Every acupuncturist who has attended my courses since 1997 has said it is entirely *than anything I've ever learned in acupuncture school*. Are they the same? There's overlap. The biggest difference I will emphasize to you is that acupuncture is a discipline and dry needling is a technique that, yes, belongs in the field of acupuncture but I also teach a course for veterinary doctors who use dry needling on horses and other animals. Dry needling is a technique. It is not a discipline. When they say acupuncture takes a certain number of hours of training, they are talking about a discipline. The practice of dry needling by physical therapists constitutes a small portion of the total training of acupuncture, if they're even comparable. I've looked at the Harvard University medical training in acupuncture for doctors, structural acupuncture program and only about 20 percent of the 300-hour program is within the scope of physical therapy practice. It pertains to musculoskeletal and chronic pain conditions. The rest of the physician training for this program and probably for acupuncture training in general does not apply to the scope of physical therapy. It's irrelevant. To say that we need the same training as an acupuncturist to do that tiny little fraction where it might overlap would not make any sense because it's only a very small percentage where they overlap. The arguments in the comments that acupuncturists should be able to take 54 hours of physical therapist training and do physical therapy – that makes no sense and shows a total lack of understanding. Physical therapy is a discipline and acupuncture is a discipline. If you want to compare the two, you need to look at the total education.

Q: While we're on that topic, I believe one of the comments said that physicians require 300 hours for certification for medical acupuncture. Do you know whether medical acupuncture training covers more than just dry needling. Is that why it's 300 hours versus 54?

R: Yes, it is much more. The Harvard medical acupuncture program, only about 20 percent is on the topic of dry needling. Physicians learn acupuncture for fertility issues, physiological issues that are outside the scope of physical therapy. There would be no need for us to study 300 hours for dry needling to do 20 percent of what physicians do.

Q: Can anyone give me a definition of a trigger point? I've been doing research from many different peer-reviewed articles and it seems like there is not a consistent of what a trigger point is.

R: The most common definition is from Travell and Simons who are the authors of the textbook of myofascial pain which is considered the gold standard. Since they published this book, a lot has changed in the scientific understanding of trigger points. Trigger points are areas in muscles that are very strongly contracted. They are so contracted that they actually block the local blood flow from the muscle. Because they block the blood flow, there is a lack of oxygen coming into that part of the muscle causing hypoxia or lack of oxygen. As soon as you create a lack of oxygen anywhere in the body for whatever reason, that part of the body becomes very acidic. As soon as that happens, the body starts releasing chemicals into the tissues and cause more pain. It's a vicious circle especially for chronic pain patients where they can't get out of it. By essence it's a contracture of a muscle. If you palpate your shoulder muscles I'm sure you will find them. You can release trigger points manually but it takes a lot longer than doing it with a needle and it's very specific. As far as your question, what the needle does is many different things. One, there are many studies through the National Institutes of Health that show as soon as the needle hits the particular trigger point, the chemical concentrations diminish within minutes, meaning the patient will no longer have the same pain because the nervous system is no longer irritated. Even if you just put the needle in the muscle itself, such as the trapezius muscle in the shoulder, it will immediately lead to increased oxygenation. The needle is not so specific. You probably could use any kind of needle. Needles made for the specific purpose are probably less painful but the fact is that there is an immediate physiological that patients will report to you immediately. It's quite different.

Q: Is the identification of trigger points included in entry-level physical therapy curricula or is it only provided for folks moving on to do dry needling?

R: Trigger points are described in pretty much all physical therapy curricula because there are many ways you can treat trigger points, with your knuckle, with a needle, or electrical stimulation. So, yes.

Q: If you can quantify it, how often when a patient comes in and is assessed would they have comprehensive treatment that includes dry needling and other treatments? Are there times when it only includes dry needling?

R: Because so much of what we do is integrative from a sense of treating functional outcomes, it's absolutely critical for a physical therapist using a dry needle. We're doing a comprehensive evaluation but always relates it to movement and function. From there, if we decide they are an appropriate patient to receive dry needling, we've already done an evaluation including a movement assessment. We use that needle to facilitate a response we expect and then we retest them to make sure we did, whether it was range of movement or muscle activation that we wanted. From there, we are going to follow it up with a motor action or exercise, neuromuscular facilitation or manual technique that will then increase the retention of that. If we don't, then the patient will come back with the same tightness again, so it absolutely is a comprehensive treatment plan.

Q: Related to the one year of clinical experience prior to endorsement, can you tell us what is gained during that year if you are not allowed to practice dry needling during that time? Also, is it expected that they will be working full-time during that year and how will that be verified?

R: Many of the programs, not all of them, but many of them require one year. Because the physical therapy board is doing such a great job of showing that commitment to safety so I believe they are requiring physical therapists have one year under their belt before they enter into a dry needling program. I think the intention of that is just to show that because dry needling is an advanced technique, they want to show that physical therapists have a little time under their belt for maturity and application of motor skills, like palpating patients because we do that on a daily basis and spend thousands of hours in physical therapy school. It gives them a little more time, more out of respect for the technique and the safety considerations.

Q: So you are assuming this is a year of full-time practice?

R: Yes.

Q: How does this differ from the other endorsement you mentioned, electromyography?

R: For the spinal manipulation endorsement, students learn that technique in PT school and then have a year of internship where they practice that. We have students going in to internships all the time where they are using the techniques, as well as dry needling. They are actually using the techniques in states like Montana, Utah, Oregon and pretty much all the states surrounding Washington. As far as training after, if the person wants to practice in Washington, they have to get an endorsement so they have to work under someone who has an endorsement already or who can sign off on their hours. I have clinical specialists and that person works with the new graduate for a certain amount of time to cover their hours and then can apply for the endorsement post-grad.

Additional R: Electromyography and nerve conduction studies usually go hand in hand. This test is usually done by neurologists, physical medicine doctors, podiatrists, and physical therapists. All of them need special training. None of them get this in their basic training. The purpose of that is actually diagnostic evaluation. Dry needling is much more a treatment modality. Electrodiagnostics or electromyography needles are placed inside the muscle to a great depth as well and requiring very good understanding of anatomy. Nerve conduction studies is part of that. The nerve is stimulated and the time it takes for the signal to get from point A to point B is measured and compared to the norm. So, if you have nerve compression, the nerve conduction test will be abnormal and physical therapists have been qualified to do this in Washington to do this technique as a diagnostic test, not a treatment.

Q: Would you say the placement of the needles is of a similar location and depth as dry needling or does it vary?

R: It's actually quite different because in electromyography there are set protocols and every in test the needle goes in certain locations. In dry needling placement is based on palpation of the patient. Also, the depth of the dry needle tends to be greater, depending on the muscle.

Follow-up R: One clarification, for nerve conduction studies, the needle can be a lot deeper than for dry needling.

Q: In regard to the AMA position that they recognize dry needling as an invasive procedure and that it should be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed physicians and licensed acupuncturists. Do you have any comments on that?

R: That's one of the reasons that the HumRRO study was so critical for this review. If you look at the knowledge criteria and tasks that are needed to define safe and competent dry needling, there is only 14 percent that we haven't gotten in physical therapy school, so it literally comes down to 16 knowledge criteria, so to try to equate 300 hours to cover 16 pieces of knowledge criteria would not make sense.

Follow-up R: I would also state that from a governance standpoint, the AMA position, when you look at the study that JJ was involved with, it really demonstrates what physical therapy practice and education is. As opposed to having an opinion that physical therapists shouldn't do this without training per se. The other aspect of that is that it's a position statement and their opinion and not necessarily based on fact.

Q: Regarding informed consent for a patient if you are going to be using dry needling on them or one of the other endorsements, is there a separate informed consent for the specific technique or is it just a general informed consent?

R: I believe it varies from state to state where some address this topic and some don't. I believe in Delaware, they specifically require informed consent and it's a separate consent.

Public Testimony

(A two-minute time limit was imposed on testimony because of the large number of participants signed up. Some participants handed in written testimony in addition to speaking. In those cases, we have included the longer, written testimony here.)

Ashley Goddard

My name is Ash Goddard. I am an EAMP and Vice President of WEAMA. Thank you for the opportunity to comment today. A physical therapist is highly qualified to do their job, but that does not qualify them to do mine. Dry needling is acupuncture. Ask a physical therapist if they're qualified to perform this invasive, therapeutic procedure, some will tell you yes. Others, one of whom you'll meet today, will tell you no, as will the needle therapy expert, an acupuncturist. You might also ask an unbiased third party such as the American Medical Association, that recently adopted the policy, "That ...dry needling is an invasive procedure that should be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists." An AMA Board member added, "Lax regulation and nonexistent standards surround this invasive practice. For patients safety, practitioners should meet standards required for licensed acupuncturists and physicians." We are here today in hopes that this lax regulation takes a turn for the better in Washington state.

The language of this proposed scope expansion is problematic for two primary reasons.

First, it could be interpreted in such a manner that restricts the scope of EAMPs. Something the RCW is specifically intended to avoid. The proposed scope expansion attempts to create a false distinction between acupuncture and dry needling, and place dry needling specifically in the scope of PTs and not EAMPs. They argue that acupuncture is different because it is "used to restore energy flow within the body," but what is actually relevant is the RCW for EAMPs which specifies the insertion of acupuncture needles into the body. This action does not occur in a physiological vacuum. Stimulation of underlying muscular and connective tissue is inherent in the treatment of acupuncture points or meridians, including myofascial trigger points; and "trigger point needling" is a procedure commonly performed by acupuncturists. As a sports and pain specialist, I personally have utilized trigger point needling on literally thousands of patients in my 16 years of practice. This scope expansion then could be argued to preclude acupuncturists such as myself from performing a procedure that is well within my scope.

Secondly, the proposed scope expansion specifies that "dry needling does not include the stimulation or treatment of acupuncture points or meridians." yet this is impossible to distinguish and therefore unenforceable. The most obvious illustration of this point is a) evidence that some dry needling programs--including ones indicated in the sunrise review application--utilize acupuncture points and theory, and b) additional evidence that PTs are using acupuncture points and protocols nationwide, yet call it dry needling. Certified participants from these programs would then be practicing in direct conflict with the proposed RCW change. This highlights the lack of standards in dry needling education and raises some serious questions as to the ability to differentiate what is acupuncture and what is dry needling. If it cannot be differentiated, it cannot be enforced.

The proposed language of this scope expansion is fundamentally flawed due to this unenforceability, and the aforementioned EAMP scope limitations.

Thank you for your time.

Andy McIntyre

Good afternoon. My name is Andy McIntyre and I'm a licensed WA East Asian Medicine Practitioner and the current president of the Washington East Asian medicine Association. I have been in practice for 22 years and taught for 13 years at Bastyr University, where I was core faculty.

The real reason we're all here today is because some physical therapists refuse to acknowledge the common-sense fact that dry needling is a form of acupuncture. Acupuncture is a procedure with many different forms. Physical therapists have to call it something different to circumvent existing state law in order to enable them to perform dry needling acupuncture with unsafe standards.

The problem is that it's not different.

1. The procedure is the same: the insertion of a monofilament needle into the body for therapeutic purpose.
2. The tool is the same: the monofilament aka "filiform" or "acupuncture needle."
3. The intended targets of dry needling, trigger points, are acupuncture points and therefore the same.
 - a. Acupuncture points known as "ashi" points have been recognized by medical doctors and *physical therapists* as trigger points.
 - b. But even beyond this kind of acupuncture point, the more famous meridian-based or channel-based points overlap with trigger points upwards of 95% percent of the time.. In 2008, two medical doctors, Dorsher and Fleckenstein, demonstrated that 93.3% of the "common trigger points" in Travell's *Trigger Point Manual* corresponded anatomically to established classical, channel-based acupuncture points.
 - c. The applicant submission on this point badly misrepresents the issue. It cites only an editorial by Stephen Birch, but not the quantitative research by Drs. Dorsher and Fleckenstein. It also fails to mention Dorsher's rebuttal of Birch's piece, describing it as Birch's "conceptual opinions." Finally, applicants fail to include Dorsher's revisiting Birch's analysis and finding that the clinical correspondence of trigger points and acupuncture points for pain is **likely 95%1 or higher**.
 - d. [All claims are referenced and cited in my written testimony, with numerous examples.]
4. The actual needle manipulation techniques of dry needling are the same and were described and named 2000 years ago: the lifting and thrusting technique; the twirling technique; and the "cone" or "fan" technique was described as the "joining valleys" technique and was used for the same purpose: painful muscles and muscle spasms.
5. Even the twitch response to trigger point dry needling was described in the colorful language of the time, as the "fish bite" response, as though the twitch to the needler feels like the sudden tug on a fishing line.
6. Beyond the procedural aspects, Physical Therapists Use Acupuncture - Studies to Support Dry Needling. Literature reviews of dry needling resort to using acupuncture studies to support their claims. This would not only be questionable, but highly problematic if PT's did not already understand that the same therapeutic phenomena were occurring in the body and that DN was indeed a form of acupuncture. No modern PT would otherwise use a system they claim relies only on ancient, "mystical" paradigms to support their biomedical claims.
7. Physical Therapists Agree that "Dry Needling" is a Form of Acupuncture
 - From the Journal of Orthopedic and Sports Physical Therapy:
"Acupuncture represents a range of interventions, such as traditional Chinese needle acupuncture, other forms of needle acupuncture (eg. Dry needling)."
 - After claiming that dry needling was *not* a form of acupuncture as late as 2006. Jan Dommerholt, a renowned DN instructor and co-owner of Myopain Seminars, which teaches DN to PT's, apparently

reversed course: he acknowledged in 2008 that there was considerable overlap of trigger points and acupuncture points; and that myofascial referred pain traveled along acupuncture channels. He regretted his prior position. The following are his direct quotes:

"There is no question that some of the trigger points have been described previously as acupuncture points, a shi points ...etc." "Similarly, there are close similarities in between the pathways of some acupuncture meridians and referred pain patterns of myofascial trigger points." "...In some past articles I may have expressed a rather biased and simplistic opinion of acupuncture. ... I believe that some of my comments were partially in response to assertive efforts of particular acupuncture practitioners to prohibit any needling procedures by physical therapists, and partially due to ignorance. In retrospect, I regret that sometimes I resorted to 'turf behavior' and that I did not study the various schools of acupuncture in more detail to gain a better understanding of the varied perspectives of acupuncturists. I had restricted my perspective to the energetic concepts of traditional Chinese medicine." [Emphasis added.]

The procedure is the same. The tool is the same. The target is the same. The needle manipulation and response to manipulation are the same. The only thing different is the name. And in this circumstance, the training standards requested by the physical therapists. I urge you to deny the physical therapy petition.

Iman Majd

My name is Iman Majd. As a board certified integrative medicine physician and double board certified in acupuncture- eastern & medical acupuncture- and fully certified in GUNN IMS dry needling; AND also as a physician who regularly refers patients to PTs, I am here today to express my deep professional concerns about extending DN privileges to physical therapists in WA state. I am a practicing physician at UW and faculty at Bastyr University. My evaluation of the proposal is:

- 54 hours is only a mere fraction of the training necessary to safely perform an invasive procedure, such as needling patients. I know, I've trained for thousands of hours.
- Dry needling acupuncture is one of the most aggressive forms of acupuncture and requires extensive training to ensure the safety of patients. I am not alone in my concerns, which are shared by:

The American Medical Association

The American Academy of Physical Medicine and Rehabilitation

The American Academy of Medical Acupuncture

The World Health Organization,

All of these bodies hold the position that dry needling acupuncture should only be performed by trained physicians and fully trained acupuncturists. THIS proposal creates a separate, much lower, and less safe standard for therapeutic needling than what already exists in this State ...for the Acupuncture profession!

It calls for zero outpatient clinical training hours, which is arguably the most important part of medical training.

Dry needling acupuncture cannot be covered in workshops over a couple of weekends.

Training is essential to patient safety, yet PTs who take these brief dry needling classes go back to their Clinics and start practicing on their patients, without any clinical supervision. They lack the skills and knowledge to needle safely. By comparison, Naturopaths and Chiropractors in Washington are given up to one year of credit for their western medical training when they pursue licensing in acupuncture. It should be the same for physical therapists.

I urge you to reject this proposal. It would create a dangerous precedent in our state that expands the scope of practice of a profession without adequate training.

Thi H. Nguyen-Phuoc

My name is Thi Nguyen-Phuoc. I've been a licensed Physical Therapist for 14 years, and I am here to testify against the inclusion of dry needling into Physical Therapist scope of practice. I'll be graduating from Bastyr University as an Acupuncturist in December 2016, and by then I will have had more than 900 supervised hours of needling practice. There are public safety concerns beyond the physical safety that my colleagues have identified for you today, and those safety concerns center around proper needling technique, physiological effects of the needle beyond trigger point release, and public awareness and understanding of what needling is, whether it's called acupuncture or dry needling.

The current structure to train Physical Therapists to practice dry needling is grossly inadequate. There are no uniform standards to ensure safety, and continuing education courses require only 54 to 104 hours. An analysis of a published schedule provided by Myopain Seminars shows a total of 88 hours spread over 3 courses. There are 53 hours of practical lab, which in reality is only 26.5 hours since the time is divided between 2 students practicing on each other. As a result, a Physical Therapist graduating from one of these seminars may have practiced needling a particular muscle group once, twice, at most three times, prior to needling on real patients in the clinic, without supervision. What is more alarming is that anyone who attended the first of three classes are able to start needling, or after only 8 hours of actual practice! This is a serious public safety concern!

In Winter 2014, I started needling practice, and by this time, I had been a Physical Therapist for 12 years. Even though my hands have palpated and treated thousands of patients, even though I had been receiving acupuncture treatments for more than five years, I still remember how nervous I was that first class when we needled our own quadriceps or gastrocnemius muscle. I wasn't alone in my nervousness, for all of my classmates expressed similar feelings, and the nervousness wasn't just in the mechanics of how to needle the muscle. Intellectually, we knew to palpate an area in the muscle where we felt no blood vessels, away from tendons and nerves, and quickly flick our wrist for a painless needle entry into the skin. Emotionally, it was an entirely different story.

In our hands were tiny thin filiform needles that could change someone's life, for better or worse, depending on our skills and understanding of the point locations, point actions, and their relationships to each other. We had heard stories from our professors about how a few needles could induce headaches or take them away. Personally, I've experienced both constipation and diarrhea from a clockwise or a counterclockwise rotation of one needle on my Stomach 25 point, which is located about three finger's breadth away from the umbilicus. And in my fifteen clinical acupuncture shifts at Bastyr Center for Natural Health, I have witnessed many symptoms grow stronger or disappear completely from poorly-chosen points or proper needling technique. We all sensed this truth when we first held the needles. This medicine has survived thousands of years in spite of modern innovations and technological advances. It is not merely a noxious stimulation from needle insertion that elicits the cure.

I have grave concerns for those who think they are capable of needling patients after only 27, 54, or 104 hours of continuing education. Even though in my 12 years of PT practice I've become skilled at palpation, of seeing the anatomy in 3-dimensional space, of understanding tissues as they relate to each other, those 12 years did nothing to prepare me to practice needling. Perhaps my ability to locate points was quicker than my peers, perhaps I was more sure that I wasn't feeling a blood vessels, a tendon or a nerve, but the act of needling, of piercing skin, of reaching the appropriate depth, of twirling the needle while pushing or lifting, all that is new to me.

I had over 175 supervised classroom needling practice prior to needling patients, and by the time I graduate, I will have had over 900 supervised hours of needling practice. Even after this many hours, I am still perfecting my needling technique, and I needle on patients almost every day! A Physical Therapist using dry needling will not have the necessary supervision to improve on his/her technique, and he/she may not employ dry needling as a treatment on a daily basis. Every new skill requires new neurons to be laid down and establish firm connections, and feedback from someone more skilled and knowledgeable is crucial in making steady progress. This requirement is sorely lacking in Physical Therapist's training in using the needle. So while there are claims that 86% of what is needed to be effective and safe for needling has been taught in entry-level physical therapy education, and that only 14% is needed for the actual needling act itself, this statistic ignores the very important factor of supervision and feedback. In the 27, 54, or 104 hours of CEU training, Physical Therapists may be introduced to how to use a needle, but in no way are they competent in using a needle as a modality for treatment. Their path to proficiency is done in the dark, without guidance, without feedback, and without mentorship, on trusting patients who may not know the true nature of their experience with the needles.

My real fear is by giving Physical Therapists - or any other practitioners who are not acupuncturists - the right to insert needles into the skin, those healthcare professionals do not know what they do not know. When someone knows they are ignorant of an area of knowledge, they are more careful with that knowledge and tread carefully into the areas where they don't have to right to be. If they were wise, they would call upon an expert to consult with or guide them through. When someone doesn't know what he/she doesn't know, they are reckless, overestimating their ability while underestimating the dangers that lay hidden in the shadows of their understanding.

The issue of dry needling is more than just whether PT's can perform the procedure safely; the issue is also whether PT's should perform dry needling. The act of needle insertion may be simple, but the knowledge that inform when, why, and how to needle a particular point is vast. To merely stimulate a point with a needle because it is in spasms is like to patch over a crack in the corner of a house, not understanding that the crack at the corner reveals much about the foundation and integrity of the house. Needling deeply and stimulating strongly in the lower back may get the erector spinae to release, but unbeknownst to the practitioner or the patient, improperly twisting the needle or angling it can weaken the flow of the energy through that point, and if this point is a controlling point for the functioning of the organs, then the relationships of the organs to each other may go out of balance. So, one may have a better back, but over time, one loses what Chinese Medicine ascribes to kidney functions and start to experience leg swelling, incontinence, or shortness of breath.

The dry needling continuing education courses as they are taught now are taught by Physical Therapists who do not know the depth of this medicine, who do not appreciate the subtle skills of needling techniques, who know nothing of proper point prescription. The practitioners of dry needling contend that they are only working with the trigger points, not aiming to work with the acupuncture points. Yet, even the originators of the technique agree there is at least a 90% correspondence between acupuncture points and trigger points. To dismiss this fact or to insist that dry needling isn't acupuncture is a clever tactic to sidestep the necessary process to become truly proficient. Practitioners of dry needling assume only the image and not the true essence of what it means to use the needle as a tool for treatment. For patients who do not understand the difference between dry needling and acupuncture, they will misjudge what acupuncture can do toward supporting health and restoring balance to the body, and this misunderstanding is detrimental not only to the patient but to the entire profession of acupuncture.

For my colleagues who are Physical Therapists that want to use acupuncture needles to release musculoskeletal pain, there is nothing stopping you from returning to school as I have. I assure you, once you understand this medicine, the needle is the closest physical object you have to commune with the spark of divinity that is in all of us, that vital force that animates our limbs and heals our wounds.

For the acupuncturists, dry needling is the same dilemma Physical Therapists experience when we see massage therapists, chiropractors or personal trainers employ exercise without knowing how to teach it properly, which cues to emphasize, which modifications are needed for a particular patient or a specific injury, or how to progress the exercise program logically. We cringe privately because we recognize when a prescribed exercise is simply a good intention and not therapeutic, yet we rarely confront or correct the other professional because it's true, any one can teach exercise safely, but there is more to the meaning of safety when we understand exercise as a form of medicine. And exercise does not involve the insertion of sharp metal objects into the body.

For all the reasons I've outlined above, I urge you to curb the encroachment of Physical Therapists into the practice of acupuncture. There are public safety concerns beyond the physical safety of dry needling, and those safety concerns center around the indisputable fact that dry needling is acupuncture, which is a form of medicine best left in the hands of acupuncturists, and which already has laws governing its practice.

Thank you for your time and reflection on this important matter to protect public safety.

Jessica Martens

Please accept these written comments as part of my submission before the Department of Health on the issue of expanding the scope of practice of physical therapists to include dry needling. My remarks focus on the application's treatment of safety. Indeed, protecting the public from harm is one of three key criteria to gauge whether an expansion of scope is warranted. It is a foundation of State policy.

I am licensed as an East Asian Medicine Practitioner (EAMP), and I have been in practice 10 years. I studied for 3 years to attain a Master's degree, with an additional 2 years of education in Chinese Herbal Medicine, and I passed the national examination of competence in needling/acupuncture administered by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM).

Safety Standards:

Because penetrating human tissue with a needle is potentially dangerous, state law specifies training and competence standards to be met before medical professionals are allowed to needle their patients. The minimum legal standard to allow therapeutic needling in Washington State is licensure as an EAMP. Licensure requires attaining specific,

quantitative levels of theory and clinical training in both western and Asian medicine. Gaining a license requires passing a national, accredited examination.

Doctors of chiropractic and naturopathic physicians are very well-trained in their professions. When they want to add therapeutic needling, state policy directs them to add licensing as EAMPs. State law recognizes their western medical training, giving them one year of credit toward licensing as EAMPs. Physical therapists' training in the basics of western medicine matches that of chiropractors and naturopaths. The application fails to demonstrate why PTs should be allowed to bypass the training in needling theory and practice that DCs and NDs receive. There is no basis given in the application or materials for establishing an exception to meeting this well-established minimum standard of dual licensure.

State law and regulation specify that training should occur in state-approved programs and in accredited schools. In contrast, this proposal would set up a separate collection of standards and training for needling. It fails to demonstrate that it meets the established standard for educating people to needle human beings - licensure as an EAMP.

Recommendations from other Professions:

At its fundamental level, this request asks if physical therapists should set up their own separate standards and regulations for an acupuncture procedure that already has existing statutory standards and regulations. The Washington East Asian Medicine Association says no, and we join the following professional organizations that say no.

- The American Medical Association, whose 2016 resolution states that dry needling should be performed only by licensed physicians and acupuncturists.
- The American Academy of Physical Medicine and Rehabilitation, which observed that some professions do not routinely use needles; its position is that dry needling should be performed only by licensed acupuncturists or licensed medical physicians.
- The American Academy of Medical Acupuncture, which pointed out that non-physicians must have over 2,000 hours of clinical and didactic training before needling patients in most states. Its policy, adopted unanimously by its Board of Directors, is that only licensed acupuncturists and physicians should be allowed to perform dry needling.
- The World Health Organization published guidelines containing the most basic levels of training for health professionals wishing to add therapeutic needling. They would require 2,000 hours of training for non-physicians.

There's a reason these professional associations and certifying bodies set high standards. They recognize the importance of specific, deep training in what and where and why points are needed. Dry needling/acupuncture is an invasive practice and potentially harmful. Society has determined that 2,000 hours of training for non-physicians is the standard for those who needle.

In contrast, the application would allow PTs to needle after 54 hours of instruction. The applicant report is based on an introspective listing of what PTs thought should be included. Nowhere does the application compare 54 hours with 2,000 hours of training – or even the 300 incremental hours of education which MDs take.

The application also fails to compare its vague standard for assessing competency to such well-established standards as those of the AAMA and NCCAOM.

Safety Record of Dry Needling:

PTWA included in its submission on safety an article by Brady et al. which describes incidents self-reported by 39 physiotherapists over nine months in Ireland. Although Brady's limited report received no reported incidents of significant or severe outcomes, four other researchers reported 5,000 significant adverse events and 11 serious adverse events, including 4 pneumothorax cases.

I have included a summary of a systematic review, published in 2015 by Physiotherapy Alberta, entitled "FAQ: Dry Needling Adverse Events." Although most of the adverse events reported were not severe, the rate of events was significantly higher for dry needling than for acupuncture – almost twice the rate in one study (the least), and twenty

times the rate in another study. Looking beyond the single Brady study, a deeper and broader review of literature reveals the following:

- "Dry needling is likely to result in an increased incidence of serious risks, particularly pneumothorax, due to the short training courses and deep needling techniques which typify the practice."
- The authors [Ernst] observe that all deaths would likely be avoided with adequate acupuncture training.
- [From a different literature review]: Adverse events would be avoided if all acupuncturists were trained to a high level of competency.
- [From an Australian study]: Adverse event rates for practitioners with 0-12 months of CAM (complimentary and alternative medicine) education were significantly higher than for those with 37-60 months education.

The submission in support of dry needling fails to demonstrate that the proposed 54 hour training will protect the public from harm. All of the studies cited here provide evidence that Washington's minimum standard for training - licensure as EAMPs - should apply to physical therapists wishing to add acupuncture/dry needling to their practice.

Conclusion:

Washington State has established a minimum standard for training and competence in needling patients: licensing as East Asian Medicine Practitioners. Chiropractors and naturopaths acquire dual licenses when they add needling to their practice. Other medical professions have reviewed dry needling by physical therapists and recommended that only those licensed as physicians or acupuncturists be allowed to needle. The WHO has set basic standards similar to Washington standards for EAMPs. Options exist for physical therapists who believe their patients would benefit from dry needling/acupuncture: they can refer patients to fully trained and licensed EAMPs, or they can follow established policy and gain dual licensure, as numerous naturopaths and chiropractors have done. In contrast, the application seeks to bypass the established path to safe needling practice - dual licensure. However, it fails to demonstrate that its proposal will protect the public from harm - one of the three elements that are required if increasing a scope of practice. It also fails to describe accurately the problems associated with needling patients without full training. For these reasons, I urge to Department of Health to find that the application, as written, does not meet the statutory criteria to increase the scope of physical therapy. It should be denied.

Leslie Emerick

Cost-Effectiveness:

An essential criterion to judge whether or not to expand a scope of practice requires the applicant to demonstrate that the proposal will provide the most cost-effective option to protect the public. Remarkably, the application has no data on this point and therefore fails to meet the requirement. The section on cost-effectiveness (beginning at page 12) has no comparison of the cost of PTs doing dry needling to any other modality –only statistics about societal costs of low back pain. It quotes the Bree Collaborative about physical therapy, but Bree recommends standard physical therapy, not dry needling.

The most cost-effective means of providing therapeutic needling is for physical therapists to refer patients to fully trained East Asian Medicine Practitioners. The marginal cost, (*i.e.*, the additional cost to society) is zero, because licensed EAMPs already have the necessary training and licensure to practice safely and effectively. The application does not even mention this most obvious path of referral. If physical therapists assert that dry needling is more cost-effective than acupuncture, they must show that reimbursement rates are lower for them than for EAMPs.

If physical therapists want instead to add needling with an acupuncture needle, the Legislature has already established a policy called dual licensure. In the EAMP statute, RCW 18.06.050(2)(a), naturopathic physicians and doctors of chiropractic are given credit for their extensive training in western medicine when they add training for licensure in acupuncture. This is the standard for cost-effective preparation in Washington. We believe that physical therapists need comparable training as chiropractors and naturopaths to perform acupuncture. It is invalid to claim cost-effective preparation by skipping the training.

Finally, insurers do not cover dry needling. The American Physical Therapy Association reports that "currently, there is no CPT code that describes dry needling." CPT codes are written and copyrighted by the American Medical Association. It is highly unlikely that the AMA would develop dry needling CPT codes as they just released a statement opposing Physical Therapists performing dry needling. The statement reads: "RESOLVED, that our American Medical Association recognize dry needling as an invasive procedure and maintain that dry needling should be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.

The lack of dry needling code would suggest that 100% of whatever PTs charge for dry needling would be borne by patients. The bottom line is that the applicants have not shown that the proposal is the most cost-effective option for needling.

Chris Huson

Hello, my name is Christopher Huson. I'm a licensed acupuncturist and practitioner of East Asian Medicine. I've been in private practice since 1993. I was a clinical supervisor at the Northwest Institute of Acupuncture and Oriental Medicine in Seattle from 1998 to 2001. Needling of trigger points and other structures is an advanced potentially painful deep needling therapeutic medical intervention. Competent, safe, empathetic needling is a skillset that comes with practice. Preferably supervised clinical internships. To be a licensed EAMP in Washington State one needs at least 650 hours of supervised clinical internship prior to working independently with the general public. The pt-wa proposal seeks to reduce that minimum standard to zero hours of supervised clinical internship and a mere 54 hours of additional education and training for PT's. According to the AMA practitioners should meet standards required for licensed acupuncturist and physicians. PT's receive plenty of training prior to becoming doctors of physical therapy but quote the specific dry needling skills are supplemental to that knowledge. We have been told that the core curriculum provides for 86 % of the knowledge requirements needed but quote "the only skill that was not included with entry level education was the actual handling of the needle". Practitioners must receive a high standard training in a clinical setting with real patience and experienced supervisors. These practitioners need to be able to prove clinical competency through independent dept. of education of aproficulationsypermetrics. We are not seeing the measure of proof anywhere in this proposal. We move to disapprove. Thank you!

Jianfeng Yang

The Chinese community of East Asian Medicine Providers in Washington State very firmly and strongly oppose the possibility of physical therapists doing acupuncture, which they call "dry needling," with too little training. Acupuncture is a big category with many different kinds of acupuncture. Dry Needling is ONE of the many forms of acupuncture, which requires full time educational and clinical training to do safely and effectively. The physical therapists want to do acupuncture with only 54 hours of training. This is dangerous to the public health of our citizens.

Acupuncture is using needles inserted into the body for therapeutic and healing purpose. Anyone using needles to work on the body to reach therapeutic or healing purpose belongs to the practice scope of acupuncture, no matter what they call it. Some PTs who do "dry needling" say they aren't doing acupuncture. But changing the name from acupuncture to dry needling does not change the procedure or what happens in the body. It's just a different name! It's like calling William, Bill. In our Chinese medicine classics, there are descriptions of "dry needling" that are over 2000 years old! Dry needling is actually one of methods that we have used in acupuncture clinics for thousands of years in China. This is a method where needles are used based on Ashi point(s) or tender point(s), or sensitive point(s). In other words, where there is pain or sensitivity, is where the point is. The descriptions only use different language from dry needling, but they are the same thing. Dry needling is acupuncture.

John Moore

My name is John Moore and I am a licensed acupuncturist practicing in Benton County, Washington. I'm here today to testify in opposition to amending the scope of practice of physical therapy to include acupuncture under the term dry needling. There are real risks to patient safety when unqualified practitioners insert acupuncture needles through the skin and into patients' bodies.

In its application, PTWA states that "no reports of serious harm or injury from dry needling performed by a physical therapist" exist as of May 25, 2016. I am here today to provide this committee with evidence of serious injury and harm to patients caused by physical therapists performing dry needling.

In 2016, CNA, a malpractice carrier for the physical therapy profession, documents the following examples out of 21 patient incidences of harm or injury caused by physical therapists inserting acupuncture needles through the skin and into patients' bodies:

- A physical therapist punctured a patient's lung with an acupuncture needle, leading to a pneumothorax. The patient, a marathon runner, required surgery to treat the pneumothorax and was hospitalized for three days.
- There are two additional pneumothorax injuries which required hospitalization
- A physical therapist performed dry needling on a patient's hip when the handle of the acupuncture needle broke off, leaving the shaft of the needle lodged in her hip. She was hospitalized and underwent surgery to remove the shaft of the needle.
- A physical therapist performed dry needling on a patient's calf while failing to adhere to basic infection prevention and control practices, resulting in the patient developing a calf infection. The patient required "intravenous therapy and two surgical procedures" to treat the infection.

There are other documented injuries:

The Federation of State Boards of Physical Therapy reported in the Winter 2015 edition of its Forum publication an adverse event of a 15 year old girl who was needled by a physical therapist without her mother's consent. The girl collapsed from the dry needling.

In November 2013, a Colorado physical therapist punctured freeskier Torin Yater-Wallace's right lung with an acupuncture needle, leading to a pneumothorax. He required surgery and was hospitalized for five days.

In Maryland, a physical therapist punctured a nerve in high school teacher Emily Kuykendall's left leg with an acupuncture needle, causing damage to the nerve that led to pain and suffering. In a letter detailing her injury, Ms. Kuykendall wrote, "This is really taking a physical and emotional toll on me. There is almost not a minute in the day that goes by that I wish that I had not gone to see the physical therapist."

These documented serious injuries and harm should demonstrate to this committee that there is a real risk to the public's health and safety by physical therapists performing acupuncture under the term dry needling. I respectfully ask that the committee investigate these injuries further, and that it decline to endorse the applicant's request to expand the PT scope of practice.

Thank you for your time.

Bridget Boylan

I have been a physical therapist for 28 years, 25 of them within Washington State. I've been an acupuncturist for 11 years and I have looked over this so many times to try and figure out how I could justify Pt's doing acupuncture, because it is truly acupuncture without a license. I've looked at the classes that are taught. There was a class in Arizona where there was 60 students, one instructor and an acupuncturist went out of curiosity and found that the students were hovered over a mat table tiptoeing to see what was going on and then they were very minimally supervised in terms of really understanding how to do the dry needling. So this was two days of lecture, one day of practice and they were encouraged at the end of the third day to go home and work with their patients. So to me it's frightening because I believe that both professions are great and then have integrity within them but not if were practicing unsafely without the right kind of license. It took me five years to become an acupuncturist, and I did this because there are things I couldn't do as a physical therapist. So I needed to get into another profession in order to do that, and now I do both and I continue to practice both and I continue to educate patients as to safety and really be consumer beware. Don't get into something if you're not sure that the person doing it is really trained accurately to do it. So that's my main testimony and I would just say get a dual license if you want to practice acupuncture.

Lisa Vanhaagen

My name is Lisa Vanhaagen. I'm an EAMP in Skagit County. My testimony today was going to focus on the HumRRO report and point out omissions by the applicant about the report, such as out of the seven individuals on the expert task

force, all of them are either owners, instructors, or former instructors for the for-profit dry needling companies. And I was going to comment on the one study that was provided in the applicant report about safety. I have gone through the entire application line by line. We will be submitting written testimony that will repute all of the statements and claims made on the documents and the applicants' oral testimony today.

Desiree Merulli

My name is Desiree Merulli and I'm a licensed East Asian Medical Practitioner for 16 years. I'm here today because I have concerns about patient safety if the department of health or legislature allowed PT's to do acupuncture under the term dry needling. SB 6374 stipulates that a PT receives only minimum of 54 hours of training. The bill does not mention how the trainings are structured, if there is any supervision of students, nor by whom. Dry needling courses are weekend workshops consisting of two long weekend courses, 27 hours each, for a total of 54 hours. Quite literally the PTs complete his or her training on a Sunday and begin needling and charging patients on a Monday with no appropriate supervision or having passed major examinations. This is not safe practice. Two 27-hour weekend workshops do not provide adequate or appropriate safe training for practitioners to perform this therapeutic invasive procedure. Unlike EMG, wound debridement, and spinal manipulation, this bill will allow a PT to perform a potentially risky medical procedure with no referral and with substantially fewer hours of training. The applicant does not address these issues, which is a requirement of the sunrise review regulations. Thank you for your time and I respectfully urge the committee to consider the health and safety of the public and deny this application. Thank you.

Jacqueline Berg

Hi, my name is Jackie Berg. I live in Bellingham and I have been a patient that has received dry needling from physical therapists in Canada, Colorado and New Zealand. I have a long history in high impact sports, including many years as a professional snowboarder. Due to the nature of action sports, I've had many injuries and a few surgeries, including one surgery that left me with structural changes in my shoulder after a surgeon removed part of my collar bone 16 years ago. I've struggled with recurring daily pain that I've literally taken everything for, anything you can think of. So in order to manage my discomfort, I've seen many different chiropractors, massage therapist, acupuncturists, sports med doctors, physical therapists, personal trainers and various types of holistic body workers over the many years that I've had this problem. I've had very short term relief from most of these providers except from physical therapists that perform dry needling in conjunction with my treatment. I found that I have immediate relief with my symptoms following dry needling treatment and lasting pain relief, especially when I perform my exercises specific to me in the days after I receive the treatment. For me, physical therapists performing their technique of dry needling has made a significant impact on my life. Decreasing my mid back pain which allowed me to focus on more important things when I've has access to it. After my first dry needling treatment with physical therapists in Canada I immediately knew that I had found what I was looking for with so many other health care providers that spent hundreds and hundreds of dollars. She addressed my functional problems with my shoulder and my arm. She gave me exercises to address why I was having this reoccurring pain in the first place, and why it kept coming back. She also gave me tools that I could use at home that were set from dry needling to help manage my symptoms, which have been wonderful and used over many years. I've been waiting and hoping for years for physical therapists in Washington to start performing dry needling as my condition requires regular maintenance for the onset of the worsening of the chronic muscle pain that I experience in my back. With every physical therapist that I have seen for this treatment I have always felt confident and safe with how they explained and approach using needles as part of my treatment. Thank you

John Schroeder

(John Schroeder, PT, SCS Rehabilitation Specialist, THOR, 1st Special Forces Group)

I am a Washington State licensed physical therapist. For the past year I have been a civilian medical provider with the Army at JBLM. I'm embedded in the 1st Special Forces Group (Green Barretts) and treat only active duty military personnel on the base. A skill the Army wanted me to have, but I did not have, is dry needling. I was sent to a dry needling certification course about a month after beginning practice at JBLM, and I have been using it ever since. Currently, I use this intervention between 0-5 times per day. I would like to share two patient experiences with you:

A 41 year old male sustained a right knee ACL tear while deployed. Upon his return to JBLM, he underwent a right knee ACLR and cartilage repair. At 6 days post op, there was no posterior thigh or leg pain or tenderness, pain was diminishing, and he was progressing well. At 7 weeks post op, the patient drove to California and back – 12 hours in

each direction. This resulted in posterior thigh and knee pain, posterior thigh tightness, and a restriction of knee motion. I referred the patient to R/O for a blood clot, and none was found. He then received traditional PT including heat, stretching and knee range of motion for three weeks. There was no change. When he attempted to ride his motorcycle, the leg pain prevented him from affectively using the right leg and he was unable to ride. He had a moderate limp. A re-assessment revealed tightness and thickening of the medial hamstring muscles. At this juncture, I performed dry needling to the medial hamstrings for two visits. This resulted in a patient reported 80 to 90 percent reduction of pain. Objective exam revealed no muscular tenderness or tightness in the hamstrings. The hamstrings were supple, and knee range of motion and the ability to walk were improved. He was then able to ride his motorcycle for at least a half hour.

A 35 year old physician sustained a calf strain while playing recreational softball. He self-treated the injury for one month. Improvement hit a plateau with calf pain, tightness and inability to run. He self-referred himself to PT for the purpose of receiving dry needling. I evaluated him and determined he was an appropriate candidate to receive dry needling. Three sessions of dry needling were performed over a two week period as part of his program. This resulted in pain abatement and reduction of tightness. He was able to return to sports without calf symptoms.

Noted above are two examples of the safe and successful skilled application of dry needling performed by me, a Washington State licensed physical therapist. The application of this procedure is not currently allowed in the civilian sector in Washington state, and thus not an option for its citizens. It is another tool in my box that I can use to help people that otherwise might not be helped.

During the past year, the only adverse reactions I have encountered is an occasional spot of blood with extraction of the needle, and rarely, a small superficial contusion. The largest contusion was about the size of the fingernail of my little finger.

I stand here before you today as a Washington State licensed physical therapist who successfully and safely employs dry needling in my practice on a regular basis. There is no question IF PT's can safely perform dry needling, It IS being done. But, not in Washington. Whether or not the Washington state legislature approves the use of dry needling for physical therapist will not affect my current practice. However, I am here to tell you that it is a powerful tool that can be safely applied by a skilled practitioner to benefit people. It should be another tool my colleges and their patients should have access to. I'm asking you to please, strongly consider allowing physical therapists to use it.

Thank You!

Elaine Armantrout

Good afternoon. I'm Elaine Armantrout, I'm a physical therapist licensed in our state and I stick needles in people every time I go to work. I've been performing diagnostic needle EMG since 1984 and to give you a history physical therapists have been allowed to do needling since 1975 by the board, a WAC rule that stated physical therapists can do electric diagnostic testing. The AMA came out about 15 years ago and said only physicians should do needle EMG, in spite of the fact that in 2005 the legislature and the governor passed a bill that put into law that physical therapists can do needle EMG. So it moved from rules to law, but it had parameters around it. So that previous 40 something years physical therapists didn't have any parameters around doing needle EMG. Now that said you had to be proficient, it was your professional responsibility to know what you were doing. There were no complaints to the licensing board. There were no adverse effects and I'm proud to say that and to answer the former question about the depth and the placement of the needle when I insert the needle to do a diagnostic test to analyze the muscle, it goes into the muscle tissue, so through the skin and into the muscle sometimes it depending on the target muscle it can be 3 inches deep.

Nancy Mansell

My name is Nancy Mansell. I have my board certification in orthopedic and electrophysiologic physical therapy and currently practice in outpatient orthopedics for the Swedish Medical System. I am representing myself for today's testimony. I'm a graduate of the US Army-Baylor Doctoral Program in Physical Therapy. I am served on active duty in the United States Army for 7 years both stateside and in Iraq. I also worked at Madigan Army Medical Center as a government service physical therapist for 3 years.

I was one of the first active duty physical therapists to receive permission to perform dry needling in 2010. At the time, dry needling was a new technique for physical therapists to help alleviate pain and restore function. The Department of Defense now allows physical therapists with qualifications to perform dry needling. I received my hands on training from a physical medicine and rehabilitation physician at Womack Army Medical Center in Fort Bragg, North Carolina.

I utilized dry needling on Active Duty Soldiers, retirees and their families as a valuable tool in my practice. Dry needling can reduce pain for orthopedic problems, which allows patients to participate in rehabilitation programs that can return them faster to combat, work or play. After leaving the military healthcare system, I now work in the civilian sector and have not been able to practice dry needling on my patients, which has significantly affected the recovery timelines for my patients.

For example, I currently am treating a patient for post-operative therapy after a knee scope. After 2 weeks of treatment, she presented with acute lower back pain after reaching over her bed to pick up a heavy laundry basket. Due to her pain, we had to stop treatment for her knee and I needed to address her back. It took me 4 sessions to reduce her pain, whereas based on my past experience it would likely have taken 1-2 sessions if I had been able to implement dry needling in addition to manual therapy and therapeutic exercise. I treat 12 patients a day, so a savings of 2-3 sessions per patient has the potential to have a tremendous impact on healthcare costs.

Susanne Michaud

Thank you for taking time to hear our case on dry needling and why Washington State physical therapists are the best qualified to perform this technique and why it must be part of our scope of practice. My name is Susanne Michaud, DPT, OCS. I am a doctor of physical therapy and an orthopedic certified specialist. I own and operate a private out-patient orthopedic physical therapy practice in Seattle; I am the Western Washington Director At-Large on the board of the Physical Therapy Association of Washington (PTWA); and, I hold a teaching associate appointment at the University of Washington, Department of Rehabilitation Medicine in the physical therapy program, in Seattle.

The purpose of this hearing is to better understand that dry needling is, what skills are required to safely perform this technique, and why physical therapists are essential providers of this effective and efficient technique. My objective is to inform the board about what UW PT doctoral students are currently exposed to regarding dry needling, to fact check some of the misinformation that is propagated by the acupuncture community, and to illustrate why physical therapists are the ideal providers of this beneficial and cost effective technique.

Dry Needling at the University of Washington:

Chan Gunn, M.D., the founder of Intramuscular Stimulation (IMS), a form of dry needling, originally taught physicians at the UW to use this technique in the early 1990's. It remains one of the main techniques employed by the UW pain clinic. Physicians using IMS do not practice medical acupuncture. Dr. Gunn currently resides in Vancouver, BC and has taught physiotherapists in Canada for over 20 years to use this technique.

In the Physical Therapy program at the UW, the students initially learn about trigger points as they pertain to muscle physiology in their exercise physiology course (Rehab 525). At the end of their second year, in an advanced soft tissue mobilization course (Rehab 566B), students learn the clinical and physiological basis of myofascial trigger points and are introduced to the concepts, risks and benefits of dry needling. In addition to learning how to palpate and assess for trigger points, students also learn how to palpate nerves both directly and indirectly. In this introductory course, taught since 2011, students learn indications, contraindications, and precautions around dry needling, risks of possible adverse events and how to mitigate these risks, clean needle techniques, review of universal precautions, identifying signs and symptoms of pneumothorax, and protocols and procedures in the event of needle stick injuries. Due to the political climate around this topic in Washington, the lab portion of this course was cancelled in 2014. However, RCW 18.74.130 has an exemption for accredited PT programs such as the UW to allow students to perform novel techniques. As well, many of our students will eventually be practicing in states that do allow physical therapists to practice dry needling.

Physical therapists are trained in 3 dimensional anatomy not two-dimensional points on a page. They learn both in vivo and in vitro anatomy and palpation. UW PTs spend a year in cadaver anatomy, performing dissection. They spend two years in various lab courses and one year in clinical rotations that require hands on motor coordination in

handling the body. They understand the impact that trigger points play in the body, causing muscle inhibition, weakness, poor timing and coordination in movement patterns. Dry needling is not about memorizing and naming ancient points on a page. It is about evaluating the patient, diagnosing the impairments and dysfunction, determining the tissues involved and then physically palpating for specific dysfunction within that individual's tissues. It's about appropriate patient selection - not needling someone who is on anticoagulants or is in their first trimester or who is immune compromised. Dry needling is about safety for both the patient and the practitioner - we practice universal precautions, clean needle techniques, techniques to reduce adverse events, and what to do in the event of a stick injury.

Our high standards at the UW make our program intensely difficult to get into, the program itself is extremely rigorous to complete and our students become some of the best professionals in the field. By the time a student graduates with a doctorate in physical therapy, they have undergone nearly 10,000 hours of training. We would not be introducing this technique if it did not meet our criteria of best practices and innovative learning.

On the flip side, if we do not allow PTs in this state to practice dry needling, which is allowed in the majority of states now, then we as a state risk losing some of the best and brightest students and therapists to other states.

Dry Needling = East Asian Medicine:

It appears that many acupuncturists truly believe and zealously argue that dry needling and acupuncture are one and the same. This is patently false. If one takes the time to look at the foundations of each, it is very evident that they are not the same. It is a simplistic notion to assert that any insertion of a filiform needle is going to have an East Asian medical impact. The differing medical models of acupuncture and physical therapy underscore the critical reasoning and problem solving approach of each. Physical therapists are highly trained specialists in the neuromusculoskeletal system - the movement system. The objective of inserting a needle as applied by someone trained and skilled in dry needling is to affect a change in the musculoskeletal and nervous systems, whether or not it corresponds to a "meridian". The majority of the knowledge and skill required to practice the competencies for dry needling is covered in physical therapy doctoral programs (see FSBPT paper on competencies), not in acupuncture training. When PTs release a trigger point in a muscle it is done in conjunction with retraining that muscle for function. Contrary to claims made by certain acupuncturists, research shows that trigger points and acupuncture points are NOT the same (some may correlate but not a significant amount). An acupuncturist releasing an "ashi point", which they admit is a subset of their practitioners doing this treatment, is done in isolation and under the overall practice model of acupuncture. Needles alone do not make a profession. Physical therapists adeptly apply this tool and have the skill, education, critical reasoning and yes, the motor coordination to insert a needle to benefit the patient. Again, dry needling is not East Asian medicine.

A statement was made that dry needling has its origins in acupuncture. Not only was this statement not backed up with any evidence, it is a falsehood. Dry needling started with M.D.'s Janet Travell and David Simons injecting trigger points. It was later found that the needling alone without any injection into the trigger point was just as efficacious (see Karl Lewit, MD, reference). However, it is true that some researchers of dry needling, including the early work by Dr. Jay Shah from the NIH, have used the lexicon of acupuncture to state the specific site of a needle insertion and some proponents of dry needling integrate concepts from acupuncture into their technique (i.e., Dr. Ma's "Integrative Dry Needling" courses). But it still does not mean that the two approaches are one and the same, it merely demonstrates the overlap that can occur in many professions.

Dry needling is an effective, safe and beneficial treatment for physical therapy patients:

Over the past 20 years, a watershed of evidence in favor of the beneficial effects and safety of dry needling has poured out of peer-reviewed literature. The research is favorable for patients who receive a combination of dry needling with targeted exercises - in other words, needling alone is not the current best practice. Appropriate patient selection also determines the effectiveness of this treatment - carpet bombing patients with needles is not appropriate, needling people with immune deficiency or bleeding disorders is not appropriate, needling people too soon after surgery is not appropriate.

Physical therapists are also a driving force behind much of the current research on dry needling. Thus far, the evidence in favor of dry needling is compelling in terms of safety and long-term effectiveness. Research supports

that dry needling improves pain control, reduces muscle tension, normalizes biochemical and electrical dysfunction of motor endplates, and facilitates an accelerated return to active rehabilitation.

Physical therapists as the provider of dry needling would also be a cost benefit. The cost of physical therapy services is a fraction of what medical doctors or naturopathic doctors bill out. But more importantly, dry needling has the potential to reduce the cost of more expensive medical procedures such as imaging, surgery, and long term disability by reducing pain and restoring normal movement. It would be incomprehensible to limit patient's access to this beneficial effective technique for pain and disability in these times of opioid addiction and reduced access to a larger pool of providers. The greatest good for the patient would be achieved by allowing dry needling into the PT scope of practice.

Why physical therapists are the "ideal" providers of dry needling

- PTs differentially diagnose to know whether a patient is an appropriate candidate to receive dry needling.
- PTs are experts in the movement system and can immediately assess the effectiveness of the treatment.
- PTs have the best anatomical palpation skills to zero-in on targeted structures.
- PT is cost effective.
- PTs spend more time with patients to be able to deliver the service.

Professionalism:

Nationally, dry needling is not only recognized but is codified into standards of practice. The most recent Guide to Physical Therapist Practice, 3rd edition, published by the American Physical Therapy Association, includes dry needling in our scope of practice. The Federation of State Boards of Physical Therapy recognizes that dry needling is a unique part of physical therapist practice. Over 25 states have affirmed that dry needling is within the physical therapy scope of practice.

Washington State mandates that physical therapists shall recognize the need for continuing education and shall be open to new procedures and changes (WAC246915180). Therefore it is professional duty to pursue novel approaches, especially since the literature and clinical practice substantiate the effectiveness of this approach. Much has changed in our understanding and practice as PTs in the past 11 years since needle EMG and sharps debridement language was explicitly written into our scope of practice. Physical therapists practicing dry needling reflects the evolution of our knowledge and capabilities as healthcare providers. Now is the time to include dry needling into our scope of practice.

Thank you for hearing our case.

Ben Boyle

Thank you for letting me talk today. My name is Ben Boyle and I'm a physical therapist currently practicing in Washington. Prior to moving to Washington I practiced in a state where several health care professionals utilized tools and techniques that overlapped in order to provide care within their scope of practice. Spinal manipulation was performed by physical therapists, chiropractors and osteopathic physicians. Dry needling, traditional western based acupuncture, were utilized by PT's, acupuncturists and physicians who all went to their training professional care model. Multiple formal opinions have stated a technique does not define the profession. A chiropractor utilizing in a common physical therapy technique such as the McKenzie method does not make them a physical therapist nor would a physical therapist using a heal penetration technique without injecting be considered an acupuncturist, physician's assistant or an East Asian Medical Practitioner. Everyone who utilizes these techniques has their amazing outcome stories, but in reality for physical therapists dry needling is a component of an overall treatment plan that utilizes multiple techniques and skills to achieve a desired outcome. During my time I did not witness sudden increased needle related complications. This observation continues to be used by three tiers of evidence. Large prospective trials by White 2001 where the data was collected from UK physiotherapists and Brady 2014 both demonstrated that significant and adverse events from physical therapists performing needle techniques are rare. Further, more systematic reviews of case reports involving significant adverse events with needle techniques implicated physical therapist on 3 of 284 cases during a 12 year collection period. In these cases the patient fully recovered within 10 days. The reality is that in almost 25 years of dry needling used by physical therapists in the United States and 34 years using needle penetration techniques by UK Physiotherapists, significant adverse events and case reports continue to be classified as very rare. In my experience in another state, I only witnessed one outcome and that is more people had access to and receive the treatments they needed. This continuous research

suggests that the effects of biomedical treatment are greatest when delivered within the framework of the individual patient's psychosocial belief system.

Michael Baginski

My name is Michael Baginski. I'm a practicing physical therapist here in Washington State and I'm also a fellow in the American academy of orthopedic manual physical therapists which is a national organization committed to excellence and also has played a large role in helping develop the standards of orthopedic manual physical therapy scholarship programs credentialed by the American Physical Therapy Association. In 2009 the American Academy had stated support of use of dry needling by physical therapists, stating they are well trained or they are skilled to be able to provide the technique. I was first introduced to dry needling during my 2nd year of PT school at the University of Washington. As Suzanne mentioned we did cover basic principles and ethics and research and again the big reason we were taught that is because it's so widely used in different states and internationally we just have to be aware of the techniques therapists are utilizing and a lot of comments have been made in terms that PTs are referring to acupuncturists for similar effects. Again, you are coming to receive physical therapy and this is more clinical decision making. I mean for me to be able to refer someone out you have to acknowledge the diagnosis is the same, the leading issue of someone's complaint is the same, but also how we utilize these techniques. For me dry needling would be used more again to help reduce muscle tension, pain, and for that those would be temporary effects, where again you would have to follow exercise for muscular reeducation to be able to fix someone's problems. So referring them out would not only add more cost to the patient, but also it wouldn't be really in the best interest of my practice. Thank you.

Emilie Jones

Hi. My name is Emilie Jones. I'm a physical therapist and a legislative chair for the physical therapy association of Washington. We are here today to discuss whether physical therapists can perform a singular technique of dry needling. The American academy of medical acupunctures website describes acupuncture as one discipline extracted from a complex heritage of Chinese medicine, a tradition that also includes massage and manipulation, stretching and breathing exercises and herbal formulas. Physical therapists do not desire to perform acupuncture. We do not want to treat patients for allergies, stress, fatigue, poor digestion, menstrual discomfort, hormonal issues, asthma, hiccups, constipation, sleep disorders, etc. These patients are not seen in our practice and they would need to be referred to another professional for management of these issues. Acupuncture is a well-respected profession with a long history and body of knowledge. There are many other professionals that insert needles into patients on a regular basis. We do not ask phlebotomists to go to nursing school to puncture veins. We do not ask nurses to go to medical school to give injections. None of these practitioners are performing acupuncture when they insert a much larger needle into a patient's arm to give them a TB test. They don't know whether they're interacting with hundreds of acupuncture points when they do this. Physical therapists do not need to go to medical acupuncture school to perform a single technique just because the tool is the same. Physical therapists that want to perform acupuncture should go to acupuncture school. This review is about physical therapists and physical therapy. We desire to use our extensive background and anatomy, physiology, and manual treatment techniques to assist patients. We are already treating myofascial trigger points to get better faster. This allows patients to receive care in the model they choose, help most patients by improving access to care and help us improve the care we provide to patients with a neuromuscular dysfunction. Additionally it is not our intent to prohibit anyone else from performing dry needling and we would be happy to correct any language issues, if they are there, that would prevent anyone else to from dry needling. That's certainly not our intent.

Dan Tennenbaum

Good afternoon. My name is Dan Tennenbaum and I am an acupuncturist and I have a doctorate of oriental medicine, issued by the state of California in 1985. I first started practicing acupuncture 37 years ago in Boston. I consider myself as one of the founders of the profession in this country. Acupuncture is my life. I'm fluent in spoken and written Chinese and I am one of the top experts in this profession. In those early days, there were only about 100 acupuncturists in the nation, and the quality of acupuncture was rudimentary. But one by one the profession increased and started to grow new branches, flowers and fruits. At this stage there are between 25,000 to 50,000 licensed acupuncturists in this nation.

Practitioners are starting to specialize and there are some world class practitioners right here in the USA. One is Andy Rosenfarb of New York who routinely cures incurable eye diseases such as macular degeneration, detached retinas, and cataracts. In San Jose Dr. Zhu Ming Qing has found a cure for post-stroke patients along with many other neurological disorders. His miraculous cures have given him the nickname Miracle Zhu. In Florida an acupuncturist is exclusively treating in-hospital patients with nausea resulting from chemo therapy. Those are the fruit of 37 years of acupuncture

history in the USA. Do you want to stifle the progress? Do you want to destroy the tree? A tree that has just last year given the world a cure for malaria.

Why do we have to go to school for 3000 hours to study our medicine? Why? All people here think about it. It is because acupuncture and Chinese medicine is difficult to learn and... in the hands of a neophyte, it can very easily lead to injury, bruising, nerve damage, pneumothorax, hunchback, deafness and death. If physical therapists can perform acupuncture after a 35 hour course, then why would any young man or woman go to acupuncture school. They would simply go to a school for physical therapy and take their 35 hour course, et voila, I can now do acupuncture, bill for it, and in many instances get paid better than an acupuncturist. The result will be, that acupuncture will be stifled, the quality of acupuncture will go down, acupuncture colleges will be forced to close, and the legislators and state boards who allowed that to happen will be partially responsible for all the pneumothoraxes, chronic neuralgias, hunchbacks and dead patients. The AMA came out with its position paper in regards to dry needling.

We concur. We will welcome all physical therapists after they have undergone the same amount of study as we all are required to, and pass the national licensing test.

Peter Janicki

My name is Peter Janick. I'm a licensed physical therapist in Skagit County. Thank you for taking your time and thank you guys for presenting substantial data and facts for dry needling. I went to school in Denver, Colorado where we were exposed in our 2nd year how to handle needles, how to palpate, how to find trigger points, how to use this treatment effectively and safely. I really do hope out of all the scare tactics, there's a lot of data presented and there's a lot of things in the air that we do this for the good of the patients. They're the ones that are going to benefit from it. I would never say that I did acupuncture in coming back to Washington. The one technique that I wanted to use the most wasn't available, so I do hope that you take that into consideration and do this for the patients that will benefit most. Thank you.

Megan Douglas

My name is Megan Douglas, I have my doctorate in Physical Therapy, a manual therapy certification, and am a board certified orthopedic specialist. I completed the majority of my education in Ohio and treated patients there for 9 years prior to moving to WA state. I taught at two doctoral programs for physical therapy in the Greater Cincinnati area, the University of Dayton, and Mt. St. Joseph's College.

I was somewhat reluctant to move to WA state back in 2009 when I heard that spinal manipulation was not legal in the state of Washington, one of only two states that was falling behind in furthering our field in evidence based practice and allowing access to all the necessary tools and treatments to help our patients. I am pleased to say that this is no longer an issue and I now hold a "spinal manipulation endorsement" that shows that I have taken the extra time and training for the state to see that I am competent to perform this treatment with my patients.

I also own a business in the Skagit Valley where I employ 9 physical therapists and five physical therapist assistants, along with an excellent support staff. As dry needling becomes more widely used in our profession to help alleviate musculoskeletal pain for our patients, I am frustrated once more by obstacles that are hindering us from helping our patients and furthering our field of practice. A stagnant practice with no new techniques emerging is not one that we should desire to be a part of. I understand the concern for the safety of our patients with this technique that is new to many, but our doctorally trained physical therapists are ready for this challenge, and if it is most appropriate to ensure that we go the extra mile with our continuing education for an "endorsement" similar to spinal manipulation, I understand this need as well.

Physical therapists as a whole are known for being a very safe and conservative treatment option. A physical therapy malpractice insurance agent once told me that our biggest claim was for patients falling off plinths at our clinics. We understand that dry needling is a technique that is not without risk.

In fact, a study by White in 2001 of physiotherapists and medical doctors in the UK showed minor adverse events at a rate of 6.7 percent and a significant adverse rate calculated at 0.1% with no serious adverse outcomes. Also, a more recent study by Brady in 2013, showed Irish physiotherapists have a minor adverse event rate at 19 percent, significant adverse event at 0%.

This is in comparison to:

In 2009, Witt did a survey of patients receiving acupuncture for musculoskeletal and medical dx and found 8.6 percent of patients reported at least one minor adverse event and 2 percent significant adverse event rate. Obviously, there is some risk with dry needling as a treatment, but this is true for several other treatments that physical therapists employ, and several medical professionals employ on a daily basis - including, as I mentioned previously, just getting on and off of a treatment plinth!

Our PTs are highly trained professionals that have gone thru rigorous training and have been competitively selected from a wide pool of applicants prior to entering their doctoral programs. They are professionals that can safely and effectively perform dry needling, especially given the extra continuing education to further and hone in their skills for trigger point dry needling.

Aaron McLuen

I thought I would come and speak as the least qualified person in the room. I'm a patient. I've been a patient of both acupuncture and dry needling, and for me completely different experiences. I went to acupuncture for some back pain and got whole body treatment and it was wonderful. I would absolutely go back, but it's completely different than what I receive when I go to see somebody for an acute injury like back pain or a sore shoulder or whatever. You get treated on the spot. You get a set of exercises to go with it and the recovery time is amazing. So I wanted to share that. I'm a father of two. I have two kids that have played high level soccer. They have both had injuries. My daughter has a strained MCL and she was back on the field playing in four weeks because of this treatment. It needs to be something that is available for us. A friend of mine that referred me, literally for eight years could not raise his shoulder above his head. He went in for one treatment, like that, after eight years. It's super effective. As a patient, when you get hurt, your doctor is going to refer you to a physical therapist and to have this treatment not available when we know how well it works would be wrong in my opinion. So as a patient I want this to be available to me. It's part of a comprehensive set of techniques that physical therapists use and should be allowed to use in Washington State and I hope that we can join the majority of the rest of the states and make it explicitly allowed and if not I guess I can go to Canada to use it.

Romi Epstein

Hi my name is Romi Epstein. I am an East Asian Medicine Practitioner since 2003. My practice specializes in sports medicine and I hold a certificate in structural integrational work. Of course dry needling works because dry needling is based on acupuncture and acupuncture has been around for well over 2,000 years. In our day and age we take a lot of things and look at the active constituent and say if we pull it out this will be better and that's a little bit of what dry needling does. Acupuncture is a system that looks at the whole person and PT's don't want to treat headaches and menstrual cramps but we also treat a lot of pain. I treat predominantly pain and if physical therapists want to continue to do dry needling there's a very clear protocol that's been set up by chiropractors and doctors for what that training looks like. It's comprehensive and creates a level of safety that protects all of us. We are fortunate to live in a time when we are able to share so much information with each other and to support each other and I would never presume to send any of my patients home with exercises, strengthening and protocols that are outside of my scope of practice for which I have a four year certificate degree in. The dedication that it takes to put needles into a person's body and know that the direction, depth and timing of that insertion is more than just sticking the needle in and with a little bit more training that has been established by these other professions we would greet physical therapists with open arms and say yes please support us in this process in helping peoples' pain be healed. Thank you.

Ron Mimaki

My name is Ron Mimaki. I am a physical therapist for 24 years. I practice up in Poulsbo. Thank you for your time. Thank you for allowing me to say my peace I guess. I don't think any one of us as far as physical therapists want to do acupuncture. I think a lot of acupuncturist see the benefits of trigger point dry needling and I myself have, by experience. I took a class from Kinetacore five years ago when Washington State was a grey area and I was allowed to practice dry needling. My patients benefitted from it greatly. I saw the same type of results that people are talking about here. One treatment, full recovery, for a lot of different things and I could go on and on about the different patients, the different case studies that I could tell you about. If a patient comes into my clinic and says "hey do you do acupuncture, I'm interested in acupuncture." I don't say yes I do, when I could do dry needling. I give them the clinics in the area that do it, ok. So, I'm not trying to take any patient away from acupuncture. I'm just trying to allow that trigger point dry needling's more readily accessible. Because again it's a wonderful tool to have, and granted again it's a tool. I wanted to say at the

same time there's been a lot a talk about safety. I've done probably about 4,000 plus needle applications, with zero significant complications. Bruising that's about it. Muscle soreness and that's about it. So, I have no statistics to support that obviously but I can definitely testify that I have had no complaints. And again it's an inherently safe technique. I don't mean to be cavalier about it. I totally respect acupuncturists and what they do. But let's be honest, I mean they want it to be kind of a turf issue and the same thing with chiropractic. I don't believe that that's what we are trying to do. We're just trying to help the patients. Thank you.

Shane McDonald

My name is Shane McDonald. I'm a doctoral trained military physical therapist board certified in orthopedics and credentialed in dry needling with the military health care system. I'm also a supervisor, since the acronyms have been thrown around, a FPPE supervisor to doctorate level physical therapist seeking to get their credentialing within the Madigan health care system. When I and my colleagues use dry needling we do not perform this within the vast scope of practice as an acupuncturist. When my patients see me and I've been in the military a long time and my patients tend to have more tattoos than outside the military. My patients are covered in tattoos and then ask if they have ever had dry needling before? And I pull out a needle and there are like, oh good, this looks like it will be fun. I do it as part of the muscular skeletal component of what we do. Other physical therapists and acupuncturists in this room have talked about the other scope of practice within which could be considered dry needling and we don't want to. I don't intend to lead my patients to believe that they are getting acupuncture. I worked in a hospital of traditional Chinese medicine in Beijing for two weeks about thirteen years ago and I've seen what acupuncturists can do and I don't do that. I have no intention to do that. We use this tool in conjunction with other techniques within our scope of practice and within my area of specialization as a busy military health care provider. I want to provide the least amount of care and with the least amount of inconvenience to my patient and limiting use of this tool to one profession may not be in the best interest to both. Thank you.

Applicant Follow-Up

Mr. Fernando asked the applicant group to address a question from him during their follow-up comments. To what extent were other disciplines either involved in the HumRRO report or consulted when developing it?

JJ Thomas

The intention of the report was to identify competency standards for physical therapists. The task force members were all physical therapists. There was a misrepresentation however. They were not all owners. There was one instructor of an educational program. There was myself and two others who are instructors in the technique, and one was from a doctor of physical therapy program who was considered a specialist and he also dry needled. His chief component was his specialty in understanding the knowledge criteria, etc. to a level higher regarding CAPTE criteria which is the criteria used in our doctor of physical therapy program to make you an accredited school. There were also support-staff from the Federation of State Boards of Physical Therapy and the APTA.

There were a couple of items in particular that I heard from my acupuncture colleagues. There was a consistent mention that dry needling is acupuncture and acupuncture is dry needling. I think this needs to be clarified. The actual literal term of dry needling is that a needle is used without an injectate. Typically people perform dry needling using a solid filiform needle. There are acupuncture needles and there are needles specifically designed for physical therapists but all of them are dry needles. The intent and application that you are using that needle for will depend on your scope of practice, so for instance an acupuncturist is dry needling absolutely. They are calling on their foundational knowledge of Eastern medicine and I hate to even begin to describe what they do because it's not in my scope of practice. A physical therapist will use our background knowledge and skill set that we have within our physical therapy scope of practice which is centered around the neuromusculoskeletal system as it relates to movement impairments and dysfunction. I think that's the key criteria. I also want to go into the idea of dual licensure. I personally find that disappointing as an option and I don't see it as an option. Where I work in Delaware, I have acupuncturists I refer to regularly and that's because they perform techniques with that dry needle that are outside my scope of practice. Yet I believe and have a lot of respect for what all you acupuncturists do. I want to have that available and I don't want to do those things. I want to only use that needle for what I am capable of, which is within my scope of practice in the neuromusculoskeletal system. Lastly, I would like to speak to the supervision component. I see how that's a very important component. I don't think it was clearly mentioned that in the educational programs that are advanced training programs currently in the United States. All of them that I'm aware of test for competency, both written and practical. From there, it will be up to the board and professional to make sure that they're implementing those standards based on their professional responsibilities. With that, physical

therapists already have a great track record and I believe they'll continue to do so and on top of that the Board of Physical Therapy of Washington has already shown that commitment to ensuring public protection in this regard. I think that covers the competency standards.

Panel Questions

Q: Regarding intent of practice, when we first started testimony, I asked about the definition of trigger points, which are from what I've read and what I've heard today are the aim of dry needling for physical therapists. So, if there's a common definition of what a trigger point is and common needles being used by both physical therapists and acupuncturists, you are stating that intent of practice is what differentiates the two practices.

R: That's not the only thing, but I think what might answer your question is recognizing that, yes, they may be treating components within their acupuncture that address the neuromusculoskeletal system. However, that small component would be the only part that would be classified under our scope of practice. To follow that up, for us to go and get dual licensure, now we would be taking additional hours that would take us outside our current scope of practice. So we would be able to do these other skill sets that currently are not, but we don't have an interest in that.

Jan Dommerholt

If I believe the testimony of many of the opponents of this bill, I can only conclude that physical therapists in this state aren't as well educated as anyone else in the world. Because I hear again and again that this is a public safety hazard, a risk for patients. This has not happened in Canada, or any other state, or any other country. I think physical therapists in this state have the exact same education as I do and they should be totally fine. There are a couple of other things worth paying attention to. Comments were made several times that dry needling is based in acupuncture. The way I teach dry needling at my institute has nothing to do with acupuncture. I learned it personally from Dr. Janet Travell and Dr. David Simons, who were my mentors. They never did dry needling. They never held an acupuncture needle in their fingers. They used injection needles and Travell does describe in her autobiography that occasionally she would use an injection needle to do dry needling although she did not use that term. What I learned is from a medical doctor who treated Kennedy and others, was an injection therapy that she developed. She never looked at acupuncturists, never. That is not true. You're shaking your head, I can see that, but it's not true. I knew her personally, you didn't. In 1983, Travell published a book on trigger points. By 1985 or 1986, some very prominent acupuncturists called her and went to visit her. One of them wrote a book about it, about the missing link to acupuncture practice, not the other way around. That does not mean that acupuncturists were not doing similar things. That's an entirely different development. Acupuncturists probably have done this for 2,000 years. I don't question that at all. But to say that what we do as physical therapists is acupuncture is a very one-sided interpretation. Travell never did any of that. I think we have to be careful. There are terrible courses. I am very familiar with the story from an acupuncturist about 60 students in one class with one instructor. Actually she's taken some of our courses and I've talked to her at great length about it. I'm not necessarily speaking for the physical therapy association. But I am not opposed to, as other states do, setting standards for what courses will be approved. My state, Maryland does that. For us to be accredited by the state of Maryland I have to submit my information and there's certain criteria I have to meet. If I don't meet it, I won't be approved and people would not be allowed to take my courses to practice. Every province in Canada has done the same thing. To set a standard by the physical therapy board and have them evaluate the process as to what makes sense, I totally agree. Sixty students with one instructor is ridiculous. That's insane and would be a public health hazard. That person no longer teaches so that's good. The problem took care of itself. But I think some standards for what would be allowed for physical therapists to follow, with criteria from Washington's physical therapy board, makes sense. Every other state has done that. The board already has standards for any continuing education course. That is no different for dry needling and to put dry needling on another level is really not necessary. Yes, we've all heard wonderful stories. I've never heard of acupuncture curing malaria or hunchbacks. Those are new to me. Physical therapists have made claims and acupuncturists have made claims. I think that's the bottom line, because we want to help our patients. We're not here to fight. I've done this many, many times. I've testified in more states and the arguments are always the same. Physical therapists and acupuncturists co-exist. I've referred a lot of patients to acupuncturists because you do something that I do not. I've seen patients who are very depressed individuals and have asked whether I think acupuncture could help. I've said that I wasn't sure but was happy to refer them. I refer to acupuncturists in my community and the results are amazing. I have no idea what to do with depression. The acupuncturist clearly did. Mr. Moore made several comments about where it went wrong. It is an invasive procedure. Sometimes it does go wrong. I have stuck millions of needles in people. I have never caused a pneumothorax, and I don't intend to do it either. He mentioned issues of a calf infection. I was an expert witness in that case and the injection was not from dry needling. It was caused from the calf being placed in a dirty tank after dry needling. I recommended to the

attorney to get water sampled and have them tested. Dry needling provided the pathway for these microbes to get in from the dirty water in the tank but it had nothing to do with dry needling. Arguments like that don't make sense. It's not a meaningful dialogue. Let's have a meaningful dialogue so you can make a good recommendation. The insurance company has acknowledged there are pneumothoraxes. But they are few and far between in thousands of dry needling treatments every day. There are a few, but so are there in acupuncture. This can be avoided with knowledge of anatomy. That's what physical therapists know. We have superb knowledge of anatomy. Lastly, someone said patients don't want to treat patients with headaches. I treat patients with headaches every day, so if your knowledge base of what physical therapists do is lacking if you think we don't treat people with headaches.

JJ Thomas

Just a few more points that I think might answer a question earlier where you were looking for a comparison of trigger points in relation to how an acupuncturist might define it. I think we might agree on a definition but I don't think that is helpful. What we are here today is to show that we are competent in learning this technique but for the sake of today and out of respect for my colleagues I would like to read part of the law, 18.06.005. In the acupuncture law, it says that the legislature intends to recognize that acupuncturists licensed by the state of Washington engage in a system of medicine to maintain and promote wellness and to prevent, diagnose, and treat disease drawing upon the experience, learning, and traditions originating in East Asia, which include more than acupuncture alone. While that may not be the pure definition in their scope, it does explain the differences between our training, education and background and how we would implement our techniques, whether it's dry needling or something else. On top of that, there is one other thing from the legislature that I think is relevant. They have exemptions in 18.06.045 that nothing in this chapter shall be construed to prohibit or restrict the practice by an individual credentialed under the laws of this state and performing services within such individual's authorized scope of practice. This gets back to the real question of whether we or are not within the realm of our capabilities to be competent and safe in treating our patients.

Another member of applicant group – did not identify himself

In conclusion, I would like to say that dry needling is a technique that is used through PT clinical judgement. Not all physical therapist in all physical therapy settings use dry needling. It's only those who have pursued further education beyond their DPT degrees. It's part of a plan of care. It's not used in isolation for physical therapists. It's used as part of a plan to develop functional movement and to retrain functional movement. It's also been suggested and demonstrated that it's part of a cost-effective treatment plan and it's primarily used as part of neuromuscular function. It's not used for curing cancer or other things that medical acupuncturists might treat. We're not asking for that. We're not intending to take away from acupuncturists. We respect what they do. We hope that the evidence has been appropriate for you to decide that PTs are able to safely perform dry needling in Washington and would ask you to carefully consider the evidence and facts which we have presented today and will continue to present over the next two weeks. We thank you for your consideration.

Hearing Wrap-Up

Mr. Fernando thanked the hearing participants and provided next steps in the sunrise process. These included:

- An additional 14-day written comment period starting today through August 16th at 5:00 for anything you feel has not been addressed.
- Sharing an initial draft report with interested parties in September for rebuttal comments. Those of you participating today will receive the draft as long as we have contact information for you.
- Incorporating rebuttal comments into the report and submit it to the Secretary of the department for approval in late September.
- Once the Secretary approves the report, it is submitted to the Office of Financial Management for approval to be released to the legislature. OFM provides policy and fiscal support to the Governor, legislature, and state agencies.
- Releasing the final report to the legislature prior to legislative session, and posting it to our Web site once the legislature receives it.

Hearing Attendees

Applicant Group who Presented Proposal

JJ Thomas

Jan Dommerholt

Dan Anton

Erik Moen

Public Testimony

Name	Representing	Position	Testified
Ash Goddard	WEAMA	Oppose	Yes
Andy McIntyre	WEAMA	Oppose	Yes
Iman Majd	WEAMA	Oppose	Yes
Thi Nguyen-Phuoc	WEAMA	Oppose	Yes
Jessica martens	WEAMA	Oppose	Yes
Leslie Emerick	WEAMA	Oppose	Yes
Chris Huson	WEAMA	Oppose	Yes
Jianfeng Yang	WEAMA	Oppose	Yes
John Moore	EAMP	Oppose	Yes
Bridget Boylan	PT – EAMP	Oppose	Yes
Lisa vanhaagen	Self – EAMP	Oppose	Yes
Desiree Merulli	Self – EAMP	Oppose	Yes
Jacqueline Berg	Self – PTWA	Support	Yes
John Schroeder	Self – PTWA	Support	Yes
Elaine Armanrout	Self – PTWA	Support	Yes
Nancy Mansell	Self – PTWA	Support	Yes
Austin Woods	Self – PTWA	Support	No
Susanne Michaud	Self – PTWA – UW	Support	Yes
Melissa Johnson	PTWA	Support	No
Jackie Barry	PTWA	Support	No
Ben Boyle	Self – PTWA	Support	Yes
Inessa Pasko	WAPTA	Support	No
Jim Shepherd	PTWA	Support	No
Michael Baginski	PTWA	Support	Yes
Robin Schoenfeld	PTWA	Support	No
Jay Goldstein	PTWA	Support	No

Nicole Kinney	PTWA	Support	No
Heather Cavaness	PTWA	Support	No
Emilie Jones	PTWA	Support	Yes
Paul Killoran	PTWA	Support	No
Jen Hass	PTWA	Support	No
Dan Tennenbaum	South Sound	Oppose	Yes
Acupuncture Association			
Jamie Shoot	WEAMA	Oppose	No
Mayme Fu	WEAMA	Oppose	No
Chunlin Gao	WEAMA	Oppose	No
Jon Pontrello	WEAMA	Oppose	No
Jianjun Wang	WEAMA	Oppose	No
Chun-Sheng Li	WEAMA	Oppose	No
Sean Li	WEAMA	Oppose	No
Lee Huang	WEAMA	Oppose	No
Ying Hu	WEAMA	Oppose	No
Peter Janicki	Northwest PT	Support	Yes
Megan Douglas	Northwest PT	Support	Yes
Sikchi Stanley Chan	LEAMP Acupuncturist	Oppose	No
Joy Smedley	Acupuncturist	Oppose	No
Jing Gao	Acupuncturist	Oppose	No
Laurie Connolly	Therapy Works OT	Support	No
Carrie Helminger	PT	Support	No
Ying Zhu	DC	Oppose	No
Wareeya Jazkaan	DC	Oppose	No
Lynda McLuen	Public	Support	No
Jan Galvin	PTWA	Support	No
Bart Hawkinson	PT	Support	No
Aaron McLuen	Public	Support	Yes
Romi Epstein	WEAMA	Oppose	Yes
Jennifer Lesko	PTWA	Support	No
Tom DiAngelis	PTWA	Support	No
Sarah Berkshire	PTWA	Support	No
Ali Schoos	PTWA	Support	No
Brad Callan	PTWA	Support	No
Dan Swinscoe	PTWA	Support	No

Amanda Costigliola	PTWA	Support	No
Jana Wiley	WEAMA	Oppose	No
Parke Humphrey	PTWA	Support	No
Diana Godwin	PTWA	Support	No
Yanmin Tan	Acupuncturist	None indicated	No
Xeuzhong Way	Acupuncturist	None indicated	No
Naja Minshower Neumann	Patient	None indicated	No
John Neumann	PTWA	Support	No
Dan Dingle	SSAH	Oppose	No
Andrea Love	PTWA	Support	No
Katharine Chen	PTWA	None indicated	No
Alexa Silver	House of Representatives	None indicated	No
Bing Zhou	Acupuncturist	None indicated	No
Xiapin Song	Acupuncturist	None indicated	No
Xia Che	Acupuncturist	None indicated	No
Megan Bell	Physical therapist	None indicated	No
Diana Hester	Acupuncturist	None indicated	No
Xinli Du	Acupuncturist	None indicated	No
Shane McDonald	Physical therapist	None indicated	No
Shannon Long	PTWA – Self	Support	No
Ron Mimaki	Kitsap PT	Support	Yes
Kevin Bratt	Self	Support	No
Sarah Collins	Self	None indicated	No
Amanda Scharen	PTWA – Self	Support	No
Deb Schaack	Central PT	None indicated	No
Jutta Schneider	Central PT	None indicated	No

Appendix D

Written Comments

Physical Therapy Dry Needling Sunrise Hearing
Written Comments Received
July 28, 2016

I wanted to weigh in on the issue of dry needling treatment in Washington. As a recipient of both acupuncture and dry needling, I feel they are quite different treatments and believe that certified practitioners should be allowed to practice both in the state.

In my experience, dry needling is a "reboot" of an injured area. It is quick to break down barriers that the body has put up to protect an area. By being able to break down the defenses, other treatment (physical therapy, massage, etc.) can get into the area sooner and speed the healing process.

By contrast, I feel that acupuncture is more holistic. While it targets an area - whether for an injury, or something else - it is more subtle and slower to "work". I've had acupuncture over the years for a variety of issues and I like it.

It is unfortunate that I cannot get dry needling here though. It has been extremely helpful in the past for a shoulder injury. My PT is doing great things on this recurring injury (initially a dislocation), but without the dry needling, it's a much slower healing process.

Please consider these are very separate treatments. I would appreciate being able to get dry needling again as well as acupuncture.

Anne O'Rourke

On page 4 of the "Applicant Report: Dry Needling in Physical Therapist Scope of Practice" by PTWA, the applicant states: "It is acknowledged that some physical therapists in Washington state were performing dry needling prior to the 2015 statement by PTWA urging physical therapists to cease performing this technique..." In reviewing the citations listed, the appendices, and attachments, I do not find the "2015 statement by PTWA" that the applicant references in this statement. I would very much appreciate receiving a copy of that correspondence prior to this coming weekend.

Additionally, regarding oral comments made in response to the applicant's presentation and report at the hearing on August 2, 2016, can you tell me what will determine the time limit on hearing attendees' (audience)oral comments? Is it based on the total number of attendees wishing to speak before the conclusion of the hearing, with equal time for all? If some comments are of shorter duration will that leave longer time for others to speak?

In advance, thank you very much for your assistance and reply.

Lisa vanHaagen, MS, EAMP

I am a recent graduate from Bastyr University's Acupuncture program. I recently learned of the Sunrise Review for Physical Therapist Dry needling. I have some information regarding this issue as I have spent the last three years of my life thoroughly studying Traditional Chinese Medicine (also known as East Asian Medicine). An interesting fact I just learned is that the early promoters of Dry Needling considered both acupuncture and dry needling to be the same and even suggested renaming the acupuncture points in modern terms to allow acupuncture to be more acceptable by medical doctors. Interestingly, we have had more than a few medical doctors come thru Bastyr and they have had no problem with acceptance of acupuncture, nor have the many several other MD's that highly recommend acupuncture to their patients.

However, being that dry needling has its origins in acupuncture, it should be governed by the same statutes that apply to acupuncture. Furthermore, the American Medical Association (AMA) recognize 'dry needling' as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists and the American Physical Therapy Association (APTA) said that "there is no CPT code that describes dry needling nor do any of the existing CPT codes include dry needling techniques in clinical vignettes utilized by AMA in their process to establish relative value units." In order to establish is new CPT code, you must go through the AMA.

First, and possibly most importantly, is that acupuncture and dry needling are, at their essence, the same thing from the perspective of regulatory and legislative standpoints. By simply referring to acupuncture by a different name such as dry needling, it does not change the procedure. As such, in order to bill, PT's would have to use the CPT codes for acupuncture.

Acupuncturists train under very strict supervision for at least a year to learn how to needle without causing injury. Furthermore, at Bastyr, we have access to cadavers to attain a very deep understanding of how our needles actually interact with tissues- different body types require different needling approaches. Anyone using a dry/acupuncture/filiform needle should meet benchmarks for safety before touching the human body with a needle for therapeutic purposes, which requires extensive training to perform safely. Furthermore, Washington state has benchmarks for didactic education, supervised clinical hours, and a third-party national psychometrically created exam to test for minimum competency that involves the insertion of filiform acupuncture needles, therefore, anyone wishing to the insertion of filiform needles needs to undergo the same competencies.

What physical therapists call trigger points are one of the two broad categories of acupuncture points: channel-related points and pain-related points, also known as "ashi" points. Trigger points are ashi points, and have been recognized as acupuncture points since the 7th century CE at the latest. I was trained as a massage therapist before attending Bastyr. When we first learned about common locations of ashi points, I was amazed at the overlap with trigger points. We discussed the ancient texts that first identified these points, I realized at that time that many different western modalities borrowed from ancient medicines. Thus it is no surprise that "dry needling" is also commonly called "trigger point needling." This is a technique commonly performed by acupuncturists treating myofascial pain. Dry needling/trigger point needling is a technique that is documented as a subset of acupuncture and is practiced readily in modern treatment. The technique of needling taut bands of tissue is described in the earliest acupuncture text. It is now taught more specifically with greater emphasis on musculoskeletal and neuroanatomy by acupuncturists to acupuncturists, both in formal programs and in continuing education programs alike. It is readily used in modern practice and, as such, is commonly called trigger point needling, which is also an alternate name for dry needling.

Lastly, the language of SB 6374 is problematic for two primary reasons. First, the language of the bill could prevent licensed acupuncturists from performing dry needling, a technique that is inherently within their scope. Secondly, the RC18.74.010, if adopted, will be unenforceable as written.

Thank you for taking the time to read my concerns as I begin the journey into my career as an acupuncturist- something I have worked very hard to be able to do legally, professionally, and most importantly safely.

Crystal Rose Tay, Graduating class of 2016, Bastyr University

In 2013, I took a fantastic course offered by Kinetacore to learn dry needling skills. As a Physical Therapist, I felt I was completely capable of adding this treatment to my practice after the course.

When using my dry needling skills I found it to be a unique, successful treatment that was unavailable from other healthcare professionals. One detail I observed, was that I was often dry needling an area very different from where patients were receiving their acupuncture treatments, in those patients that were receiving both disciplines concurrently. This proved to me that the philosophy and overall treatment are different even though we are using a similar tool.

Since the court decision of 2014, I have had many patients requesting to receive dry needling, as they have been unable to find similar pain relief from other treatments and professions, and I have had to deny them the option.

Physical Therapists have extensive schooling inherent in our graduate programs and continuing education to learn the vast majority of knowledge needed to skillfully implement dry needling. I feel we are a talented group of health professions that can safely and effectively offer dry needling.

There is overwhelming international and national support for dry needling to be in the Physical Therapy Practice Act. Please support the addition of dry needling into our scope of practice for Washington State Physical Therapists.

Shelly Skiles, PT, OCS

I am an acupuncturist in Mount Vernon, WA commenting on the PT trying to add dry needling to their scope of practice.

Several points need to be made. When thinking of adding a technique to a profession we should ask is there something it is replacing. Is what it is replacing better or the same. If it doesn't then are we just adding another layer of cost to the medical system. In this case there is. Acupuncture has a long history of use. There is years of clinical data to show it's effectiveness. PT will say what they are doing is different. But how is it different where is their clinical data where is their scientific basis for what they do. One or two studies does not constitute a rigorous study. This was pointed out in a law suit that was filed against a PT company trying to teach a class in WA State. The PT lost this in court If PT are certain about the mechanism of what they are doing why is there not a clear set of national standards of what needs to be taught. This is the most worrisome part of their argument. The PT think that a weekend class is sufficient to practice this. As an acupuncturist I must take a one day class in just clean needle technique. How they think they can teach this in one weekend is beyond my understanding. They imply that because they already have the anatomy background they can stick needles anywhere in the body to any depth. This defies logic and is certain to create many adverse problems.

The PT lost this in court which has clearly stated that dry needling is acupuncture. They are trying to ignore the court ruling. If they have further evidence they should present it to the court.

Donald Butterfield EAMP

I am lei ding. I have a MS from bastyr. I spent 3 years to study acupuncture. I can't imagine the physical therapist spending 30 hrs will be qualify for "stocking needles in patients". They don't have the knowledge and enough training. "Dry needling" and acupuncture is a complete different thing. Please say no to dry needling performed by physical therapist. Let me know if you have any questions.

The Chinese community of East Asian Medicine Providers in Washington State very firmly and strongly oppose the possibility of physical therapists doing acupuncture, which they call "dry needling," with too little training. Acupuncture is a big category with many different kinds of acupuncture. Dry Needling is ONE of the many forms of acupuncture, which requires full time educational and clinical training to do safely and effectively. The physical therapists want to do acupuncture with **only 54 hours** of training. This is dangerous to the public health of our citizens.

Acupuncture is using needles inserted into the body for therapeutic and healing purpose. Anyone using needles to work on the body to reach therapeutic or healing purpose belongs to the practice scope of acupuncture, no matter what they call it. Some PTs who do “dry needling” say they aren’t doing acupuncture. But changing the name from acupuncture to dry needling does not change the procedure or what happens in the body. It’s just a different name! In our Chinese medicine classics, there are descriptions of “dry needling” that are over 2000 years old! Dry needling is actually one of methods that we have used in acupuncture clinics for thousands of years in China. This is a method where needles are used based on Ashi point(s) or tender point(s), or sensitive point(s). In other words, where there is pain or sensitivity, is where the point is. The descriptions only use different language from dry needling, but they are the same thing. Dry needling is acupuncture.

Acupuncture is not just sticking a needle into the body. Nobody can learn how to do it safely, properly and effectively in 54 or less hours. In China, acupuncturists train for five years to obtain bachelor degree, eight years for master degree, and 11 years for doctor degree. In this country, the training requires three or four years of classroom study and clinical training to develop enough basic skills and be practiced safely.

Physical therapists may be trained well in physical therapy, but their training does not include therapeutic needling of any kind. The PTs are trying to use only 54 or less hours of instruction in needling into the body. This short time leaves out important learning for safety and effectiveness. Without formal and full time training in acupuncture schools or institutes, nobody, including PTs are qualified to provide training courses or to teach students and even worse to treat patients. Otherwise, physical therapists will be practicing acupuncture at an unsafe and ineffective level.

We ask you NOT to approve this request to expand the PT scope of practice. Thank you for your consideration.

Jianfeng Yang L.Ac. EAMP.
Guojun Duan L.Ac. EAMP

I am writing on the current proposal to add dry needling to the physical therapy scope of practice in the state of Washington. I am a physical therapist in the U.S. Army currently stationed at Joint Base Lewis-McChord. The following views and opinions are my own and are not endorsed by the United States Army or the Department of Defense.

I have been utilizing dry needling as an integral part of my physical therapy practice since 2013. It is a tremendously beneficial treatment that is cost and time effective. I use it daily to reduce pain and improve the functional abilities of my patients. I typically see excellent responses, often immediately. I have never had a serious outcome. The worst case scenario is a patient's pain may return to their baseline after 1-2 days of increased soreness. Army Physical therapy is leading the way in research to show the effectiveness of this treatment and while it shouldn't be the only thing a physical therapist does, it is a vital tool in our "toolbox" to offer patients.

The common argument against physical therapists having this skill is that we aren't fully trained because we can go to a brief course to get certified. I feel that does an injustice to the thousands of hours I spent in a doctorate level physical therapy program. Standard DPT curriculum includes hundreds of hours of human dissection plus extensive classes on anatomy and muscle function. We are taught the course of muscles and other body systems that need to be avoided long before we are ever allowed to pick up a needle. Placing the needle is truly the easy part, knowing where and when to place it requires a thorough education and thought process that physical therapists are more than adequately trained for in our unique role as musculoskeletal injury and rehabilitation experts.

I am unable to attend the meeting on 02AUG16 but would be willing to discuss my personal feelings further if necessary,

NATHAN A. PARSONS, PT| CPT, USA |
OIC, Winder Physical Therapy Clinic, Madigan Army Medical Center |

I am writing as a licensed physical therapist in Washington State regarding the current Sunrise Review for dry needling as within the scope of PT practice. Aside from owning a private clinic for ~4 years, I instruct dry needling courses throughout the US to physical therapists, chiropractors, and physicians. Research literature, incidence data, and supporting endorsement from FSBPT and APTA along with precedents across the US all support dry needling as safe and effective when employed by physical therapists - but I can personally vouch for instructing >30 courses over the past 2 years that physical therapists with advanced training are the ideal clinician to perform an intramuscular therapeutic technique. 30 courses represents over 600 clinicians in 2 years and during this coursework (when these clinicians are *first* learning and practicing dry needling) there has been ZERO pneumothorax or severe adverse event encountered. Nonetheless it is instructed with utmost precaution in regards to universal precaution, clean needle technique, and identification and management of adverse events that are possible. A thorough understanding of anatomy is a paramount foundation to ensure safety and physical therapists are the most capably trained discipline in terms of neuromusculoskeletal anatomy.

With physical therapy already an established cost-effective healthcare option, dry needling will allow management of both chronic pain and acute/subacute musculoskeletal injury with more efficacy and less expenditure.

Please accept this email as endorsement in support of allowing physical therapists to practice dry needling in Washington State.

Paul Killoren PT, DPT, CSCS

Over the past few months I have received a handful of dry needling treatments for my shoulder and hip. Both areas have been chronic problem areas consisting of tight muscles and joint pain, and both recently exacerbated by a car accident. Over the years I have done numerous alternative treatments for these 2 areas -- traditional physical therapy, chiropractic, massage, strengthening, and yoga. The dry needling therapies have been by far the most effective treatments. Each session of dry needling has provided immediate and lasting relief. From my experience and in my opinion it would be a huge disservice and a great disadvantage in our health care system to no longer have access to dry needling. I strongly believe that the health care model should place more emphasis on services that prevent and quickly remedy disease, sickness, and injury. Dry needling is one of those services.

Please keep dry needling an option in the scope of Physical therapy practice!!!

Heather Balajadia
Kirkland WA 98033

I was diagnosed with peripheral neuropathy in August of 2015, with low back problems, extreme leg muscle tightness, and numbness with tingling when I walked. Although to date I am not completely symptom free, dry needling has improved my symptoms by 85%!

My pain has been significantly reduced, my muscle tightness is gone, the numbness is slowly receding, and my quality of life is greatly increased!!

David, Gig Harbor, WA

I would like to share my experiences with dry needling. I was treated several times for various conditions related to back, lower extremities, etc. While I was initially skeptical about the method - the first session proved me wrong I received quick relief from painful condition and subsequent sessions progressively helped to improve my condition in conjunction and without traditional physical therapy exercises on different occasions. What is also interesting that the same trigger points became less reactive overtime (initially needling in areas that where painful or tender resulted in a strong spasm like reaction of the muscle tissue) going hand in hand with improvement in tissue quality/health.

I am fully supporting dry needling as a medical practice and (after trying it) am convinced that it is an effective method supplementing other physical therapy methods.

Vlad., Redmond, WA.

My son has had knee pain for over a year with no successful results until we went to a Doctor that did dry needling on his knee. The few treatments he had cured his knee problems and has allowed him to return to his sports and other activities that he loves.

I also had dry needling done on my neck several years ago and it cured a long term issue in just a few treatments. This type of treatment is reducing the amount of health care needs my family requires.

I am asking you to please give the physical therapists the right to continue to help patients with dry needling in Washington state so they may be free of pain as we have been.

Connie Chapin
Kirkland, WA

My name is Cece, I live in Woodinville, and I can vouch for the legitimacy of dry needling as physical therapy. My husband Kevin was the one who did the research, found a physical therapist, and went in for a few sessions to see if it would improve his chronic back pain. He had nothing but good things to say about his experience so I decided to give it a try. I have had issues with muscle tightness in my upper back for years and was seeking relief. Admittedly I never sought out a deep tissue massage, but the massages I have had never relaxed my muscles for more than a few hours. I set up an appointment and the physical therapist explained that dry needling evoked the same response as deep tissue massage, but it was quicker. Now having the procedure done on me a few times I can say that dry needling is very effective. While the muscle release is temporary, it is by far longer lasting than any massage I have ever had.

Please continue to define dry needling as a legitimate form of physical therapy. Thank you.

Cece Lema

Please feel free to use my information for your upcoming hearing.

Dry Needling has been the only treatment that has helped with my ongoing neck and upper back pain. I have had cortisone injections, physical therapy, pain medications, anti-inflammatory medications, massage, chiropractic treatments and acupuncture. None of these treatments helped except for Dry Needling.

I had a recurrence of the pain after suffering a fall. My primary care doctor, an MD, recommended Dry Needling combined with massage to treat the pain. She stated that she did not want me to pursue any other form of treatment as they are not as effective.

Tana Anderson
Sammamish, WA

I am an athlete who competes in half marathons and other sports. I have had issues as a result of being an athlete ranging from hip, glute and hamstring pain to other running woes. I had tried massage, pain relievers, stretching, rolling out, and other treatments with absolutely zero improvement. I went to Doctors of Physical Therapy seeking relief from my pain as I had researched the benefits of dry needling. They performed dry needling on my problem areas – and it WORKED!! Specifically I had piriformis issues that were causing me severe pain. As a result of the dry needling, all pain went away and I was able to resume my racing.

From a patient perspective having tried a number of treatments, I am a firm believer in dry needling and continue to recommend not only Doctors of Physical Therapy, but also the treatment to other athletes.

Lisa Brandli, Bellevue, WA

I am writing to you because I have recently learned that Physical Therapists in the State of Washington may no longer be allowed to practice Dry Needling. In the past several years I have had severe pain from neck problems due to an auto accident. I have had routine physical therapy which helped short term on several occasions. I have also had to use medications to relieve the pain so I could function throughout my normal work day. A couple of years ago I came across a PT Group that offered Dry Needling. I tried it and have been close to pain free now for a couple of years. I no longer have to use muscle relaxers to prevent my neck from tightening up when I sleep. I rarely need to take over-the-counter pain relievers during the day. I attribute this to my physical therapist who combined routine physical therapy along with dry needling to help me find non-surgical relief. I sincerely hope that you advocate for this practice to continue in the State of Washington so that others may continue to benefit.

C Mulholland

Online Petition - Say NO to Dry Needling in WA State

Dear Department of Health Sunrise Review Members:

East Asian Medicine Practitioners and Acupuncture patients in Washington State very firmly and strongly oppose SB 6374 / HB 2606 which expands the scope of physical therapists to include acupuncture, which they label as “dry needling.” Acupuncture is an aspect of entire ancient practice that is within the larger system of Chinese Medicine. Understanding and correctly utilizing this technique require at least 4 years of western and eastern training in an accredited institution, with over 1200 hours of clinical and didactic training. In addition to the training, East Asian Medicine Practitioners (EAMP) must undergo rigorous National Examinations through National Certification Commission for Acupuncture and Oriental Medicine in order to be qualified to provide treatment to patients of Washington State.

Physical therapists want to do what they call “dry needling” which essentially inserting acupuncture needles into patients with only 54 hours of training. This is dangerous to the public health of our citizens. Without the adequate training in the full scope of the system in which needling originated from Chinese Medicine, it would be a total disregard to the health and well-being of patients as well as

disrespecting the entire profession of Acupuncture and Chinese Medicine domestically and internationally.

Physical therapists may be trained in physical therapy, but their training does not include therapeutic needling of any kind. There is no way in 54 or less hours of instruction can PTs equate that to the extensive requirements of what EAMPs must undergo in order to practice acupuncture in the state of WA or nationally. This short time leaves out important learning for safety and effectiveness. Without formal and full time training in acupuncture schools or institutes, no one, including PTs are qualified to provide training courses or to teach students and even worse to treat patients. Otherwise, physical therapists will be practicing acupuncture at an unsafe and ineffective level.

We, as residents of Washington State, ask you NOT to approve SB 6374 to expand the PT scope of practice to include “dry needling.” Thank you for your consideration.

Sincerely,

This petition will be delivered to:

- Washington State Department of Health
John Wiesman
- Policy Coordinator
Sherry Thomas
- Governor
Jay Inslee
- Washington State Health Officer
Kathy Lofy

I am writing to you today concerning the proposal to add Dry Needling to Washington State Physical Therapists' Scope of Practice.

Dry Needling is Acupuncture! Changing the name of the procedure does not make it a different therapy nor change the risk associated with it's use. Acupuncture is any therapy which involves the insertion of a filiform needle into the body to achieve a therapeutic effect.

This therapy requires extensive training to perform safely. The Washington State Department of Health requires 100+ academic hours to learn the procedures and safety guidelines associated with this treatment with an additional 660 hours of supervised clinical training. Physician's require a minimum of 300 training hours to acquire a certification in medical acupuncture. I can't understand why a special exception is being made for Physical Therapists. All professions should be held to the same standards and laws regarding this therapy. This is especially true for an expansion that involves the insertion of sharp objects into the body.

Approving this expansion of scope of practice with the current proposed training requirements put's the citizens of Washington State at significant risk. Please deny this proposal as currently written.

Benjamin Chang, DTCM, ADS, L.Ac.
Chang's Chinese Medicine Wellness Center, P.S.

I am writing today to urge the DOH to maintain the high standard for the practice of acupuncture as has been the case in Washington State for 30 years. The attempt by the physical therapy profession to rename the practice of using an acupuncture needle to treat pain should be seen for what it is, an attempt to practice acupuncture by simply calling it something else. Before acupuncture needles were readily available in the west, the term "dry needling" was used by medical doctors to describe the use of hypodermic needles in place of acupuncture needles. The term "dry" was used to mean "without an injectable fluid". The term "Dry Needling" and the use of hypodermic needles has since been abandoned now that high quality acupuncture needles are generally available to practitioners. Physical Therapists are simply trying to borrow an abandoned phrase to rename the practice of acupuncture and co-opt the practice without having to meet basic safety and efficacy standards. Dry needling, as Physical Therapists are describing it, is simply the East Asian tradition of using palpation and communication with the patient to find tender or tense points to needle. This is called "Ashi" in Chinese, meaning "Oh Yes!" or "Yes, that's the spot!". The term "Ashi Acupuncture" refers to points that are not on major meridians and can be a point virtually anywhere on the body. "Dry needling" is "Ashi Acupuncture".

This is not the first time a profession has attempted to borrow a portion of the practice of acupuncture. The history of this bears mention as a cautionary tale. Medical Doctors originally felt that acupuncture could be useful but didn't want to take the time to understand the foreign and therefore challenging concepts of acupuncture therapy. They dubbed the term "Medical Acupuncture" in much the same way as the PT's are now using the term "dry needling". It did not take long before cases of patients ending up in the ER with conditions such as collapsed lung started to pop up, illustrating the need for adequate safety training. Perhaps most notable is how the term "Medical Acupuncture" has evolved because I suspect that, should the term "dry needling" be allowed to be adopted by PT's, a very similar trend will occur. It would be best for the PT's to learn from the Medical Doctor's example and start out with a solid education in East Asian Medicine rather than fumbling around for decades trying to reinvent the wheel.

Medical Acupuncture was originally to be a term to describe the practice of acupuncture based solely on empirical evidence-based medicine with the notion that the theories of East Asian Medicine were arcane and had no basis in empirical science and were therefore irrelevant. Medical Doctors felt that they should be able to practice acupuncture with just a short "intensive" course. Aside from patients actually being harmed by doctors who didn't know what they were doing, something else also happened, patients did not get the benefit of receiving the full system of medicine. Practitioners of Medical Acupuncture started to realize that there was currently no scientific explanation that better described the best practices than the traditional East Asian system. More and more, Medical Acupuncture as practiced today relies heavily on the traditional East Asian system of medicine.

In closing, I would urge both the DOH and the profession of Physical Therapy to not simply attempt to separate out the needle from the medicine, but instead uphold the same high quality of educational standards that have proven to be safe and so useful to both practitioners of East Asian Medicine and their patients in Washington State for more than 30 years.

--

George Whiteside, MS, EAMP, President Emeritis, Washington East Medicien Association (2005-2010)
Mindfulness Medicine Northwest, Licensed Acupuncturist, Certified Herbalist

I am writing to add my professional opinion and experiences to the many East Asian Medicine Practitioners who oppose the use of "dry needling" by physical therapists. Allowing physical therapists to use the "dry needling" technique without proper training is dangerous and can harm patients. Acupuncture is not simply inserting needles into any problem area for a patient. Acupuncture points are carefully mapped on the body. These points have been determined after thousands of years of research and recent electromagnetic testing. This treatment is based on a wealth of knowledge of physical medicine and a cultural understanding of the flow and blockage of Qi that underlie physical maladies.

I understand the desire of therapists to utilize the best treatments available for their patients. Medical professionals in all fields share the desire to help our patients. They are our neighbors and our

community. However, without the proper training and practice this is far more likely to cause harm to patients. Inserting needles incorrectly can lead to the development of scar tissue, damage organs, and worsen a patient's condition.

State licensed acupuncturists complete a supervised internship program and have extensive coursework and training to prepare them to treat patients correctly. Acupuncturists must also pass the National Certification Commission for Acupuncture and Oriental Medicine examinations. These assessments are put in place to ensure the best care for patients.

I value physical therapy and believe it can be of great benefit for many conditions. However, physical therapists complete entirely different training and assessments that do not teach the proper basis and use of needles to treat patients. A short training course cannot replace the in-depth education and practice required to treat patients safely and effectively with needles.

I ask that you do not approve "dry needling" by physical therapists. This is important for the health of our community.

Li-Juan (Leah) Chen, L. Ac. OMD

I am writing to voice my opposition to the proposal to add dry needling to the scope of practice of physical therapists per Senate Bill 6374.

As a naturopathic physician, when I refer patients for PT it is my expectation that they receive interventions for their conditions as currently described by the PT scope of practice, not a form of acupuncture. Recent research has called the benefit of dry needling and acupuncture into question (<http://www.scientificamerican.com/article/research-casts-doubt-on-the-value-of-acupuncture>). In light of this, I do not see how increasing the number of providers who can offer dry needling, particularly PTs whose training in needling techniques will be significantly less than trained acupuncturists, will benefit the general health and safety of Washington State residents.

Miranda Marti, ND

If physical therapists (PTs) would like to include dry needling in their scope of practice, they must have the same amount of hours in training as acupuncturists. A shorter training period for PTs is not sufficient to ensure the safety of patients that may get dry needling from them.

Marie

As a licensed acupuncturist and nutritionist in the state of Washington, I am (again!) vehemently opposed to PTs adding "dry needling" to their scope of practice.

Just a few months ago, WA legislature affirmed that "dry needling;" i.e., acupuncture, as practiced by PTs is illegal and outside their scope-of-practice.

Now the PT lobby is coming back again with the same desire to practice acupuncture ("dry needling"). As Shakespeare said, "A rose is a rose is a rose." Therefore, whether PTs call it "dry needling" or acupuncture, it still involves the insertion of metal needles into patients.

Most importantly, for the safety and assurance of patients and patient health, the patient safety issues are still the same; a few months of lobbying the WA legislature has NOT changed the lack of patient safety around PTs increased/ desired scope-of-practice. They lack the 4 years of Oriental Medicine school that all EAMPs and LAc have taken; they lack safety of point insertion knowledge; they lack knowledge of Oriental Medicine theory and diagnostics; they lack knowledge of Oriental herbs and formulas; and they lack knowledge of Clean Needle Technique.

Bottom line, PTs will INCREASE the risk to patients, and subsequently, INCREASE the liability to ALL practitioners who practice acupuncture. EAMPs and LAc have the LOWEST liability rates to patient safety in the healthcare sector, and subsequently, the lowest insurance rates of all healthcare practitioners. Adding other practitioners such as PTs to this scope-of-practice would substantially increase the risk of patient safety, and thus everyone's insurance rates because no distinction would be made between a practitioner who practices "dry needling" vs true acupuncture.

Please keep the precedent set a few months ago with this issue in mind as this bill makes it way thru the WA legislature (again!), and keep our patients safe from unlicensed and untrained practitioners!

Dorothy D Zeviar, EdD, LAc, MPH/CPH, MS/LN
"Compassion is the Radicalism of our day." The Dalai Lama

Regarding the PT dry needling sunrise review. This is a concern for me and my colleagues who have devoted thousands of hours to be able to practice Acupuncture and Chinese Medicine in the state of WA.

Monica Szelachowski

Please carefully consider allowing physical therapists to practice acupuncture after 54 hours of training and one year of practice.

I am not going to use the term dry needling because I have yet to find a consistent definition for what it is. It seems to be the use of a needle inserted (by physical therapists to much deeper depths) into the body for the purpose of alleviating pain and allowing the body to heal. Please explain to me how this is not acupuncture.

The Washington State Department of Health came up with clear guidelines about what training is needed to practice as an acupuncturist. To meet these requirements, I attended an accredited university program for three and one half years. I took and passed (with an 80% or better) close to 700 hours of Western medical sciences. My studies solely related to acupuncture comprised over 700 hours and also required a passing grade in each (80% or better). I passed a series of test to be allowed to practice as a student practitioner in a teaching clinic. Of the 1356 hours I spent as a student clinician, 828 of those were spent practicing acupuncture.

After graduation, I passed the required exams to be licensed by the state of Washington.

I am grateful for my education, for the ability to practice, and the recognition by the Washington State Department of Health.

I am confused by the new expedited licensing guidelines for physical therapists. Has the Washington State Department of Health now decided that the training required to practice acupuncture is much lower? One year of clinic (an unspecified number of hours) and 54 hours of instruction.

54 hours of instruction may sound like a lot. Here is my educational experience. I have completed 44 hours of study in pharmacology. No one has licensed me to practice as a pharmacist. I have completed over 500 hours of study in anatomy and physiology, living anatomy (with time spent in a cadaver lab), organic chemistry, inorganic chemistry, biochemistry, orthopedic testing, western medical pathology and a survey of western medical clinical sciences (a systems overview of everything that can go wrong in the human body). No one has licensed me as a doctor. I have completed over 100 hours of study in Western and Chinese medical nutrition. No one has licensed me as a nutritionist. I do not disagree with this

situation. I have learned enough to respect these different licenses and the proper training required for each.

From an outside perspective, it may seem like there is not a lot to acupuncture. We place thin, sterilized, single-use, disposable needles shallowly into certain areas of the body. We ask people to rest with those needles for at least 30 minutes. Then we remove them. How could something so simple require any real course of study?

In 3 years of acupuncture school, I learned to be judicious in my placement, direction and depth of needling so as to avoid significant damage to my patients: the avoidance of puncturing of lungs, internal organs, and the peritoneal cavity was stressed at all times.

In the last 5 years as a licensed practitioner, I have begun to learn the nuance of the medicine. I now know how many needles to place in my patient who is battling stage 4 cancer, nausea and unspeakable pain. I now know what questions to ask about someone's migraines, because they are so different. I know how to treat children, something I was never taught in school. I know how to assess the energy level of my stroke survivor on dialysis, so my treatment gives him energy and decreases his headache, instead of draining his energy. I know how to react when someone experiences needle shock (experiencing a blood sugar drop because of acupuncture), how to let them recover, and how to proceed should they trust me enough to return to try again.

Will one year of clinic and 54 hours of training be enough to train physical therapists in the subtleties of acupuncture? Will it be enough to finesse their technique so they aren't hurting people? Will they learn when to avoid the area of injury, when active inflammation might still be present and they might do more harm than good? Will they know enough about the medicine to figure out why their treatments aren't working? Or will they blame acupuncture as ineffective, when in truth they do not know or respect the medicine?

Thanks for licensing me and allowing me to alleviate suffering in my community through acupuncture. I truly appreciate it. Please consider how consisted of a message you wish to send about what training is needed to be licensed as an acupuncturist.

Cynthia Gorsuch, Washington state native and resident, Licensed Acupuncturist and/or East Asian Medical Practitioner

Using any needles for therapeutic purposes in clinical practice, this will require a lot of training in order to be safe for patients, to meet the safety benchmarks. "Dry needle" promoters and users without the proper training will seriously jeopardize patients' health and safety! This is a very irresponsible action to patients' well being. We resolutely oppose SB6374/HB2606 based on patients' health and safety.

Fengshan Zhu, L.Ac., O.M.D.,
Amasia acupuncture and Herbs Center Inc

I want you to know I signed the recent petition regarding "Dry needling" because no matter how you slice it, "Dry Needling" is acupuncture.

I believe we already have a group of highly trained individuals ready and willing to serve the community of Washington State in regards to this need.

I appreciate you taking the time to review my comments and note my concerns.

Jeremy Gilsoul EAMP

Regarding the PT dry needling sunrise review. This is a concern for me and my colleagues who have devoted thousands of hours to be able to practice Acupuncture and Chinese Medicine in the state of WA.

Dry needling is another word for a technique we use in acupuncture called Ashi points (tender points or trigger points). Which is one of the foundations on how acupuncture was created thousands of years ago. Changing the name does not change the procedure, nor the risk associated with its use.

The American Medical Association recognizes dry needling as an invasive procedure and that should only be performed by practitioner with standard training and also routine use of needles in their practice, such as an licensed EAMP or acupuncturist or licensed medical physicians. As I am in the process of receiving my license as an EAMP who has trained for more then 1300 clinical hours, and thousands of hours spent in the classroom and labs perfecting our needling safety and skills.

The SB 6374 threatens my profession that I have yet to step foot in to and have trained for much longer then the PT performing this procedure. By the wording in this bill could prevent licensed acupuncturists from performing dry needling (ashi/ trigger points) that is inherently in our scope of practice and that I have been training for, for over 3 years.

Monica Szelachowski

1. Are they required to gain training in dry needling to the same level as an MD, who has regular use of needles in their practice and has extended training in the use of this invasive instrument?
2. If physical therapists are saying dry needling is not acupuncture to avoid the extensive training to gain a degree in acupuncture, then please have them wait to use this technique until there are insurance codes that reflect a different code for dry needling and a different code for acupuncture.
3. Does the training physical therapist are requesting approval for, require oversight by a qualified practitioner with enough practice to establish safe practice?
4. Limit what can be taught under the clause of dry needling to exclude any type of training that is similar to acupuncture such as meridians, and acupuncture points.
5. Require extensive training on contraindications of strong needle stimulation ie pregnancy, asthma, COPD, weak constitution, prolonged illness etc.

I am requesting that if you approve dry needling for physical therapist, please mandate that their training requires at a minimum more hours than an MD including supervision by a highly qualified practitioner.

I also request that you mandate that insurance codes for dry needling are separate from acupuncture codes and until that time no dry needling is to be used on patients.

Referring to practitioners that are experts in their field is the safest and best practice for patient well-being. Please encourage PTs to refer out to highly trained acupuncturists and develop relationships with acupuncturists with the patient's best in mind.

All the best, Catherine
Certified orthopedic acupuncturist

My name is Sharalyn Castro and I was very fortunate to have received dry needling from Austin Woods. I have 2 children with autism and taking care of them often comes with a heavy price to my body, they jump, pull and sometimes need to be carried for their safety. They don't comprehend the

pains this can cause on my body. For many years I was getting physical therapy with little change. Once I started getting dry needling the change was immediate, within 24 hours I was renewed each time, my hips could stabilize better, my shoulders could hold better. Without dry needling I wouldn't be able to care for my children the way I needed to when they were younger. I only wish I had known about it sooner, I could have saved half the time being in physical therapy to spend with my sons. Dry needling is effective and vital for those of us who suffer from occasional injuries and need the precise area affected to be treated.

Sharalyn Castro Kirkland WA

I am writing to express my support for the practice of dry needling" in Washington State. I come from a family of doctors and also have had extensive physical therapy in the past. I was coaxed to try dry needling by my personal trainer. I was HIGHLY skeptical of any potential benefits and also concerned about potential negative consequences and pain (who in earth wants someone to stick a needle directly into a muscle?! :)

My experience has exceeded all expectations. After suffering from a quad injury for over two years and almost given up hope that I would ever be able to resume certain physical activities without debilitating pain, I now have hope. After six appointments, I have had such great results. After each session the pain has noticeably decreased. It is an amazing feeling. I urge you to continue to allow the practice of needling in our State and everywhere else.

In case there is any question, I have no financial interest or friends in this needling industry, my interest is simply the hope that needling remains available to me, and any others who might benefit. Please feel free to contact me should you have the need.

Drew Myers

Thank you for allowing me the opportunity to share my thoughts and personal experience with dry needling as a therapeutic treatment. In early 2014, I sustained a major shoulder injury. I tried many forms of therapy including strength exercises, stimulation and cortisone shots. After little success with those treatments I was referred to a physical therapist who administered dry needling. A day after treatment, my mobility and pain subsided tremendously. Unfortunately, due to the severity of my injury I still required surgery.

After surgery, I returned for physical therapy and dry needling treatments. Interestingly enough, a close friend of mine had a similar surgery four months earlier. Her post surgery therapy plan did not involve dry needling but rather more traditional therapeutic techniques. As a researcher by trade, I realize that an n-size of 2 should not be used to make sweeping conclusive statements but anecdotally, I noticed that although she had a four month head start with regards to recovery, my range of motion and strength improved much more rapidly. I'm sure there are additional factors that come into play, but I can't ignore the fact that I diligently received dry needling treatments throughout my recovery and she did not.

I'm so grateful to have received dry needling treatments and I can't imagine what my recovery would have been like if I didn't have access to this level of care.

Candice M. Young, Ph.D., Research & Metrics Consultant, The Microsoft Corporation

The attempt by physical therapists to include dry needling in their scope of practice without adequate training and education is not only illegal, but unsafe. Washington State already has laws governing the use of filiform needles.

Acupuncture has been practiced for millennia and includes all the areas that the physical therapists now want to include under the name 'dry needling.' Technically, just by virtue of the needles themselves, you could call acupuncture and dry needling the same thing, but I beg to differ. Acupuncture includes an entire different area of study and far surpasses the simple act of needling the body with filiform needles. The safety and effectiveness of the practice without the depth of knowledge required to practice East Asian Medicine simply does not meet modern legal standards.

Please refuse to allow the dry needling by physical therapists.

Kitty Bradshaw, Licensed Acupuncturist, EAMP

I am writing to you today about recent push by physical therapists to add "dry needling" to their scope of practice.

This should not be allowed under the few hours of instruction that they are currently suggesting is enough in order to safely needle their patients. They should be allowed to do dry needling if they have met the same requirements in schooling, clinic hours and examination that acupuncturists in this state already do to become qualified as a licensed acupuncturist. I wouldn't be able to practice physical therapy in this state with 54 hours of instruction or even 500 hours of instruction so they shouldn't either.

They will make the argument that what they do is not acupuncture. Dry needling is a relatively new term to distinguish it from needling with a hypodermic hollow needle, is most certainly is acupuncture. Dry needling is in actuality trigger point needling and trigger point needling is acupuncture. In written history as early as the 7th century AD documents acupuncturists needling "ashi" points which correspond to trigger points. One of the first classes I had in acupuncture school discussed ashi points and used the trigger point manual books by Janet Travell MD. The very same books most PT's as guide in some of the dry needling classes.

Scope creep. We have seen evidence freely distributed on websites and Facebook pages of PT's using acupuncture points, acupuncture meridians and acupuncture books in other states that have allowed dry needling by acupuncturists. (I believe some of my colleagues will be posting this evidence) Prior to the recent stop that a judge in this state put on the company that teaches dry needling, I personally saw an acupuncture manual in a PT's office. No harm owning a manual but I hope you realize that if dry needling is passed patients will ask and receive acupuncture by some of the PT's. It is inevitable.

Safety: Even the AMA is against this. As you have probably heard (more than once) the AMA have come out with a paper suggesting that only those qualified to the same level whether medical acupuncture doctors or licensed acupuncturists be allowed to perform dry needling.

There are many styles of acupuncture, TCM, Microsystem acupuncture, Classical Chinese, Korean (at least three major types), Japanese (multiple types), Vietnamese, Master Tung style, Trigger point therapy, New American acupuncture etc., etc., it goes on and on. They are all acupuncture and originally based on Tradition Chinese theory but they have evolved into different traditions. Some use the original meridian theory and some do not. Acupuncture, trigger point needling or dry needling is not a physical therapy tradition in this or any other country in the world.

I say if they want to be acupuncturists then go to an acupuncture school, graduate and get a license. I remember in my class of 1999 we had, MD's Veterinarians, Physical Therapists, Chiropractors, and Nurses taking the whole three year course minus the Bio-medicine classes that they already qualified for. They had to do the clinic portion and hours just like everyone else. Not one of them that I talked to thought it was a waste of their time.

Thank you for reading my letter today and trust that many of these points will be used in consideration of the sunrise review for PT's. This is not just a minor move to be able to perform one technique but potentially a huge scope creep that could undermine safety and efficacy of acupuncture in Washington State.

Jill

I have been a licensed acupuncturist in the state of Washington for nearly 20 years. I completed a long and expensive training program to meet the standards of our fine state so that I would be allowed to wield acupuncture needles. It has been horrifying to me in the last two years to witness the upsurge of the practice by Physical Therapists to do what they cleverly call "Dry Needling". The "dry needling" practice (or desired practice) is of great concern to me and the safety of my community. "Dry needling" is no different than acupuncture; it is rudimentary but it carries all the risks associated with an unlicensed acupuncture practitioner. The "technique" used in "dry needling" is the same as I use with many of my sports medicine clients as I specialize in orthopedic injury and pain. The notable difference between it and what I do is there is no in-depth understanding of the energetic fields or physiology that makes acupuncture a complete medicine in unto itself.

The American Medical Association (AMA) has come out in fervent opposition to the practice of "Dry Needling" by Physical Therapists, acknowledging that MDs and Licensed Acupuncturists be allowed to purchase and use acupuncture needles for the purpose of therapeutic effect.

I was traveling recently on the east coast and saw many advertisements by Physical Therapists in the state of North Carolina. I stood and watched a demonstration that would have had me thumbing the pages of my malpractice insurance had I been the one performing this incredibly misguided treatment. I also saw advertisement for their "Dry Needling" to help people with insomnia, stress, digestive disorders and hypertension. These weren't PTs trying to help someone with a tight muscle... they were attempting to practice Chinese Medicine without the education or training.

"Trigger Points" ARE acupuncture points; they are actually commonly used in my practice. Physical Therapists have lots of tools in their kits, but acupuncture, and it's need for extensive training, should NOT be one of them. Leave the needles to those of us fully trained; LAc and MDs.

Barbara Beale, LAc LLC

I oppose the WA State Physical Therapy Association's request for an increase in the scope of practice to include "Dry Needling" for the following reasons:

- 1) It has been my experience that patients who have acupuncture needles inserted into them by untrained or poorly trained healthcare practitioners can suffer untoward effects. I have seen injuries to patients who have been needled by untrained MDs (pneumothorax) and other HCPs (evidenced by bruising, and patient reports of a lot of pain.) It is my belief that putting acupuncture needles into a being, whether human or animal is the practice of acupuncture, even if it is called another name. Please note that acupuncture does not always include all aspects of Traditional East Asian Medicine, as alluded to by the P.T. groups. I often work on a very structural level as warranted.
- 2) In California, where I was originally licensed, my clinical rotation consisted of 2500 hours, SUPERVISED patient contact. The physical therapists across the country are taking weekend courses and being told that they are ready to go. This is absurd. I do not perform Physical Therapy, and in fact, frequently refer patients locally to them for the work that they do, as they refer patients to me.

- 3) The AMA approved training course, such as the Helms Course, is 2 weeks long per one of my local MD friends. Even with 2 weeks, he did not feel that it was adequate to really do good work.
- 4) WA State should not be swayed by the fact that other states have implemented this increase in scope. From what I have heard, the other states did not take the time to perform due diligence to ensure safety and efficacy. Most of the P.T.s that I know locally do not even know what their State Association has been doing.
- 5) A separate code for "dry needling" should not ever preclude the ability of acupuncturists to continue our work with trigger points (which I received training in). If the increased scope is passed, then there needs to be a rider within the coding process that allows acupuncturists the ability to use the full scope of our medicine for which we have trained extensively, with full use of any new code that a reluctant AMA would issue, with equal reimbursement mandates.
- 6) If WA State DOH approves this expanded scope, how will they then continue in good conscious, to demand all the training required of acupuncture students, especially in the realm of clinical supervision. Personally, I feel that WA State has too low of a requirement for clinical hours, but I understand the rationale used to lower it when they did. Clinical supervision is where academia meets real world practice, and safety, techniques and contraindications become solidified. THIS LEVEL OF ACCOMPLISHMENT DOES NOT HAPPEN QUICKLY, thus the 800 hour requirement currently for WA State practice. I used to supervise students in the largest teaching clinic within the U.S. Believe me, even with immersion, the students in CA needed every hour to really become excellent and safe..
- 7) There should be an endpoint where a profession cannot continue to create the need for the same expanse of scope repeatedly. It takes time from the DOH and all concerned parties to address it.

Thank you for considering my thoughts.

Jana Wiley, M.S., R.N., EAMP

As an East Asian Medicine Practitioner, I am saddened to hear that Dry Needling is still being considered in Washington State. The practice of Dry Needling is not only dangerous for patients receiving the therapy, but dangerous for the EAMP/Traditional Chinese Medical Community as a whole. At its core, Dry Needling *is* acupuncture, regardless of what OTs/PTs/DCs, etc. say about the matter. And the fact that their training is far less than what I was required in one *quarter* of a 3.5 year program is insulting. Time and time again, people are getting injured, and are victims of "bad medicine" from these so called "healers". I *URGE* you to not allow this bill pass, and keep acupuncture with the professionals who study and *respect* the medicine, and are not pursuing it to have something more they can bill their patients.

Please, leave acupuncture to the acupuncturists.

Thank you for your time and consideration.

N. Brandon Leahy, LAc. - Licensed Acupuncturist, Chinese Herbalist

An example of great concern, for the welfare of patient care, has been spoken of and shown to me (individuals moving clothing aside for me to see their dry needling application) are method/techniques I am extremely concerned about for the welfare of the individuals 'experimented' upon with such approaches:

- Bundles of needles are inserted, wrapped with tape and secured to the body, at a point/area of pain/injury for 'needle' retention lasting several days. The patients have expressed how painful this procedure is. Some individuals do state they have had some relief of their original discomfort, others state repeat technique necessary without relief of original pain with the additional pain of the bundled needles present in their body.

"Dry needling" is referred to as 'trigger point needling' a technique already performed by us acupuncturists (ancient therapy, not a new approach).

- The language of SB 6374 being problematic for two primary reasons. First, the language of the bill could prevent licensed acupuncturists from performing dry needling, a technique that is inherently within their scope. Secondly, the RC18.74.010, if adopted, will be unenforceable as written.
- Stated to me by a western medical consultant for personal liability law suits: 'claims' related - circumstances of needles 'remaining in the body' as if in error. Needles that imbed, that move through the skin 'in to' the body cavity. As a well trained practitioner, this is extremely concerning (and unacceptable experiences).
- I'm also aware that those not licensed (as EAMP's) and utilizing acupuncture needles 'claiming' to be needling yet are not responsible to indicate within their case notes the 'points' actually needled and/or method of application (such as 10+ needles inserted in a specific area, bundled, and taped for several days retention). This lack of clarity leaves further vulnerability for patients health and welfare in the event adverse reactions are experienced.
- Further confusion for coding and insurance purposes continues. Currently, CPT codes are specific to acupuncture, lead to reimbursements (or lack of) by insurance, and at differing rates of reimbursement depending on the 'medical degree' of the person practicing any of these techniques (and the CPT codes utilized and necessary for insurance reimbursements).

I appreciate this opportunity to attempt to address only a few of the many issues challenging my profession by the pressures of the physical therapists desire to diminish the effective and beautiful work acupuncture already provide with dry needling.

Michael Flynn Carver, EAMP (LAc), Masters in Acupuncture, Dipl. NCCAOM

I am a Lic.Acupuncturist in Seattle I would like to add comments regarding physical therapists using dry needling

We as acupuncturists , receive vast training on how to address the electrical system of the body. This cannot be learned with some continuing Ed classes by PT's. There is so much opportunity to do real confusion in the body , by needling incorrectly.

I vote no for p t's having that ability

Andrea Booth EAMP

I am writing to urge you to deny the bill that allows physical therapists to perform dry needling and to promote responsible dialogues between various health communities.

Aside from the reasons that various petitions may bring you to carefully consider, I wish to contribute my voice to this matter and share why this bill is irresponsible and should be dismissed.

- The practice of puncturing a needle through the skin indeed falls under the Eastern Asian medical model and there should be no question that this is a sub-category of acupuncture, no matter how the physical therapists or sponsors behind this bill wishes to craft their argument. This should not be an intellectual property/trademark discussion - claims of plagiarism or medical ethics does not

address the core reason for how health practice boundaries are defined. The territory war serves no one in the community.

- Patients seeking relief and care do not know any better and the burden to stay educated should not rest upon them when they are in the state of pain, illness, and a desperate condition that would seek them to nodding yes to anyone that offers to provide a solution. I share that because I've been there, and asked my physical therapist why she can't just poke a needle in my hamstrings because in my pain mode, I only wanted relief, and I didn't care what my provider had to do other than to get me out of pain and tension so I can think and function again. Patients promoting this bill only want short-term solutions & instant relief.
- Why does a yoga teacher require 200 hours to be certified to teach (something not physically intrusive) and Physical Therapists only get 54 hours to administer needles (something physically intrusive)? PTs are not trained to handle needles, and it takes more than 54 hours to fully comprehend the possible consequences and impacts of administering needles. A dentist is not an oral surgeon, just like a physical therapist is not an acupuncturist. Pick the right programs and schools for the right training; this patch-on 54 hour training is not adequate nor appropriate to be even be practiced, let alone safely practiced. No human guinea pigs, please, especially not when they are required to sign a liability waiver form.
- This bill discourage PTs from collaborating with the acupuncture community and attempts to re-invent the wheel that has been around in Eastern Asian medical community for thousands of years. At the surface, the intention of PT is well received because I understand they wish to offer expanded service (trigger point release) to their patients effectively. However, the human physiology is complex and has many layers, energy systems, meridian points, aura/chakras, electromagnetic fields, matrix energetics, and on and on - all of which are not covered in the Physical Therapy program and cannot be trusted to be covered in 54 hours if they intend safety to be the top priority.

I encourage you to consider declining this bill, for the highest good and protection of patients that are in pain and are only focused on short-sighted pain relief and any offering of hope just to get out of desperate conditions. It is a different mode and cognitive process when you are in that much pain chronically, and it is so easy to say yes to any being that comes along and offers help. I know PTs have good intentions, but they are not the best specialists to handle needles, unless they can confidently see the bigger picture in a patient's health and cause of dis-ease. No PT providers can tell a patient that they know why they are in pain and how to remove the cause of pain (with trigger point dry needling). Approving this bill shows that you are missing the forest for the trees, but I trust you as decision makers to not make that mistake, which is why I've taken the time to write.

I copy the acupuncturists that have contributed to my knowledge and understanding of the proper ways to think about and look at my health on a holistic level, each from their unique expertise and extensive training in addition to clinical and private practice experience. I support their perspectives. None of them have asked me to write this but has brought this to my attention.

As a health and wellness seeker/consumer, I truly believe people need to be better directed and protected, especially from what they may not know or be aware of, and we must have a policy that inflict no harm and chaos. We must have a policy that promotes interdisciplinary collaboration and communication with safety, responsibility, peace, and harmony in mind. This bill is not it.

Thank you for considering the petitions against this bill and for taking the time to review my perspective as a consumer of all healing modalities, Eastern, Western, and beyond. If I can participate or be of help in clarifying or elaborating anything I've mentioned above, please do not hesitate to contact me.

Christina

As a licensed Acupuncturist actively practicing in the State of Washington, I feel compelled to offer my professional comments as follows:

1. Anyone using a dry or acupuncture needle should meet safety criteria before touching the human body for therapeutic purposes, which requires extensive training to perform safely. I graduated from Bastyr University's Master Program (3.5 years) for Acupuncture and Oriental Medicine and then passed all the required Board Exams per NCCAOM, and the Washington State Licensing requirements, in order to practice in Bellevue, WA. Here are links that offer you a glance to the currently required course work and clinical hours required for MS Graduation:
 - <http://www.bastyr.edu/sites/default/files/images/pdfs/curriculum/15-16%20Acupuncture%20and%20Oriental%20Medicine.pdf>
 - Total clinical hours for acupuncture are 828 actual clinical shift hours at the Bastyr Clinic and other affiliated clinics in the Program.
 - The bar will be raised even higher beginning by Fall/2017 when the Master Program will be replaced by the 4-year Doctorate Program in Acupuncture Medicine.
2. The American Medical Association (AMA) views dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.
3. Dry needling/trigger point needling is a technique that is documented as a subset of acupuncture and is practiced readily in modern treatment.
4. Physical Therapists who want to practice DN or Acupuncture legally in Washington should satisfy whatever the minimally required training, credentialing, licensing and competence that have been required for acupuncturists in a level playing field.

Mayme Fu, LAc, LEAMP, Dipl., Oriental Medicine
People's Acupuncture, Eastside

I oppose PT practicing dry needle in Washington!

PT dry needle practitioners use the same tool: acupuncture needle as we acupuncturist do. We have minimal 1200 hours training.

I even got 11 years training in China for both western medicine and Chinese medicine. 54 hours dry needle training can not cover

the basic conceptions of acupuncture points and clinic usage. PT dry needle is not suitable and unsafe for the patients!

Jing Gao PhD, OMD

I am writing to urge you to vote against SB 6374/HB2606 which expands the scope of physical therapists to include acupuncture, which they call "dry needling." As an acupuncturist who finished 3 1/2 years of graduate school, took the national boards, and has taken extensive continuing education to maintain my national credentials, I do not believe physical therapists should have "dry needling" in their scope of practice.

"Dry needling" is essentially an attempt to expand into acupuncture. Merely changing the name does not mean PTs are trying to do something new and different. They use the exact same needles as us. They use the same trigger points and many of the acupuncture points as us. Therefore, they are practicing acupuncture, but without a proper education, experience, or national license. And in my book, that is an extreme liability.

According to the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM), the minimum hour requirements for Acupuncturists course work is 1,600 hours and clinic hours is 410 hours at a minimum. Those practitioners, such as myself, with herbal program degrees included do at least 2,500 minimum course hours. The fact that Physical Therapists are taking weekend courses of ~30 hours and using that limited knowledge to needle their patients is a disservice to both their patients safety and the acupuncture profession.

Beyond that, there is the Clean Needle Technique Course, which is required before any acupuncturist can needle a patient. There are set requirements and parameters around this that must be met. This is not covered (or at least very limitedly covered) in the PT's course.

At the AMA annual meeting in June 2016, they adopted a policy that said physical therapists and other non-physicians practicing dry needling should – at a minimum – have standards that are similar to the ones for training, certification and continuing education that exist for acupuncture.

The language of SB 6374 is problematic for two primary reasons. First, the language of the bill could prevent licensed acupuncturists from performing dry needling, a technique that is inherently within their scope. Secondly, the RC18.74.010, if adopted, will be unenforceable as written.

Please oppose SB 6374/HB 2606 and help maintain clear boundaries within these professions.

Thank you for your thorough review of this issue.

Michele Halfhill, EAMP, LAc
Vital Essence Acupuncture

I'm a traditional Chinese medical doctor, scientist and licensed acupuncturist in WA with over 30 years of combined experience in Acupuncture, Chinese medicine and western medicine. I'm writing this email to let you know that I'm strongly against the the proposal SB 6374 for physical therapist (PT) to practice dry needling.

"Dry needling" is part of acupuncture practice. "Trigger points" are the pain or Ashi points in acupuncture. Chinese medical doctors and acupuncturists have been practicing so called "Dry needling" using the "Trigger points" over thousand years. PTs can't just rename acupuncture, use different terms and then claim that is under their scope of practice. If they really want to practice "Dry needling" (i.e., acupuncture), they would need to take 5 years TCM school, pass the board exam, get NCCOAM certification, and get state license. American Medical Association (AMA) establish the CPT code, there is no such code called "dry needling" to let the PTs practicing "Dry needling".

As the agency of Department of health as well as healthcare professions, we should place our patients health and safety first. Without proper education, extensive training and years of practice, it is very dangerous to do "Dry needling" and risk peoples' life.

Please do not pass the proposal SB 6374.

Hongping Ren, LAc, MS, OMD
Authentic Chinese Acupuncture, PLLC

I am an acupuncturist and Doctor of Oriental Medicine. I have trained in China, Japan, Korea and Florida, practiced in the states of Florida and Washington and even taught as a professor at the Dragon Rises College of Acupuncture. I was asked to weigh in my thoughts on dry needling and why it should be respected as more than just minor surgery (to enter through the body's first line defense or breaking of the skin).

Please understand that this issue goes well beyond legislation differences but rather directly effects the safety and health of our citizens who seek these types of treatments. The public will not be served if "dry needling" is allowed to be performed by anyone other than a licensed and trained acupuncturist. Please allow me to share some of my most important points.

The Mayo Clinic defines Acupuncture as: "the insertion of extremely thin needles through your skin at strategic points on your body."

<http://www.mayoclinic.org/tests-procedures/acupuncture/basics/definition/prc-20020778>

Dry needling (Myofascial Trigger Point Dry Needling) is defined as the use of either solid filiform needles (also referred to as acupuncture needles) or hollow-core hypodermic needles for therapy of muscle pain. https://en.wikipedia.org/wiki/Dry_needling

Changing the name of a procedure does not change the procedure, nor the risk associated with its use.

Acupuncture is a technique for balancing the flow of energy or life force — known as Qi or Chi (CHEE) — by inserting needles into specific points along pathways (meridians) in your body. To master any acupuncture technique requires extensive training in anatomy and understanding of the bodies Meridian System to be performed safely. PT's do not get didactic or clinical training in these areas. As an acupuncturist, I understand the connections and effects of these Meridians, vessels, collaterals and dermatomes (called trigger points) on the body. I know how to combine points, direct Qi, disperse excess and tonify Jing to promote elimination of stagnated blood and energy...dry needling does not address the dangers of the wrong needling prescription. How could they when their scope deals strictly with "impairments, activity limitations and participation restrictions". http://www.apta.org/uploadedFiles/APTAorg/Practice_and_Patient_Care/PR_and_Marketing/Market_to_Professionals/TodaysPhysicalTherapist.pdf
INTERNAL MEDICINE is not in their scope and PTs are not trained to know how stimulating these points affect the internal health.

Washington state already has benchmarks for didactic education, supervised clinical hours, and a third-party national psychometrically created exam to test for minimum competency that involves the insertion of filiform acupuncture needles.

The American Medical Association (AMA) recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists: "The AMA adopted a policy that said physical therapists and other non-physicians practicing dry needling should – at a minimum – have standards that are similar to the ones for training, certification and continuing education that exist for acupuncture.

"Lax regulation and nonexistent standards surround this invasive practice. For patients' safety, practitioners should meet standards required for licensed acupuncturists and physicians," AMA Board Member Russell W. H. Kridel, M.D." (**THAT WOULD MAKE THEM ACUPUNCTURISTS!!!)
<http://www.ama-assn.org/ama/pub/news/news/2016/2016-06-15-new-policies-annual-meeting.page>

Thank you for considering my point of view and for your support in opposing the physical therapy scope expansion.

Nelson Valentin, OMD, LAc

I am writing to oppose SB6374 / HB2606 which expands the scope of physical therapists to do dry needling / trigger point needling / acupuncture with 54 hours or less training!

A few years ago, some weight-loss promoters who misused one Chinese herb, ephedra, and caused some death. Those promoter claimed that they did some research and "discovered" the herb could be used to lose weight by inducing inspiration. People took the herb and went to gym and collapsed. Chinese Medicine was blamed for the number of death. The herb was banned from the market. We, East Asian Medicine Practitioners, never used the herb for weight loss rather than respiratory conditions, according to the Traditional Chinese Medicine. As you can see, if the laymen misused our tool the public safety is threatened. In fact, some serious injuries have been reported since Physical Therapists using acupuncture needles without sufficient training.

It is not the first time other therapists tried to invade our scope of practice and wanted to have a share of this ancient therapy! Chiropractors and naturopaths in the past attempted to force in. They were denied and pushed out due to the public health safety issue. This time, the physical therapists tried to use a different route by changing the acupuncture name into a western medicine terminology by disguising the public without the proper training like what acupuncturists go through.

You would not let us learn a few hours and do spinal manipulation without going through what chiropractors or osteopaths go through in school. I sincerely hope no more tragedies would happen due to dry needling from physical therapists.

Sik Chi Stanley Chan, LEAMP

I strongly urge the Health Department to not endorse including Dry Needling in the Scope of Practice for Physical Therapists. Chief among my reasons for not supporting this, is that it would endanger Public Safety by allowing inexperienced and untrained professionals, to perform procedures that they are unqualified, untrained and inexperienced to perform.

Dry Needling, as proposed by Physical Therapists, is Acupuncture and Acupuncture technique, that has been around for over a thousand years. As such, the performance of these Acupuncture techniques are regulated and licensed by Washington State. Dry Needling *((Trigger Point Therapy as outlined by Janet Travell, M.D.) constitutes the application of needles into many recognized Acupuncture Points and what are referred to in Acupuncture literature as "Ashi Points". If it is recommended that Physical Therapists perform these procedures, then how would this effect my current use of these points in my Acupuncture practice?

Training, didactic and clinical, to obtain a license as an East Asian Medicine Practitioner is extensive, requiring both graduation from an accredited school and National Board Certification, demonstrating mastery of the skills necessary to practice Acupuncture safely and effectively. This requires many thousands of hours of didactic and clinical training to master. Without this extensive training, safety is not and could not possibly be, achieved.

I strongly recommend that Physical Therapists not be allowed to practice "Dry Needling" in this state.

Douglas L. Daniels, M.Ac., Dipl.Ac., (NCCAOM), East Asian Medicine Provider

What is termed "dry needling" by physical therapists is essentially acupuncture, a form of Chinese Medicine that has been practiced for thousands of years. As an acupuncturist, I've dedicated several hundred hours to the safe practice of needling the skin as well as the rich theory and intricacies behind point selection in graduate school (and beyond) and taken and passed national board exams to ensure that

I am a safe and effective practitioner. Once the skin surface is breeched such as in "dry needling", acupuncture, trigger injections, etc a whole host of concerns arises as more permanent damage can be caused without proper training, monitoring, and qualifications. Please, I implore you to either ensure that should PT's have such rights to perform what is essentially acupuncture, that they be held to the same degree of proper training and regulation as acupuncturists, or reserve the rights of this ancient, but effective to the licensed and trained acupuncturists.

Autumn Ta, LAc

I am writing to express my deep concern for the expansion of the physical therapy scope of practice in Washington to include dry needling. I am a practitioner who has been in practice for 21 years and also a faculty member at the Seattle Institute of Oriental Medicine. Every day I teach students who are training to become acupuncturists who have previously had careers in other health professions. Training in massage or physical therapy does not prepare one to insert needles into the public after a few weekends of training. I have grave concerns about physical therapists being allowed to needle into the body with out proper training.

The practice of "dry needling" as it is being called, is actually nothing more than the practice of acupuncture, for which acupuncturists are required to undergo 3 years of training and over 1000 hours of supervised practice in clinic in order to be licensed in this practice of acupuncture, or "dry needling" as they are calling it.. Please do not decrease these valuable safety standards for other professions.

Christina Jackson, EAMP

I have had over thirty years of acupuncture experiences. I think in the benefits of our patients each branch or type of practitioner should stick to what we were trained for so that we can give our patient the best service as they need. So physical therapist should refer the patient to acupuncturist for needling regardless what they are going to call the kind of needling they are going to give because they are less trained for it.

Joy Smedley

I'm writing to you today to voice my agreement with the position taken by the Washington East Asian Medicine Association in regards to Physical Therapists not being allowed to do what they call "dry needling." In my professional opinion dry needling is acupuncture and acupuncture is much more broad in it's scope than to compare it to just one component within the modality.

I do not want to belabor the points that have already been made by my acupuncturist colleagues. The fact of the matter is that PT's do not have needle training in their formal schooling. They have not met the standards of Washington State to allow them to put needles in a persons body for therapeutic benefit. This is no different than an acupuncturist wanting to do chiropractic adjustments on patients. It's not in our training and even if we received training and thought we could, it does not mean we should. Granting Physical Therapists the right to needle people in Washington State without the same clinical standards needed by EAMP's is a threat to public safety and a threat to the profession and reputations of EAMP's in this state. I ask that you do not allow the sunrise review to go forward, as written, for PT's to conduct dry needling.

Thank you for your time and consideration.

Jon-Paul Boisvert EAMP, Lac, Clinic Director, Eastside Natural Medicine

I am an East Asian Medical Practitioner, who has been practicing in the state of Washington since 2007. I am appalled that Physical Therapists would have the gumption to think that they could practice what even the lay person would recognize as Acupuncture or Chinese Medicine under the scope of their current license. If they do in fact want to practice "dry needling", let us call it what it really is: Acupuncture. And in order to practice acupuncture, they must therefor not only have a current EAMP license, but they should also be required to complete the appropriate continuing education in order to stay current on their EAMP license.

I am looking forward to attending the Sunrise Review this coming Tuesday.

Sarah Collins, EAMP

I have suffered with severe chronic pain for 20+ years and was introduced to dry needling a year ago while in physical therapy. I had not heard of it before, but oh what a life saver! I absolutely think that this should be in the scope of a PT practice. The therapist can use this to relieve pain that allows the patient to move forward with exercises and treatment. There have been numerous times I have gone in and not been able to turn my neck and after one treatment I am able to walk away and turn my head without pain. This treatment has been a valuable source of relief that is drug free! I urge you to allow dry needling by a Doctor of PT. There are many people who could benefit from this and I am one of them.

Nancy Hatch

Dry needling was very effective in treating chronic shoulder pain when other treatments weren't as effective over time. I have seen marked improvement in mobility and quality of life. I would recommend it to my friends and would like to continue to have the option for future treatment through a qualified PT.

John Chestnut, Seattle, WA 98107

I rely on dry needling for pain management, long-term surgery recovery and acute injuries. I have been suffering from Reflex Neurovascular Dystrophy since 2004 and dry needling is a key player in helping me live a functional life. Additionally, I have had four knee surgeries on the same knee. The post-operative rehabilitation on my knee is on-going and getting my knee and the surrounding tissues treated is preventing another operation. Then there are the acute injuries I consider to be normal wear and tear like tension headaches from clenching my jaw or a strained back muscle from exercising. Those are both examples of conditions I've had treated by my physical therapist where dry needling was a quick, safe and incredibly effective treatment.

The physical therapists I've been treated by have an exceptional level of knowledge about anatomy and the practice of dry needling. Excluding dry needling from the physical therapy scope of practice would be taking away my lifeline and the lifelines of many people who suffer. Dry needling has provided me with effective relief from pain and injury without the need for habit-forming medications and costly interventions.

I have been dry needled by both a physician (MD) and a physical therapist over the past 3-4 years. In both cases, I was confident in their deep understanding of my body and their experience using dry needling to treat my condition. Seeing my physician for dry needling cost roughly \$300 per visit in out of pocket costs. I was told that to get the most out of the treatment, I needed to be seen 2 time a week but more often than not, my MD was booked weeks in advance. Seeing my physical therapist for

treatment costs roughly \$25 per visit in out of pocket costs and their schedule is very flexible, allowing me to get treatments frequently.

Including dry needling in the scope of practice for physical therapists means patients like me have access to effective, safe and affordable treatment.

Jessica Winkler, Seattle, WA

Some years ago I broke my ankle in multiple places. I had to wear a cast for a number of weeks and progressively return to using it as normal. I, regretfully, only attended 2 PT sessions for rehab at that time. I was fairly young, very healthy, and it seemed to be healing just fine to me. Fast forward 8 years...one car accident, and probably over 25,000 miles on my feet, and the result is me having to suffer through some back pain.

I am a US mail carrier - I have delivered mail day in and day out since I was 19 years old. I have a beautiful, but very steep, hilly route in Seattle. All of my customers have mailboxes at their front door or garage, which adds additional steep driveways. Needless to say - I spend A LOT of time walking - and I need to be able to do that without pain in order to make a living.

For the most part - I am able to complete my job without any problem. But every once in a while, the effects of a stiff ankle, and high physical demands, flares up my back. I have tried stretching and massage, and I keep up with my core exercises. But a couple times a year, this is not enough. Previously, I was able to manage these symptoms with a quick and easy session with a PT. I was amazed how the next morning I was back on my feet with none of my original pain!

I honestly can not imagine what I will do the next time my back flares up if I do not have access here in WA to this treatment. I would probably be out of work for days, and even upon return, not at full duty for another week or so. I hope the system can get this one right and allow PTs to continue to provide this service to active people like me who rely on it once or twice a year to perform their job duties without missing a day of work.

Kevin B., Seattle, WA

Thank you in advance for taking the time to read my email. I'll begin by saying that there is SO much more to inserting a filiform acupuncture needle to release a muscle. There are multiple bio-molecular functions that occur that poses a heavy risk/danger to patients if they are at the mercy of someone who has had a mere weekend - week training in needling.

What American Medical Association Board Member Russel W. H. Kridel, M.D., had to say on June 15th, 2016, regarding regulating dry needling is confirmation that it is an unsafe minor surgical procedure that most healthcare providers aren't properly trained for. Dr. Kridel states, "Lax regulation and nonexistent standards surround this invasive practice. For patients' safety, practitioners should meet standards required for licensed acupuncturists and physicians." The AMA adopted a policy that said physical therapists and other non-physicians practicing dry needling should, at a minimum, have standards that are similar to the ones for training, certification, and continuing education that exist for acupuncturists.

I) Acupuncture and dry-needling are the same thing. Western medicine practitioners have coined inserting a filiform needle through the skin a different name to lead people to believe that it differs from acupuncture. Both, acupuncture and "dry needling", insert a filiform needle into the skin, thereby impacting surrounding tissue such as connective tissue and musculature, etc. Changing the name of the procedure doesn't change the procedure itself, nor the risk associated with its use.

II) Anyone using any sort of surgical instrument, such as a filiform needle, should meet the minimum standards of an acupuncturist or a physician. Medical doctors have extensive minor and major surgical training and they still meet the bench mark of significant additional training, even with their already extensive foundation of surgical procedures.

III) Washington state has minimum requirements for didactic education, supervised clinical hours, and a third party psychometrically created national board exams to test for minimum competency that involved the insertion of filiform acupuncture needles and the biomolecular functions when certain musculature and tissue is needed.

IV) The American Medical Association (AMA), as mentioned above, is opposed to allowing any healthcare professional without the proper training be allowed to pose a risk to the public.

V) Acupuncture points have two broad categories: pain-related points and channel-related points. Pain-related points are also called “ashi” points, and has been documented in text books for over a thousand years. It’s not new science. Coincidentally, trigger points are ashi points, and have been recognized as acupuncture points since the 7th century CE, at the latest.

VI) The American Physical Therapy Association (APTA) said that “there is no CPT code that describes dry needling nor do any of the existing CPT codes include dry needling techniques in clinical vignettes utilized by the AMA in their process to establish relative value units.” One must go through the AMA in order to establish a new CPT code. The AMA has made a public statement that they do not support other healthcare professions to practice minor surgery by inserting a filiform needle through the skin unless they have the minimum benchmark standards that an acupuncturist and/or a medical doctor does.

VII) The language of SB 6374 is problematic for a couple of reason. The language of the bill prevents licensed acupuncturists from performing dry needling, a technique that is inherently within our scope of practice and is commonly used. It’s actually one of the first techniques that is taught in acupuncture programs. Secondly, if the RC18.74.010 is adopted, it will be unenforceable as written.

VIII) "Dry needling" is also commonly called “trigger point needling.” It’s a technique that is commonly performed by acupuncturists treating myofascial pain, and it is a technique that is documented as a subset of acupuncture that is practiced readily in modern treatment. I specialize in orthopedics, sports medicine, and rehab, and I use this technique more commonly than I use the other techniques that was taught in our program.

IX) The technique of needling taut bands of tissue is described in the earliest acupuncture text. It is now taught more specifically with greater emphasis on neuroanatomy by acupuncturists to acupuncturists, both in formal programs and in continuing education programs alike. It is readily used in modern practice and, as such, is commonly called trigger point needling, which is also an alternate name for dry needling.

Last, but not least, there is much more than inserting a filiform needling through the skin to elicit a desired affect to surround tissue. There are multiple biochemical processes that occur resulting from them, and the biomolecular secretions that occur vary from point to point. This provides an inherent danger to patients whom are being needled by healthcare providers that haven’t been properly trained to understand both, the physical changes and the biomolecular changes in in the body. Needling certain “trigger points” can cause a patient to faint, miscarry a baby, lower blood pressure, increase palpitations, cause needle shock, and so many other processes. It’s not just to release a muscle. It’s much deeper than that, and proper training is a must in order to ensure the safety of the public. I had a patient that was needled to release the muscle, however, she ended up miscarrying her 4 month old baby because the physical therapist that needled her didn’t know that the biomolecular function of the specific trigger point he needled also induces labor. Not to mention that he was aggressive in needling her. It was a tragic outcome that could have been avoided had there been proper benchmarks in place for proper training, both clinically and physiologically.

I hope you take the time to consider the safety of the public and not play the numbers game. This is truly important.

Minerva Henson MSA, EAMP, Eastside Acupuncture & Integrative Medicine

I am writing you to include my comments in the PT Sunrise review process.

1. Acupuncture and dry needling are the same. Changing the name of something does not change it or the risk associated with it.
2. Originally, dry needling was done with hypodermic needles without any substance injected. It was a painful technique. Wet needling is injecting a substance into the body using a hypodermic needle.
3. Anyone using a filiform needle (commonly referred to as an acupuncture needle) should go through a rigorous supervised training before being allowed to insert needles into the body. I recently finished a 2000+ acupuncture program in the state. The skill of inserting needles into the body takes a long time to master. The ridiculous low bar training that the PTs are suggesting is inadequate and not safe.
4. WA state already has benchmarks in place for the didactic training, clinical hours which are supervised and exams to test for competency for inserting filiform needles into the body. Why would another non-physician group be allowed to skirt these training minimums? There is no question that these therapies work and that patients want and deserve highly skilled people performing acupuncture, that is why the supervise clinical training is in place.
5. Physical therapists have distorted the truth regarding these points that they use. They call them trigger points. Trigger points are called ashi points by East Asian Medicine practitioners. They have literally replaced "Ashi" with the translation "Trigger" and are pretending that it is something different. Early proponents of Trigger point needling, literally took what they learned from acupuncturists and tried to rename. Ashi points have been recognized as acupuncture points since the 7th Century, probably before that.
6. PTs are trying to redefine acupuncturist's scope with this bill. We utilize Ashi points (trigger points) in our practice of East Asian Medicine. They are trying to say that we only utilize points on meridians (channels) following Chinese Medicine Theory. Actually, Chinese Medicine Theory includes the use of Ashi points.
7. The American Medical Association (AMA) recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists. PTs have limited training with these instruments. They are suggesting treating patients unsupervised after a weekend course! That is appalling.
8. The American Physical Therapy Association (APTA) said that "there is no CPT code that describes dry needling nor do any of the existing CPT codes include dry needling techniques in clinical vignettes utilized by AMA in their process to establish relative value units." In order to establish is new CPT code, you must go through the AMA. Additionally, PTs are using codes that do not describe what they are doing. They aren't allowed to use Acupuncture codes. They are fraudulently using manual therapy and other codes to get paid for acupuncture.
9. The language of SB 6374 is problematic for two primary reasons. First, the language of the bill could prevent licensed acupuncturists from performing Ashi Needling (trigger point needling) what PTs call Dry Needling, a technique that is inherently within their scope. Secondly, the RCW18.74.010, if adopted, will be unenforceable as written.

10. “Dry needling” is also commonly called “trigger point needling.” This is a technique commonly performed by acupuncturists treating myofascial pain. Dry needling/trigger point needling is a technique that is documented as a subset of acupuncture and is practiced readily in modern treatment.

11. The technique of needling taut bands of tissue is described in the earliest acupuncture text. It is now taught more specifically with greater emphasis on musculoskeletal and neuroanatomy by acupuncturists to acupuncturists, both in formal programs and in continuing education programs alike. It is readily used in modern practice and, as such, is commonly called trigger point needling, which is also an alternate name for dry needling.

12. Instead of trying to expand their scope to include acupuncture, physical therapists should focus on what they are good at and refer their patients to the filiform needle experts – East Asian Medicine Practitioners! We would be able to lower costs for the patients if we work together instead of trying to adopt each other’s methods.

Thank you for your support in opposing the physical therapy scope expansion attempt to include the acupuncture they call dry needling with inadequate training!

These comments submitted in separate emails from:

Jamil Shoot
Fatimah Jamshidi

Please consider the following in regards to SB 6374.

1. Acupuncture and dry needling are indistinguishable from each other from a regulatory and legislative standpoint. Changing the name of a procedure does not change the procedure, nor the risk associated with its use.
2. Early promoters of DN considered them the same and even went so far as to suggest renaming acupuncture points in modern terms so acupuncture would be more accepted by medical doctors. Hence, dry needling should be governed by the same statutes that apply to acupuncture.
3. Anyone using a dry/acupuncture/filiform needle should meet benchmarks for safety before touching the human body with a needle for therapeutic purposes, which requires extensive training to perform safely.
4. Washington state has benchmarks for didactic education, supervised clinical hours, and a third-party national psychometrically created exam to test for minimum competency that involves the insertion of filiform acupuncture needles.
5. What physical therapists call trigger points are one of the two broad categories of acupuncture points: channel-related points and pain-related points, also known as “ashi” points. Trigger points are ashi points, and have been recognized as acupuncture points since the 7th century CE at the latest.
6. The American Medical Association (AMA) recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.
7. The American Physical Therapy Association (APTA) said that “there is no CPT code that describes dry needling nor do any of the existing CPT codes include dry needling techniques in clinical vignettes utilized by AMA in their process to establish relative value units.” In order to establish is new CPT code, you must go through the AMA.

8. The language of SB 6374 is problematic for two primary reasons. First, the language of the bill could prevent licensed acupuncturists from performing dry needling, a technique that is inherently within their scope. Secondly, the RC18.74.010, if adopted, will be unenforceable as written.

9. “Dry needling” is also commonly called “trigger point needling.” This is a technique commonly performed by acupuncturists treating myofascial pain. Dry needling/trigger point needling is a technique that is documented as a subset of acupuncture and is practiced readily in modern treatment.

10. The technique of needling taut bands of tissue is described in the earliest acupuncture text. It is now taught more specifically with greater emphasis on musculoskeletal and neuroanatomy by acupuncturists to acupuncturists, both in formal programs and in continuing education programs alike. It is readily used in modern practice and, as such, is commonly called trigger point needling, which is also an alternate name for dry needling.

Thank you for your support in opposing the physical therapy scope expansion attempt to include the acupuncture they call dry needling with inadequate training!

These comments submitted in separate emails form:

- Dr. Fred Russo, DAOM, EAMP, Lac, Transformational Oncology Center, LLC
- Kimberly Chenoweth
- Ying Wang. OMD, LA.c
- William F. Wulsin, ND, MPH, MA, LAc
- Xiapin Song L,Ac, EAMP
- Debbie Yu
- Jihua Wang LAc.
- Ann Murphy
- Kathy Albert
- Roxane Geller, EAMP, Union Center For Healing, PLLC
- Heather Falkenbury – added “I am writing as a concerned citizen and Licensed Acupuncturist of Washington state. It is a danger to the public health if Physical Therapists are allowed to practice dry needling with inadequate training- of which they are proposing in this sunrise review.”
- Angie Hughes, L.Ac – added “As an acupuncturist of 30 years and an instructor in the practice and theory of acupuncture, I am frustrated and very concerned that the issue of Physical Therapists administering "dry needling" continues to take up time and energy. Please take note of the following points that have been outlined again and again.” “This seems to be an issue that we, as an acupuncture profession, are asked to defend over and over again. Please consider ending this request by the Physical Therapists of Washington to have this included in their scope of practice once and for all. Thank you for your time and attention to this matter.”
- Melissa Dana – added “I have received over 3000 hours of training and passed national board exams to be able to call myself a licensed acupuncturist; I would never consider a weekend course in stretches and exercises sufficient to suggest to my patients they see me for physical therapy. So why should PTs for acupuncture?”
- Steve Bogert, EAMP – added “I support the 10 point position taken by the Washington East Asian Medicine Association. These points are detailed below. In addition, I want to emphasize the importance of being completely trained in acupuncture theory, and being tested to NCCAOM standards before being allowed to treat with filiform needles.

When a fully trained practitioner selects points for an acupuncture prescription, they draw upon multiple sets of rules regarding the safety and efficacy of the points chosen. For example, the “pain location” or “dry needling” rules may suggest that a needle be inserted in the ankle area near the point known as SP6 to relieve leg/ankle pain. A fully trained and qualified practitioner would also review this point selection with respect to the rules of Qi movement. This secondary review would reveal that SP6 is contraindicated in a pregnant person as it has the potential to cause

spontaneous abortion. A PT who has only been trained in the “pain location” rules would miss the secondary review and may cause unintended loss of life. It doesn’t matter whether you call it acupuncture or dry needling – the body will respond to point stimulation as it has always done, since the origins of acupuncture thousands of years ago.

There are many other examples of potential unintended consequences resulting from incomplete training in the rules of acupuncture. The bottom line is that NCCAOM and the AMA have set forth guidelines regarding the minimum acceptable training and demonstration of competency required before a practitioner can safely perform acupuncture /dry needling. The proposed training /proficiency testing for PTs falls far short of satisfying these requirements. Approving the proposal would needlessly endanger the public.”

- Susan Moore, L.Ac., EAMP, Dragonfly Holistic Healing – added “I am writing to express my concerns over the PT request for Dry Needling as part of their scope of practice. I agree fully with other acupuncturists in our profession regarding the following statements listed below. I am concerned that the PT profession is trying to mislabel dry needling as something other than acupuncture which has been in practice for well over 200 years with extensive texts written on the subject.. We have an established benchmark in our state for didactic and clinical competency that I feel all PT's must adhere to to practice what they call "**Dry Needling" which is Acupuncture.** I am concerned that the language in SB 6374 could prevent me from practicing acupuncture - I have been practicing for 20 years and also teach in the profession. The PT proposal does not even include acupuncturists in their listing of "Authorized healthcare practitioners" Our standard of care is exceptional and 54 hours of training is unacceptable for PT's. I am requesting that PT's be held

The needling of Dry needling "trigger points" and muscular and connective tissue are also Acupuncture Points known as "ashi" points. We have full training in the treatment of these points that, again is more extensive and holds to a much higher level of standard of care that is safe in its application of technique. Dry Needle/Acupuncture requires a multi-tiered level of understanding of how to insert and stimulate acupuncture needles. I do not think that the proposed training for PT's is adequate for patients. I have had patients who have received "dry needle" acupuncture from a PT complain of the ineffectiveness and discomfort of the procedures. I do think that PT's could do dry needle/acupuncture but they would need a greater level of training from the acupuncture profession to give an adequate treatment. I recommend that the PT profession collaborate with the East Asian Medical Profession to determine what would be an appropriate level of training for their profession. It might include attending an Acupuncture/East Asian Medicine school or require that an Acupuncture/EastAsian Medicine be taught in the training program.”

I rely on my health care professionals to be fully trained by accredited institutions and licensed by the State of Washington. The proposal by the Physical Therapy Association of Washington to perform “dry needling” is woefully inadequate. By their own descriptions what they describe is acupuncture. There are many dual licensed practitioners in the state of Washington, who hold multiple licenses to practice multiple disciplines. **This is important to protect the public health and safety of the health care consumers in Washington State.** The Department of Health should require the physical therapists to complete the training to perform needling as is required under RCW 18.06. Please **deny** the Physical Therapy Association of Washington’s application in its entirety.

These comments submitted in separate emails from:

Margaret Cartwright
Cheryl Denman
Cail Shope

Attached you will find documents submitted by me on behalf of the WA East Asian Medicine Association. The subject matter is listed below:

- Cost Effectiveness Testimony
- Representative Cody’s Letter to the Attorney General Requesting an AGP Opinion



Washington East Asian Medicine Association

RE: Testimony by Leslie Emerick, WEAMA Governmental Consultant for August 2, 2016,
Physical Therapists Dry Needling Sunrise Review

Cost-Effectiveness

An essential criterion to judge whether or not to expand a scope of practice requires the applicant to demonstrate that the proposal will provide the most cost-effective option to protect the public. Remarkably, the application has no data on this point and therefore fails to meet the requirement. The section on cost-effectiveness (beginning at page 12) has no comparison of the cost of PTs doing dry needling to any other modality – only statistics about societal costs of low back pain. It quotes the Bree Collaborative about physical therapy, but Bree recommends standard physical therapy, not dry needling.

The most cost-effective means of providing therapeutic needling is for physical therapists to refer patients to fully trained East Asian Medicine Practitioners. The marginal cost, (*i.e.*, the additional cost to society) is zero, because licensed EAMPs already have the necessary training and licensure to practice safely and effectively. The application does not even mention this most obvious path of referral. If physical therapists assert that dry needling is more cost-effective than acupuncture, they must show that reimbursement rates are lower for them than for EAMPs.

If physical therapists want instead to add needling with an acupuncture needle, the Legislature has already established a policy called dual licensure. In the EAMP statute, RCW 18.06.050(2)(a), naturopathic physicians and doctors of chiropractic are given credit for their extensive training in western medicine when they add training for licensure in acupuncture. This is the standard for cost-effective preparation in Washington. We believe that physical therapists need comparable training as chiropractors and naturopaths to perform acupuncture. It is invalid to claim cost-effective preparation by skipping the training.

Finally, insurers do not cover dry needling. The American Physical Therapy Association reports that “currently, there is no CPT code that describes dry needling.” CPT codes are written and copyrighted by the American Medical Association. It is highly unlikely that the AMA would develop dry needling CPT codes as they just released a statement opposing Physical Therapists performing dry needling. The statement reads: “RESOLVED, that our American Medical Association recognize dry needling as an invasive procedure and maintain that dry needling

should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.

The lack of a dry needling code would suggest that 100% of whatever PTs charge for dry needling would be borne by patients. The bottom line is that the applicants have not shown that the proposal is the most cost-effective option for needling.

State of
Washington
House of
Representatives



June 30, 2015

The Honorable Bob Ferguson
Washington State Attorney General
PO Box 40100
Olympia, WA 98504-0100

RE: Request for Opinion—Dry Needling by Physical Therapists

Dear Attorney General Ferguson,

I am writing you this letter to formally request an opinion as to whether the practice of dry needling is within a licensed physical therapist's scope of practice as defined in Chapter 18.74 RCW.

Dry needling (also known as intramuscular stimulation, intramuscular manual therapy, trigger point dry needling, or intramuscular needling) is an invasive procedure involving the insertion of a solid filament needle through the skin for therapeutic effect. It has come to my attention that some licensed physical therapists in Washington are already engaging in this practice. To date, the Board of Physical Therapy (Board) has not officially stated whether it believes dry needling is included in a licensed physical therapist's existing scope of practice as defined in statute.

As mentioned above, the scope of practice for a licensed physical therapist is defined in Chapter 18.74 RCW. Included in that scope are:

- "Alleviating impairments and functional limitations in movement by designing, implementing, and modifying therapeutic interventions;"
- "Training for, and the evaluation of, the function of a patient wearing an orthosis or prosthesis;"
- "Reducing the risk of injury, impairment, functional limitation, and disability related to movement;" and
- "Performing wound care services." (RCW 18.74.010)

Neither dry needling nor any of its synonyms are mentioned in Chapter 18.74 RCW or rules adopted by the Board.

It could be argued that dry needling is subsumed within some of the broader items in the physical therapist scope of practice, such as alleviating impairments and functional limitations in movement or reducing the risk of injury, impairment, functional limitation and disability relating to movement. This argument, however, is not compelling for two main reasons.

First, as your office acknowledged in AGO 2010 No. 2, under the doctrine of *ejusdem generis*, a general term in a statute should be interpreted in a manner consistent with the specific examples provided in that statute. See also, *State v. K.L.B.*, 180 Wn.2d 735, 741 (2014) ("Under settled principles of statutory construction, general words accompanied by specific words are to be construed to embrace only similar objects"). The broader, general items in the physical therapist scope of practice are followed by lists of examples that are not invasive procedures. It is therefore clear that the Legislature did not intend invasive procedures like dry needling to be included in those more general items.

Second, the Legislature specifically authorized in statute the only two invasive procedures physical therapists are authorized to perform: wound debridement (RCW 18.74.010) and electromyography (RCW 18.74.160). If the Legislature had intended dry needling to be part of a physical therapist's scope of practice, it would have specifically done so in statute (I can personally vouch that there was no discussion of dry needling when these two modalities were added in 2005). The fact that wound debridement and electromyography are specifically identified in statute also shows that invasive procedures are not included in the broader items in the physical therapist scope of practice—if invasive procedures were included in those broader items, it would not have been necessary to separately and specifically authorize wound debridement and electromyography in statute.

It should also be noted that in *South Sound Acupuncture Association v. Kinetacore*, the King County Superior Court, No. 13-2-04894-9, Laura C. Inveen, J., on October 10, 2014, entered a summary judgment in favor of the state that stated, "The plain text of the physical therapy statute, applicable case law, and the legislative history of RCW 18.74.010(8) each support that there was no legislative intent to authorize physical therapists to insert acupuncture needles into human tissue for the purpose of dry needling or any similar purpose."

Thank you for your time and consideration of this important issue. I look forward to response. In the meantime, please do not hesitate to contact me if you need any additional information.

Sincerely,



Eileen Cody
Representative—34th Legislative District
State of Washington

Survey of Errors and Omissions in Sunrise Review Applicant Report: Dry Needling in Physical Therapist Scope of Practice

Submitted by
Ashley S Goddard, EAMP
Vice President, Washington East Asian Medicine Association

What follows is a summary of logical and factual errors included in the application for scope expansion by physical therapists to include dry needling. **For ease of scanning, main ideas appear in boldface.**

This survey is organized by section in order of the original application. Responses to the applicant's answers to follow-up questions from the Department of Health appear in boxed comments placed within their original related section.

2. BACKGROUND: The History and Definition of Dry Needling in Physical Therapy.
Dry Needling /S Acupuncture: See Sec 7 below.

3. EFFICACY

a. Pain Reduction

The application states, "Dry needling has been shown to reduce pain and improve outcomes in patients with myofascial pain. Research in the medical community on the benefits of dry needling date back to the 1970s and 80s." It then quotes the work of Chan Gunn, MD. **Gunn's early work was based on trying to find a modern understanding and presentation for acupuncture.** He then developed IMS and began teaching IMS (Intramuscular Stimulation) i.e. "dry needling."¹ Gunn stated, "It is suggested that, as a first step towards the understanding and acceptance of acupuncture by the medical profession, the present anachronistic systems of acupuncture locus nomenclature be dispensed with in favour of a modern, scientific one using neuro-anatomic descriptions."² It was a re-branding of acupuncture.

4. COST EFFECTIVENESS

P. 3 The applicant claims that "many patients with musculoskeletal pain are already receiving physical therapy, at a fraction of the cost of other interventions" but provides no cost comparison of these other interventions. **Currently dry needling is not covered by insurance, as there are no CPT codes that cover dry needling. Patients must pay for dry needling services out-of-pocket.**

The APTA has advised against billing it under other codes.³ The creation of CPT codes is under the jurisdiction of the American Medical Association. The AMA recently adopted a policy: **"RESOLVED, That our American Medical Association recognize dry needling as an invasive procedure and maintain that dry needling should be performed by practitioners with standard training and familiarity with**

¹ Gunn IMS: Intramuscular Stimulation. <http://www.istop.org/ims.html>

² Gunn, CC, Ditchburn, F, King, MH, Renwick, GJ. Acupuncture Loci: A Proposal for Their Classification According to Their Relationship to Known Neural Structures. *The American Journal of Chinese Medicine* 1976;4(2):183-195.

³ http://www.iamt.org/wp-content/uploads/2014/04/APTASTatement_DryNeedling-2014.pdf

routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists. (New HOD Policy),⁴ so the creation of a new CPT code may prove to be challenging.

P. 13 “Many patients are already receiving physical therapy care and prefer to get treatment within the western medical model. If physical therapists are not able to utilize this technique, patients will require many more sessions of physical therapy to treat their condition or the patient may need additional treatment from another healthcare practitioner.”

A way to ensure the patient gets the best treatment available would be to refer them to a needle expert, an acupuncturist. No supporting evidence is given that patients believe it is more important to receive treatment from within the western medical model rather than from a fully-trained needle specialist.

5. Education

c. Dry Needling Post-Doctoral Continuing Education

In discussing dry needling postgraduate education they name three institutions: Regis University in Colorado, where little information on dry needling education could be found online, and that was a course offered through Kinetacore. Two other institutions were mentioned:

- Mercer in GA: as of 2015, a physician consultation is required for PTs to perform DN in the state of Georgia.⁵
- University of British Columbia - Canada has vastly different laws surrounding dry needling; in fact, even massage therapists can be certified (one of whom caused a pneumothorax in an Olympic athlete).⁶

d. Doctoral Education

It is clear that physical therapists are highly qualified to do physical therapy, but it is not established that they are also qualified to do acupuncture. East Asian Medicine Providers (EAMP) must have “successfully completed five hundred hours of clinical training in East Asian medicine, including acupuncture, that is approved by the secretary.”⁷ For licensure, EAMPs must also pass national board exams (third-party psychometric testing). **There are no such requirements for third-party testing or clinical supervision in the certification of dry needling.**

For commentary on the applicant’s comparisons of dry needling education to that of medical acupuncture, see notes on Appendices below.

Q4. In a follow-up to the applicant, the Department of Health requested additional clarification:

The applicant report lists objectives of available continuing education courses on dry needling, stating that the average length of these courses is 54 hours and satisfies the task force’s recommendations, however:

⁴ AMA Adopts New Policies on Final Day of Annual Meeting. 2016.

<http://www.ama-assn.org/ama/pub/news/news/2016/2016-06-15-new-policies-annual-meeting.page>

⁵ TITLE 43. PROFESSIONS AND BUSINESSES CHAPTER 33. PHYSICAL THERAPISTS.

http://sos.ga.gov/plb/acrobat/Laws/15_Physical_Therapists_43-33.pdf

⁶ <http://news.nationalpost.com/news/canada/judo-acupuncture-needle>

⁷ RCW 18.06.050 East Asian Medicine Practitioners: Applications for examination—Qualifications

- *The objectives listed for the above do not demonstrate the courses meet the 16 knowledge requirements that require advanced/specialized training for competency in dry needling identified in the HumRRO report (Table 2, page 12);*
- *Please provide more detail to demonstrate that the 16 recommended knowledge requirements are met through the available post-graduate/continuing education training programs*

The applicant replies, “Each course highlights a unique list of learning objectives and therefore the knowledge criteria may fall under a slightly different objective or multiple objectives,” so a table comparing the top five courses was supplied. **It is clear from the table that the objectives taught vary considerably between the five courses, highlighting the lack of standardization in dry needling training.** The question arises: With no oversight, regulation or established standards, what measure will the Department of Health having in determining which courses are acceptable?

It should also be noted that some companies (Kinetacore, for example) include the use of electricity with needles (electroacupuncture) in their training, while others (Myopain, for example) does not. Certification in dry needling doesn't specify training requirements on the subject of electrostimulation. There are additional considerations to using “e-stim” on needles that practitioners should understand. For example, instances when electrical stimulation may cause: increased depth or a change in angulation of a needle, a particular concern when needling over the rib cage; or a bent needle when penetrating multiple muscle layers-- “Needle fracture is clearly a risk if this is allowed to occur repeatedly throughout a treatment session.”⁸

Q5. *How much of the specialized training is didactic and how much experiential?*

The table used to indicate an answer by the applicant **shows a wide variance of didactic vs experiential (from 4%-40% didactic and 60%-96” experiential), again highlighting the lack of standardization in current dry needling training.**

6. Public Safety

a. Risk of Pneumothorax

In a follow-up to the application the Department of Health requested additional clarification, e.g. Q6. *Please provide more details on the physical therapist disciplinary cases related to dry needling described on page 20 of the applicant report, particularly the nature of the complaints. Were there other complaints involving physical therapist dry needling that resulted in action other than discipline (e.g., agreed orders, probation, etc.); if yes provide details.*

There are some known occurrences that were not listed in the FSBPT letter responding to this question:

- An Olympic athlete in Colorado was presumed to have suffered a **pneumothorax** from a PT practicing dry needling⁹; and
- the documented incident referred to in a legal case in North Carolina in which an amended complaint submitted as part of an ongoing North Carolina lawsuit states: “The Acupuncture Board is informed and believes that injuries to patients in North Carolina have occurred as a result of physical therapists’ deficient performance of “dry needling,”

⁸ Cummings. Safety Aspects of Electroacupuncture. *Acupuncture Med.* 2011;**29**:83-85

⁹<http://www.usatoday.com/story/sports/olympics/sochi/2013/12/13/torin-yater-wallace-dew-tour-ion-mountain-championship-halfpipe-qualifying/4019707/>

including, but not limited to, an incident at Cornerstone in or about 2014 involving Mr. Hager which resulted in a **pneumothorax** (collapsed lung) in Asheville, North Carolina, which required the patient to undergo surgery for correction.”¹⁰

- As mentioned above, a Canadian Olympic athlete was similarly injured by dry needling.¹¹

There are other known accounts of injury via hearsay and, while hearsay can of course be unreliable, it is worth mentioning that these may go unreported, presumably because a patient has a relationship with and does not want to endanger the livelihood of their therapist.

Appendix A contains numerous third-party position statements *against* the practice of dry needling by physical therapists, as well as the 2016 opinion of the Washington Attorney General concluding that dry needling is not within the scope of a physical therapist.

b. Risks during Pregnancy

Not all dry needling sources are in agreement on the safety of dry needling during pregnancy. The application states, “The APTA document “Description of Dry Needling in Clinical Practice” counsels caution when dry needling pregnant women in their first trimester of pregnancy.” However, “According to Gunn, IMS (intramuscular stimulation/dry needling) is contraindicated during [the duration of] pregnancy.”¹²

C. Adverse Events

A recent review of studies shows the incidence rate for adverse events among dry needlers to be more than double that among acupuncturists, (19.2% vs 8.6%).¹³

In the follow-up to the application the Department of Health requested additional clarification:

Q1. Should dry needling (DN) be performed on vulnerable patients, such as infants, toddlers, pregnant women, or medically-compromised seniors? Is there a population of clients who should not receive dry needling?

In response, the applicant states “These patients surely require special attention.” The applicant contends also that immune-compromised patients would require consideration in determining if and how to treat with dry needling. However, **there is no specific answer as to what said attention or consideration may be, or where it might be taught.** In the table highlighting knowledge criteria identified by the FSBPT task force, nowhere in the category, “Factors influencing safety and Injury prevention” is it specified that information regarding the treatment of these patient populations is offered by any company.

As for neutropenia or thrombocytopenia, one must ask: is this line of inquiry standard in PT assessment? It is essential knowledge for needling. The applicant goes on to state that these patients are likely already receiving hypodermic injections, “a much larger needle with a cutting

¹⁰ Amended Verified Complaint for Declaratory Judgment and for Permanent Injunction in North Carolina Acupuncture Licensing Board v. North Carolina Board of Physical Therapy Examiners, Elizabeth Henry, AARt, Schlenklopper, Cornerstone Physical Therapy, Inc., and Jessan Hager. General Court of Justice Superior Court Division. Dec. 2015

¹¹ <http://news.nationalpost.com/news/canada/judo-acupuncture-needle>

¹² <http://ubcgunnims.com/courses/prerequisites/>

¹³ https://www.physiotherapyalberta.ca/files/faq_dry_needling_adverse_events.pdf

edge.” However, an injection requires only a single insertion and no thrusting or manipulation of the needle, which is what often accounts for the bruising associated with dry needling, particularly in this population as well as the elderly.¹⁴

Q2. Please provide more detail on the appropriate clinical setting for performing dry needling, including maintenance of environment safety and infection control measures.

The applicant responds that, “Any physical therapy clinical setting is in principle appropriate for the practice of dry needling.” Only one course acknowledges education in clean needle technique. No clear standards for needling handling in dry needling exist. In contrast, acupuncture testing is regulated by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) whose primary goal is “to establish, assess and promote recognized standards of competence and safety in acupuncture and Oriental medicine for the protection and benefit of the public,”¹⁵ and clean needle technique is a requirement for licensure¹⁶. The applicant continues, **“Individual clinic policy and procedure documents can incorporate these guidelines.” Yet there is no requirement as such.**

7. Dry Needling in Contrast to Other Therapies

a. Dry Needling in Contrast to Acupuncture

Dry needling is also commonly called “trigger point needling”¹⁷ and is a technique commonly performed by acupuncturists treating myofascial pain. The World Health Organization defines trigger points as a subset of acupuncture points.¹⁸ A 2015 study published in the British Medicine Journal concluded, “[D]ry needling is not only a subcategory of Western medical acupuncture but also an integral part of acupuncture per se.”¹⁹ And Dommerholt himself insists, “Manual physical therapists must realize that dry needling is also within the scope of acupuncture practice.”²⁰

It is well-represented in the literature that acupuncture has measurable effects on autonomic regulation,²¹ neuroendocrine mechanisms,²² the cardiovascular system,²³ tissue repair,²⁴ and so on.

To say acupuncture only works to “restore energy flow” is a gross misrepresentation.

¹⁴ Bauer, M. Treating the Elderly. *Acupuncture Today*. September, 2002, Vol. 03, Issue 09

¹⁵ <http://www.nccaom.org/about/history/>

¹⁶ Washington Administrative Code.. East Asian Medicine Practitioner. WAC 246-803-240. Examinations

¹⁷ Trigger point needling: techniques and outcome. Vulfsons et al. *Curr Pain Headache Rep*. 2012 Oct;16(5):407-12

¹⁸ Hoyt, J. “Acupuncture, Dry Needling and Intramuscular Manual Therapy: Understanding Acupuncture’s Therapeutic Role in America.” Coalition for Safe Acupuncture Practice. Abstract. (2012): 15. CCAM Research Partners Press

¹⁹ Fan AY, He H. Dry needling is Acupuncture. *Acupunct Med*. 2016 Jun;34(3):241. doi: 10.1136/acupmed-2015-011010. Epub 2015 Dec 15.

²⁰ Dommerholt, J. *J Man Manip Ther*. 2011 Nov; 19(4): 223–227.

²¹ Li, Qian-Qian et al. “Acupuncture Effect and Central Autonomic Regulation.” *Evidence-based Complementary and Alternative Medicine : eCAM* 2013 (2013): 267959. PMC. Web.

²² Liang, Fengxia, Rui Chen, and Edwin L. Cooper. “Neuroendocrine Mechanisms of Acupuncture.” *Evidence-based Complementary and Alternative Medicine : eCAM* 2012 (2012): 792793.

²³ Ballegaard S1, Muteki T, Harada H, Ueda N, Tsuda H, Tayama F, Ohishi K. Modulatory effect of acupuncture on the cardiovascular system: a cross-over study. *Acupunct Electrother Res*. 1993 Apr-Jun;18(2):103-15.

²⁴ Yu, Zhan-ge et al. “Effects of Zusanli and Ashi Acupoint Electroacupuncture on Repair of Skeletal Muscle and Neuromuscular Junction in a Rabbit Gastrocnemius Contusion Model.” *Evidence-based Complementary and Alternative Medicine : eCAM* 2016 (2016): 7074563. PMC. Web. 24 July 2016.

It should also be noted that dry needling courses (e.g. Spinal Manipulation Institute/Dry Needling Institute) are clearly teaching acupuncture, even going so far as to draw, label, and identify acupuncture points by their acupuncture point number on bodies in their classes.

Dry needle courses (e.g. Dr. Ma's Systemic Dry Needling) are demonstrably teaching acupuncture.²⁵ According to the company's website, the textbook for the course is, "Biomedical Acupuncture for Pain Management."²⁶ Many references to acupuncture exist throughout.

In New Hampshire, a PT and senior instructor for the Spinal Manipulation Institute/Dry Needling Institute (a program cited in the applicant's response to the follow-up question regarding the 16 knowledge requirements) **uses a clearly labeled protocol from a well-known acupuncture study.²⁷ Other studies use this or similar protocols.^{28 29 30 31}**

This is the practice of acupuncture.



DNI Tommy Perreault @TommyDPT · Nov 15
Jubb et al 2008 found 10 sessions of **@dryneedling** with estim led to sig reduction in knee pain due to Osteoarthritis

i. Purpose of Treatment

A scope of practice would be difficult to enforce according to intention, i.e. "purpose of treatment." It should be enforced according to the procedure alone. As demonstrated in section 7a., the impossibility of determining when a physical therapist is practicing dry needling or when they are practicing acupuncture renders the change to the RCW unenforceable.

²⁵ <http://dryneedlingcourse.com/dr-mas-textbooks/pain-management/table-of-contents>

²⁶ Ma, Yun-tao. Biomedical Acupuncture for Sports and Trauma Rehabilitation Dry Needling Techniques. New York: Elsevier; 2010.

²⁷ Jubb et al. A blinded randomised trial of acupuncture (manual and electroacupuncture) compared with a non-penetrating sham for the symptoms of osteoarthritis of the knee. *Acupunct Med.* 2008 Jun;26(2):69-78.

²⁸ Berman BM, Lao L, Langenberg P, Lee WL, Gilpin AM, Hochberg MC. Effectiveness of acupuncture as adjunctive therapy in osteoarthritis of the knee: a randomized, controlled trial. *Annals of Internal Medicine.* 2004;141(12):901-910

²⁹ Berman BM, Singh BB, Lao L, et al. A randomized trial of acupuncture as an adjunctive therapy in osteoarthritis of the knee. *Rheumatology (Oxford)* 1999;38(4):346-354

³⁰ Tukmachi E, Jubb R, Dempsey E, Jones P. The effect of acupuncture on the symptoms of knee osteoarthritis--an open randomised controlled study. *Acupuncture in Medicine.* 2004;22(1):14-22.

³¹ Takeda W, Wessel J. Acupuncture for the treatment of pain of osteoarthritic knees. *Arthritis and Care Research.* 1994;7(3):118-122.

By also misrepresenting acupuncture in the sunrise review application, the applicant denies modern acupuncture research, practice and even training. RCW 18.06.050 (2a) requires training that includes such modern science subjects as “anatomy, physiology, microbiology, biochemistry, pathology, hygiene, and a survey of western clinical sciences.”

Acupuncture is a highly skilled intervention. The misunderstanding of this skill coupled with the belief that it can be learned in two weekends bring to mind the Dunning-Kruger Effect, put simply: *You don't know what you don't know*. Dunning et al propose, “those with limited knowledge in a domain suffer a dual burden: Not only do they reach mistaken conclusions and make regrettable errors, but their incompetence robs them of the ability to realize it.”³²

ii. Trigger Points v. Ashi Points

Dry needling is also commonly called “trigger point needling”³³ and is a technique commonly performed by acupuncturists treating myofascial pain.^{34 35 36 37} The technique of needling taut bands of tissue is described in the earliest acupuncture text³⁸ and is readily used in modern practice where it is often referred to as trigger point needling. The scope expansion language states:

Dry needling does not include the stimulation or treatment of acupuncture points and meridians. “Dry needling” is also known as intramuscular manual therapy or trigger point manual therapy.³⁹

This language is erroneous because trigger points are a kind of acupuncture point, yet the passage also defines dry needling as something that does not stimulate acupuncture points. The two statements are thus in direct conflict with each other.

A 2016 study states, “The extent of correspondence is influenced by definitions of acupoints. Myofascial trigger points are significantly correlated to Traditional Chinese Medicine acupoints, including primary channel acupoints, extra acupoints, and Ah-shi points.”⁴⁰

The applicant submission on this point badly misrepresents the issue. It cites only an editorial by Stephen Birch, but not the quantitative research by Drs. Dorsher and Fleckenstein. It also fails to mention Dorsher’s rebuttal of Birch’s piece, which

³² Kruger, J., Dunning, D. Unskilled and Unaware of It: How Difficulties in Recognizing One's Own Incompetence Lead to Inflated Self-Assessments. *Journal of Personality and Social Psychology*. 1999, Vol. 77, No.6. 1121-1134

³³ Trigger point needling: techniques and outcome. Vulfsons et al. *Curr Pain Headache Rep*. 2012 Oct;16(5):407-12

³⁴ Callison, M. *Motor Point Index*. AcuSport Seminar Series LLC, San Diego, 2007, (p.9).

³⁵ Reeves, W. *The Acupuncture Handbook of Sports Injuries & Pain*. Hidden Needle Press, Boulder, CO, 2009, (p.360).

³⁶ Goddard, A. *J Chinese Medicine*. 2011 Oct. (97):25-28.

³⁷ Nugent-Head, A. *J chinese Medicine*. 2013. Feb. (101):5-12.

³⁸ Huang Di Nei Jing. *Ling Shu*, Ch13,

³⁹ Physical Therapy Association of Washington. *Sunset Review application*, June 2016

⁴⁰ Liu, Skinner, McDonough. “Traditional Chinese Medicine acupuncture and myofascial trigger needling: The same stimulation points?” *Complement Ther Med*. 2016. Jun;26:28-32.

described Birch’s conclusions as “conceptual opinions.”⁴¹ Finally, applicants fail to include Dorsher’s revisiting Birch’s analysis and finding that the clinical correspondence of trigger points and acupuncture points for pain is likely 95% or higher.⁴²

Visual comparison of dry needling and acupuncture:

A video⁴³ was cited in the application for sunrise review that showed trigger point dry needling. Compare this to a video of trigger point acupuncture⁴⁴. Other than the wearing of gloves by the PT (not required for injections or acupuncture) and poor hand placement by the therapist in the dry needling video, the technique is indistinguishable from acupuncture. (Moreover, if the PT’s needle were to be inserted too far in any of the repetitive jabs, it could go through to the therapist’s hand, resulting in a needlestick injury and that needle being withdrawn back through the body of the patient).

Still shot from dry needling video with risky hand placement:



Still shot from video showing acupuncture trigger point needling:

⁴¹ On the Probability of Trigger Point–Acupuncture Point Correspondences: An Evidence-Based Rebuttal of Stephen Birch’s Commentary. J Altern Complement Med, Vol 14, No. 10, 2008, p. 1183

⁴² Can classical acupuncture points and trigger points be compared in the treatment of pain disorders? Birch’s analysis revisited. J Altern Complement Med. 2008 May;14(4):353-9

⁴³ <https://www.youtube.com/watch?v=I75OAZr6V4&index=49&list=FLJZHGN5-n5P2nJEP2TeVcow>

⁴⁴ <https://www.youtube.com/watch?v=G6A3ZBNw6SU>

The requirement for certification in dry needling as stated in the proposed scope expansion language could, by extension, be interpreted to preclude acupuncturists from performing dry needling/trigger point needling, which is well within the scope of an EAMP. Hence, the EAMP scope would be limited by it, something the RCW is designed to avoid.

iii. Tools for Treatment

Regarding the section in the sunrise application entitled “Tools for Treatment,” which refers to the needles themselves, there is misleading information provided. In quoting the code of Federal Regulations pertaining to acupuncture (21 C.F.R. § 880.5580) the application seemingly makes two errors.

1. First, there is an omission of the complete legal identification of an acupuncture needle which specifies its use *only in the practice of acupuncture*:

(a) Identification. An acupuncture needle is a device intended to pierce the skin in the practice of acupuncture. The device consists of a solid, stainless steel needle. The device may have a handle attached to the needle to facilitate the delivery of acupuncture treatment.⁴⁵

2. Misrepresentation of the down-classification of acupuncture needles from class III to class II medical devices; and the omission of required labeling.

This down-classification was actually in response to a request by the Acupuncture Coalition (61 FR 64616) to reclassify the needle from an investigative device to one with “special controls.” As noted in 1. above 21 C.F.R. § 880.5580, the FDA clearly states that an acupuncture needle is used in the practice of *acupuncture*.

Acupuncture needles appropriately carry the following warning, “**Caution: Federal law restricts this device to sale by or on the order of qualified practitioners of acupuncture as determined by the States.**” [emphasis added] This is much different than if it were to simply say, “qualified practitioners as determined by the States.”

A summary of this argument is best represented by the following attorney’s letter on the subject that was submitted on behalf of Washington organization NCASI to the state PT board in the state of Oregon on this subject..

⁴⁵ U.S. CODE OF FEDERAL REGULATIONS. 21 C.F.R. § 880.5580(a)

November 13, 2013

Re: Dry Needling and Violations of the U.S. Food, Drug, and Cosmetic Act (FDCA) and Food and Drug Administration Rules

Dear State Board of Physical Therapy:

I write on behalf of the National Center for Acupuncture Safety and Integrity (NCASI), a nonprofit corporation working to protect the public from the unlicensed practice of acupuncture and the illegal sale and use of acupuncture needles. NCASI is aware that a number of state boards of physical therapy have authorized physical therapists to practice what is referred to as “trigger-point dry needling” (“TPDN”), also known as “dry needling.” Those promoting “TPDN” openly acknowledge that they are using labeled acupuncture needles to practice “TPDN,” but claim that “TPDN” falls outside the statutory and regulatory definitions of practicing acupuncture. While specific state laws vary on the definition of the practice of acupuncture, the federal Food and Drug Administration (“FDA”) strictly regulates the sale of acupuncture needles as Class II prescription medical devices under the U.S. Food, Drug, and Cosmetic Act (FDCA) only to qualified and licensed acupuncture practitioners. Specifically, FDA regulations restrict that the sale of acupuncture needles to anyone but a person *authorized to practice acupuncture and for use in acupuncture*. The sale of acupuncture needles to anyone other than a qualified and licensed acupuncture practitioner is a violation of both the FDCA and the FDA rules described below.

Please be aware that to the extent your board authorizes the use of acupuncture needles by persons who are not explicitly authorized to practice *acupuncture*, your actions are inconsistent with federal law and could expose your state board to liability in the event a person is injured by one of the practitioners your board regulates. There is no dispute that the practice of “TPDN” absolutely depends on the use of FDA-regulated acupuncture needles. Any official sanctioning of “TPDN” by a state professional board signals to potential patients that those practicing “TPDN” are qualified, trained and legally authorized to possess, purchase and use acupuncture needles, a Class II prescription medical device under FDA regulations. As a result, state regulatory and professional boards that endorse the practice of “TPDN” by persons who are not explicitly authorized to practice acupuncture is inconsistent with federal law.

FDA’s regulation of acupuncture needles as Class II prescription medical devices

Acupuncture needles are regulated under the FDCA as Class II prescription medical devices that are subject to FDA’s strict prescription sale requirements. *See* 21 CFR § 880.5580

(Exhibit A); 61 Fed. Reg. 64616–64617 (Dec. 6, 1996) (Exhibit B); Reclassification Order Docket No: 94P-0443 Acupuncture Needles for the Practice of Acupuncture (Mar. 29, 1996) (Exhibit C); 21 CFR § 801.109 (Exhibit D). In authorizing the sale of acupuncture needles, the FDA was explicit that such needles “must be clearly restricted to *qualified practitioners of acupuncture* as determined by the States.” 61 Fed. Reg. 64616 (Dec. 6, 1996) (emphasis added).

In reclassifying acupuncture needles from Class III to Class II prescription medical devices, the FDA also plainly defined acupuncture needles stating: “[a]n acupuncture needle is a device intended to pierce the skin *in the practice of acupuncture*. . .” 21 CFR § 880.5580(a) (emphasis added). The sale and introduction of acupuncture needles into interstate commerce for any purpose other than for “the practice of acupuncture” is outside the scope of FDA’s approval and would make such needles legally “adulterated” and/or “misbranded” under the FDCA. 21 U.S.C. § 352(f)(1); 21 U.S.C. § 331(p); 21 U.S.C. § 352(o).

Consistent with this directive, the FDA requires that acupuncture needles, including those that are being used for “TPDN,” carry a prescription label stating: “Caution: Federal law restricts this device to sale by or on the order of *qualified practitioners of acupuncture* as determined by the States.” 21 CFR 801.109(b)(1); 61 Fed. Reg. 64616 (Dec. 6, 1996) (emphasis added); *See also* Exhibit E. NCASI is committed to seeing enforcement of this common sense public safety requirement.

Sale of acupuncture needles to those who are not qualified to practice acupuncture

NCASI is aware that many individual physical therapists, occupational therapists, naturopaths, chiropractors, athletic trainers and others are attempting to skirt state acupuncture licensing laws by claiming they are using acupuncture needles to practice “TPDN” as opposed to “acupuncture.” Some state regulatory boards have authorized “TPDN” by regulation absent any apparent awareness or consideration of FDA’s regulation of acupuncture needles as Class II prescription medical devices.

The FDA, however, has explicitly limited the sale of acupuncture needles to those *authorized to practice acupuncture* and has only approved the use of such needles *for the purpose of acupuncture*. It is therefore illegal for an individual to sell, purchase, receive or use an acupuncture needle unless it is intended to be used for the practice of acupuncture by a person who is authorized under state law to practice acupuncture.

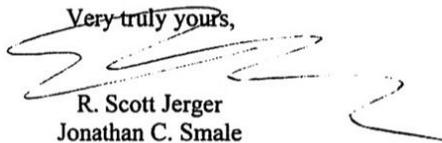
The purchase and receipt of acupuncture needles by individuals who are not qualified to practice acupuncture or for intended uses other than acupuncture make such needles legally “adulterated” and/or “misbranded” under the FDCA and is in direct violation of the FDCA and FDA’s implementing regulations. 21 U.S.C. §§ 331(a)–(c), (p); 21 U.S.C. § 352(o); 21 U.S.C. § 352(f)(1); 21 U.S.C. § 351(f); 21 CFR § 801.109(a). While a number of companies are illegally selling acupuncture needles on-line to persons who are not authorized to practice acupuncture, this does not legalize the practice. NCASI is currently investigating these sales and has submitted targeted complaints to the FDA.

Letter re Dry Needling
November 13, 2013
Page 3

With this letter your board and your state have notice that to the extent your board approves or otherwise endorses the use of acupuncture needles for the practice of "TPDN" by persons who are not legally authorized to practice acupuncture you may be exposing your board to liability for endorsing a practice that involves the violation of FDA regulations and the unauthorized use of a Class II medical device.

NCASI encourages your board to carefully review the enclosed regulations and other documents related to the regulation of acupuncture needles. To the extent your board has already endorsed or approved the practice of "TPDN" by persons who are not authorized to practice acupuncture, NCASI encourages your board to reconsider such actions. If your board has yet to address the issue of "TPDN," we encourage you to take a position that is consistent with the FDA's regulation of acupuncture needles as Class II prescription medical devices.

Thank you for your careful consideration of these issues.

Very truly yours,

R. Scott Jerger
Jonathan C. Smale

cc: client
Enclosures

This letter is equally relevant in Washington. Scope of practice that would allow dry needling with a class II medical device that is intended for only use in the practice of acupuncture, may be in indirect conflict with FDA regulations.

On a related note and resulting from a similar argument, a recent consent decree in California (in which Kinetacore and Paul Killoren are named defendants) states that the defendants "shall not sell, deliver, mail, furnish, or otherwise distribute in any way needles regulated as Class II medical device by the FDA, including but not limited to Myotech Dry Needles, within the State of California without appropriate licensure under California's Pharmacy Law."⁴⁶

Killoren, a Washington physical therapist and owner of US Dry Needling, distributes Myotech needles.⁴⁷ These are acupuncture needles made by Maanshan Medical Devices rebranded as dry needles. Maanshan also produces the following lines of acupuncture needles: :Eacu, Balance, Tempo, Acustar and Acuking. On June 24, 2016, Killoren stated the following regarding Myotech needles and his intentions : "Its [sic] just a better needle. Working with FDA to create new "dry

⁴⁶ International Center for Integrative Medicine vs Kinetacore, US Dry Needling and Physio Products LLC, IDryNeedle, Medbridge, Inc., Red Coral Acupuncture Supplies Pts Ltd.; Paul Killoren; Edo Zylstra; Austin Woods. US District Court for the Central District of CA. Case NO. 8:16-cv-00736-JLS-GJS

⁴⁷ Killoren, Paul. LinkedIn profile. <https://www.linkedin.com/in/paul-killoren-410804a>

needle" category. Doing this to define #dryneedling v acupuncture."⁴⁸ Similar attempts to do this have not been successful: In June of 2015, Maanshan received a letter from the Department of Health and Human Services at the FDA stating that Myotech needles were "substantially equivalent" to acupuncture needles.⁴⁹ **Repackaging needles doesn't make an acupuncture needle a different device and is further indication that dry needling is indeed acupuncture.**

b. Dry Needling in Contrast to Medical Acupuncture

In 1991, *A Proposed Standard International Acupuncture Nomenclature* was published by WHO in Geneva and a revised edition of *Standard Acupuncture Nomenclature* (Part 1 and 2) was published by the Regional Office for the Western Pacific in Manila.⁵⁰ Practical use has proven these WHO publications to be invaluable contributions to international information exchange on Acupuncture. Following are excerpts taken from this document regarding Acupuncture and its application. Please note the hierarchy of coding numbers used. All terms beginning with a code of 5.1 have been determined by the World Health Organization to be a subset of Acupuncture.⁵¹

- 5.1.0 Acupuncture
- 5.1.6 filiform needle
- 5.1.53 acupuncture point
- 5.1.54 meridian point
- 5.1.55 extra point
- 5.1.56 specific point
- 5.1.225 trigger point

8. CURRENT PHYSICAL THERAPY DRY NEEDLING LAWS

a. Overlap in Scopes of Practice

According to many sources, dry needling is a subcategory of acupuncture. Acupuncturists already do dry needling but refer to it as trigger point needling, ashi needling, etc.

Because dry needling is synonymous with trigger point needling, it could be argued that the requirement of an endorsement to practice dry needling precludes acupuncturists from performing the technique which is well within the scope of an acupuncturist (EAMP).

b. Dry Needling in the Military

Military-based physical therapists practicing on patients are allowed to use dry needling only after supervised encounters. No such standard is included in this bill.

⁴⁸ <https://twitter.com/DrDunning/status/746471831654240256>

⁴⁹ https://www.accessdata.fda.gov/cdrh_docs/pdf15/K150903.pdf

⁵⁰ "WHO Western Pacific Region - Publications and Documents - WHO International Standard Terminologies on Traditional Medicine in the Western Pacific REgion." World Health Organization. Web. 13 Feb 2012.

⁵¹ "WHO Western Pacific Region - Publications and Documents - WHO International Standard Terminologies on Traditional Medicine in the Western Pacific REgion." World Health Organization. Web. 13 Feb 2012.

A review of Appendices A-C of Sunrise Review Application:

Last but not least, the education requirements cited are a bit misleading.

Bear in mind that East Asian Medicine providers must show they have didactic training in basic sciences and East Asian medicine, including acupuncture, and the curriculum must also include such subjects as anatomy, physiology, microbiology, biochemistry, pathology, hygiene, and a survey of western clinical sciences. Moreover, they must also have “successfully completed five hundred hours of clinical training in East Asian medicine, including acupuncture, that is approved by the secretary.” (RCW 18.06.050 Applications for examination—Qualifications.) **The requirements for dry needling certification as proposed requires zero additional clinical hours.**

For licensure, EAMPs must also pass national board exams (third-party psychometric testing) but this requirement is lacking in the certification of dry needling.

Additionally, there are some logical errors on the table assessing overlap in education. For example, one it is indicated that “therapeutic approach” is “included in PT curriculum but not specifically related to acupuncture” but because the education in question is an acupuncture program, it should be obvious that this is *not* a standard part of PT curriculum and should not be assumed as an area of overlap.

Note: The “Five Element” training course included in the Appendix is not representative of medical acupuncture at all and should be ignored. In the state of California where it is offered, only MDs and Licensed Acupuncturists would qualify to attend.

Appendix A: Supporting documents including third-party position statements and commentary from debates in other states.



**AMERICAN ACADEMY
OF MEDICAL ACUPUNCTURE ®**

2512 Artesia Blvd., Ste 200
Redondo Beach, CA 90278
310/379-8261 • 310/379-8283 FAX

AAMA Policy on Dry-Needling

The American Academy of Medical Acupuncture (AAMA) is the premier North American organization of physician acupuncturists. The AAMA is committed to insuring public health and safety by ensuring that all persons practicing any type of medicine, including acupuncture, are properly trained and educated. It is imperative that courts and medical bodies maintain and preserve strict standards of education and training in acupuncture before any person undertakes inserting a needle into a patient. An ill-trained practitioner could, as a result of lack of education or ignorance, cause substantial medical injury.

Acupuncture, like Western Medicine is a complex subject. It cannot be mastered in a weekend or in a month. All AAMA members, in addition to four (4) years of medical school (MD or DO), must have 300 hours of didactic and clinical acupuncture education and training. In most states, a non-physician must have in excess of 2,000 hours of clinical and didactic education and training before they can become certified to treat patients.

Dry needling, like acupuncture, involves the use of solid needles (contrasted with the use of hollow hypodermic needles that are used for injections) to treat muscle pain by stimulating and breaking muscular knots and bands. Unlike trigger point injections used by physicians and licensed acupuncturists for the same purpose, no anesthetics are used in dry needling. There is controversy regarding the definition of dry needling. Licensed medical physicians and licensed acupuncturists consider dry needling as Western Style Acupuncture or Trigger Point Acupuncture whereby the insertion sites are determined by tender painful areas and tight muscles. These sites may be treated alone or in combination with known acupuncture points. Other practitioners take the position that dry needling is different from acupuncture in that it is not an holistic procedure and does not use meridians or other Eastern medicine paradigms to determine the insertion sites. Regardless of the theory, it is incontrovertible that dry needling is an invasive procedure. Needle length can range up to 4 inches in order to reach the affected muscles. It is critical to understand that dry needling, in the hands of minimally educated practitioners can cause extreme harm. Any invasive procedure has associated and potentially serious medical risks and is safe only if

performed by a properly educated, trained and experienced health professional. The technique of dry needling frequently involves needling of muscular structures that may be deep and/or hidden under layers of other muscles and tissues and close to sensitive structures and organs including blood vessels, nerves and organs as, for example, the lungs. The patient can develop painful bruises after the procedure and adverse sequelae may include hematoma, pneumothorax, nerve injury, vascular injury and infection. Angle the needle incorrectly and, for example, the lung may be punctured. Post procedure analgesic medications may be necessary (usually over the counter medications are sufficient). In the worse case scenario, vital organs can be pierced, resulting in complex medical situations or even death.

Physical therapy is not a field that has historically included the use of needles. The recent trend of some physical therapists to embrace dry needling under the umbrella of physical therapy practice is one that marks a distinct departure from traditional physical therapy practice. The fact that many physical therapists receive only minimal hours of training speaks to the potential danger of their practice.

To include dry needling into the scope of practice by physical therapists is unnecessarily to expose the public to serious and potentially hazardous risks. Because of this we feel a duty to inform legislators and regulating bodies about the inherent danger to the public of this practice.

Therefore, the AAMA strongly believes that, for the health and safety of the public, this procedure should be performed only by practitioners with extensive training and familiarity with routine use of needles in their practice and who are duly licensed to perform these procedures, such as licensed medical physicians or licensed acupuncturists. In our experience and medical opinion, it is inadvisable legally to expand the scope of physical therapists to include dry needling as part of their practice.

AAPM&R Position on Dry Needling

Dry needling is the use of solid needles (contrasted with the use of hollow hypodermic needles that are used for injections) to treat muscle pain by stimulating and breaking muscular knots and bands. Unlike trigger point injections used for the same purpose, no anesthetics are used. There is controversy regarding the definition of dry needling. Licensed medical physicians and licensed acupuncturists consider dry needling as *Western Style Acupuncture or Trigger Point Acupuncture* whereby the insertion sites are determined by tender painful areas and tight muscles. These sites may be treated alone or in combination with known acupuncture points. Other practitioners take the position that dry needling is different from acupuncture in that it is not a holistic procedure and does not use meridians or other Eastern medicine paradigms to determine the insertion sites. However, dry needling is taught in American acupuncture schools as a form of treatment for individuals using acupuncture needles.

Dry needling is an invasive procedure. Needle length can range up to 4 inches in order to reach the affected muscles. The patient can develop painful bruises after the procedure and adverse sequelae may include hematoma, pneumothorax, nerve injury, vascular injury and infection. Post procedure analgesic medications may be necessary (usually over the counter medications are sufficient).

There has been controversy in the United States as to who is qualified to practice dry needling. Since it is an invasive procedure using needles, many take the position that it should only be performed by licensed acupuncturists or licensed medical physicians (M.D. or D.O.). There are other practitioners performing this procedure who have taken a course or courses in this technique but do not routinely use needles otherwise in their practices.

The American Academy of Physical Medicine and Rehabilitation recognizes dry needling as an invasive procedure using acupuncture needles that has associated medical risks. Therefore, the AAPMR maintains that this procedure should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed acupuncturists or licensed medical physicians.

June 2012


American Academy of
Physical Medicine and Rehabilitation

www.aapmr.org

9200 W. Bryn Mawr Ave., Suite 900
Rosemont, Illinois 60018
phone 877/AAPMR 99
info@aapmr.org www.aapmr.org



Dr. David W. Miller, MD, LAc
Chair, American Society of Acupuncturists
4361 N. Lincoln Ave., Unit 5
Chicago, IL 60618
773.960.8901
ASAcupuncturists@gmail.com

July 27, 2016

Attn: Sherry Thomas, Policy Coordinator
Washington State Department of Health
Sunrise Reviews
P.O. Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas:

On behalf of the American Society of Acupuncturists, representing more than 4000 licensed acupuncturists in the United States, I would like to enter comment on the proposed addition of Dry Needling to scope of practice of Physical Therapists in Washington State.

Dry Needling is an acupuncture technique, and is performed regularly by both acupuncturists and medical doctors. Both the American Academy of Medical Acupuncture, representing the largest collection of medical doctors practicing acupuncture in the United States, and the American Medical Association have taken strong stances against the expansion of physical therapy to include this acupuncture method. Physical therapists are not appropriately educated on deep anatomic structures and how to safely insert needles into the body, nor are they educated on acupuncture safety, needle technique, western or eastern acupuncture theory, or the full complement of indications and contraindications for needle therapy. Acupuncture training for licensed acupuncturists nears 2000 hours, and for medical doctors is recommended to be a minimum of 300 hours after medical school and residency training. For this reason, the American Medical Association recently resolved, *"That our American Medical Association recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists."* (New House of Delegates policy as of June 2016.)

There is no agreed upon or otherwise vetted curriculum for Dry Needling. Courses offered to physical therapists run as short as 12 hours [see: <http://fishkincenter.com/dryneedlinginstitute/>]. Even longer courses in Dry Needling have no vetted curriculum, no outside certification testing, and no independent

examination of competency for instructors. These courses demonstrate the techniques in class, administer a test designed by the for-profit group offering the program, and then dismiss students to go back to practice and gain experience on unsuspecting patients. Therapists are often needling deep structures that can lead to pneumothorax and other complications, and patients are misled as to the level of training and experience the practitioner has. There have been reports such as this one caused by inadequately trained practitioners:

http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfmaude/detail.cfm?mdrfoi_id=5383935

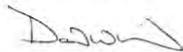
Further, classes teaching dry needling often reference acupuncture points and literature, and one of the main textbooks used is Biomedical Acupuncture for Pain Management by Yun-tao Ma, et al. In short, the dry needling movement is an effort to bypass the educational, testing, and safety standards put into place for acupuncture practice, through the simple renaming of the practice and the misleading of the public and regulatory bodies.

Many dry needling advocates claim that dry needling is a distinct western discipline arising out of the work of Janet Travell and David Simons. As a physician trained in both acupuncture and western medicine, I took as well 45 hours of advanced training in Myofascial Trigger Point Therapy (MTPT). This was a fraction of the approximately 200 hour program that explored hands-on techniques for treating trigger points via theory derived from Travell and Simons. The 45 hours I took was inadequate to fully prepare me to practice as a Myofascial Trigger Point Therapist (non-needle therapy). How then could a 12-56 hour course in dry needling begin to prepare a physical therapist or other provider to offer dry needling, an advanced skill set within MTPT, when the therapists have not even studied or showed mastery of the basic source material from which they claim dry needling is derived? There is nationally standardized board certification available in MTPT, so why is this not an absolute prerequisite to the use of an advance MTPT method? See <http://www.cbmtpt.org/> for more detail.

The potential harms of this movement include not only injury to patients, but also the direction of public and private healthcare funds towards paying for substandard treatment. The volume of claims submitted for this practice will skyrocket if it is widely permitted with access via a weekend course. Therapists will flock to a quick training, and begin billing for a procedure that they have added without adequate study or proof of minimal competency. Actual physical therapy service time will be diverted to the more easily billed and performed practice, and the public will be deprived of both vital, actual physical therapy services and high quality acupuncture services.

In short, dry needling is an essentially undefined practice and has no specific training requirements, competencies, certification testing, or continuing education requirements. It is indistinguishable from acupuncture and is in fact an acupuncture technique, and the field of acupuncture has defined these critical components. For the preservation of quality practice of both physical therapy and acupuncture, and for protection of the public safety and good use of healthcare funds, this technique should remain reserved for those fully dedicated to its mastery

Respectfully,



David W. Miller, M.D., FAAP, L.Ac., Dipl. OM
Chair, American Society of Acupuncturists

Letter from Massachusetts acupuncturist and physical therapy assistant providing an excellent overview of “dry needling” vs acupuncture. Please also refer to the letter submitted independently by Washington physical therapist and acupuncture student, Thi Nguyen.

George Leung, M.Ac., L.Ac., L.A.T.C., P.T.A., CKTP
East/West Sports Acupuncture & Orthopaedics
1683 Beacon Street, Suite #1
Brookline, MA 02445

July 29, 2015

To Governor Baker,

I am writing to express my concern about the safety and efficacy standard of care and level of intimate understanding of how acupuncture works as the Board reviews regulations for physical therapist. Dry Needling performed by health care professionals who are not trained in acupuncture such as the Physical Therapists discredited the profession of acupuncture medicine. Dry Needling is not a legal scope of practice in the state of Massachusetts by any allied health care professionals who not a licensed acupuncturists and is also not a reimbursable technique by medical insurances in the state of Massachusetts.

My name is George Leung, I am a Licensed Acupuncturist, Licensed Certified Athletic Trainer, and a Licensed Physical Therapy Assistant who had the opportunity to take the Dr. Ma Systemic Dry Needling for Sports Performance (Contemporary Dry Needling) three day course from 01/09/15-01/11/15 that was held at Central Mass Physical Therapy, 354 West Boylston Street, West Boylston, MA. I was the only Licensed Acupuncturist in attendance who also held credentials in Athletic Training and Physical Therapy, Allied Health Care Professional.

Licensed Acupuncturists are not permitted to attend any of the Dry Needling courses and I was able to because of my Athletic Training and Physical Therapy credentials. The course was taught by Sue Falsone, a Physical Therapist and Athletic Trainer but not a Acupuncturist. Sue instructed and demonstrated direct needling with acupuncture needles into various body part of the body using ½”, 1”, 2”, 3”, and 5” acupuncture needles throughout the course. Sue also taught and demonstrated the use of Cupping performing stationary and sliding cupping. The cupping was referred to as Vacuum Therapy in the course. Lastly, electro-acupuncture was taught and demonstrated using acupuncture alligator clips to an electrical stimulation unit to stimulate the acupuncture needle. This technique was referred to as intramuscular electrical stimulation. Sue Falsone is the owner of Dr. Ma Systemic Dry Needling and Integrative Dry Needling Institute and had been trained directly under Dr. MA himself to teach the Dry Needling courses. Within the course every participants performed and practice acupuncture needling, aka Dry Needling Therapy, using acupuncture needles, cupping (Vacuum Therapy), and electro-acupuncture (intramuscular electrical stimulation). The reference book used was called, Biomedicine Acupuncture for Sports and Trauma Rehabilitation and Biomedicine Acupuncture for Pain Management, written by Dr Yun-Tao Ma. Calling inserting a filiform acupuncture needle Dry Needling, and referring to the points as Trigger Points does not change the fact that Physical Therapists who are not licensed to do so are being trained to practice acupuncture and being taught that it is not acupuncture. This is a problem.

I went into the course having an open mind in hope of learning something new. Having training in both Eastern and Western Medicine I came out very disappointed to find out that Dry Needling, Cupping, and intramuscular electric stimulation was presented as a just another therapy modality and tool for health care practitioners who are not

acupuncturists to use to enhance their practices. No mention was made about any of the modalities in any relationship to Tradition Chinese Medicine (TCM). The main argument for Dry Needling not to be considered acupuncture is that it claims not to be Traditional Chinese Medicine acupuncture. The techniques they use are one method of treatment within TCM based on local acupuncture treatment for musculoskeletal issues that is commonly used in TCM acupuncture. The over simplification of a TCM medicine method with thousands of years of clinical and evidence based research and utilizing it as just another modality for physical therapist because they happen to be health care professions that the medical health insurances company recognized for reimbursement in the United States. The other main argument they gave for why Dry Needling is not consider acupuncture is that it's presented in biomedical terminology reasoning stating the technique only needles muscles, tendons, ligaments, and bony joint spaces instead. Dry Needling is acupuncture, using the same or similar TCM acupuncture points location and used finger widths measurement which is directly derived from the TCM acupuncture cun measurement for point location. The finger widths measurement was used to locate areas to needle for low back treatment. Dry Needling techniques are the same needling techniques within TCM acupuncture (perpendicular, oblique, horizontal, stationary, lift/thrust, and twirl), and cupping performing stationary and sliding cupping, and performing electro-acupuncture using acupuncture alligator clips on acupuncture stimulation units. Also none Dry Needling points were mentioned but not needle in the class referred to as homeostatic acu-reflex points that can be used to strengthen the Dry Needling effectiveness and are also TCM distal acupuncture points based on their locations on the body. Some of the acu-reflex points based on TCM acupuncture points location would be such points as Gall Bladder (GB-21, 30, 31, 34), Large Intestine (LI-4, LI-11), Spleen (SP-6, SP-9), Stomach (ST-36), Bladder (BL-57), and Liver (LV-3) to name a few.

The other concern I have is that 24-27 hours of training is clearly not adequate enough to perform needling technique correctly or safely with patients. Acupuncturists from an accredited master degree program are require to do a minimum of 700 hours of clinical training and over 2500 hours of course work with direct supervision treating patients with acupuncture needles to graduate. There was inadequate supervision and clinical training in safe needling technique and clean needle technique because there was only one instructor and one TA for over 30 students. The TA was only there for two of the three days so she could complete her required minimum of 54 hours to be legally able to practice Dry Needling in the state of North Carolina. I felt this did not provide adequate supervision for a class of 30 and more students. The only clean needle technique used was wearing disposable surgical gloves and finger condom gloves and rubbing alcohol was provided but not routinely used because Sue Falsone the instructor mentioned that rubbing alcohol is ineffective in protecting against any germs. During needle insertion demonstration the sterilized shaft of the acupuncture needle was held when being inserted into the body. This not allowed in Clean Needle Technique as practiced by acupuncturists and mandated by the NCCAOM Clean Needle Technique class all acupuncturist are required to take. At one point, the same acupuncture needle was used to insert into the same location by Sue Falsone the instructor. This is also a problem. I also observed my two practice partners doing the same thing when they were not unable to insert the acupuncture needle correctly at the first attempt. By law all the acupuncture needles are single use disposable, so the acupuncture needle should have been disposed properly and the instructor and the student partners should have used a new one. The students were only taught to just tap the acupuncture needle through the insertion tube, an acupuncture technique, and then inserted it into the skin and vibrate the skin with the non- inserted hand.

This is dangerous because Dry Needling is based on very deep needling until the tip of acupuncture needle hit the bone which may also involve some manipulating of the acupuncture needle so with only 24-27 hours of course work and practicing needling is unsafe

and can cause potential unpleasant injury to the patient such as severe bruising, muscle spasm, pain, and possible puncturing of actual internal organs. Inserting a acupuncture needle require proper skills and training which acupuncturists are proficient through accredited acupuncture schools. Another reason there is concern to the safety of Dry Needling is the use of various length and thickness of acupuncture needles ranging from ½” – 5” and thickness from 30 – 40 gauges that was used in the course. For example we were taught to use a 5” x 30 gauge acupuncture needle to use for the gluteus muscle and to me as an acupuncturist I have had advance needling techniques to show me how to properly insert a long acupuncture needle correctly without causing any discomfort or pain during insertion. Dry Needling practitioners were not in this class educated or skilled enough to insert such long acupuncture needles with proficiency.

Another safety issue was that Dry Needling technique are all deep needling until the needle touches the bone with no clear concise reasoning behind it except that the deeper you needle the stronger the effect. This present a potential safety issues of possible unnecessary inflicting injury to the patient with inadequate hour of clinical training. Another concern is the possible psychological effect of non-acupuncturists performing Dry Needling using acupuncture needle on their patients and causing a negative adverse effect experience that can potentially prevent patient from seeking an acupuncturist because of the concern of being needle with acupuncture needles again or another notion that acupuncture treatment is the same as Dry Needling treatment or that if Dry Needling didn't help then acupuncture won't either. Dry Needling is not legal, nor recognized by health insurance companies in the state of Massachusetts for the physical therapy professionals for insurance reimbursement. Also the physical therapy schooling is not acupuncture school. Acupuncture is a great tool and I encourage those who want to use it to go to school and get licensed to keep patients safe and keep the integrity of both Licensed Acupuncturists and Physical Therapists.

The other alarming concern I had was the accessibility of acupuncture needles and various acupuncture supplies through buyacupuncture.com and Lhaso OMS.com as long as someone mentions that they have taken Dr. Ma Dry Needling course and provide a copy of his/her physical therapy practice license number because of a direct relationship this two company have developed with Dr. Ma. This is not a good thing, because now, non-acupuncturists have the ability to purchase not just acupuncture needles but other acupuncture supplies that are strictly used only by the acupuncture profession, theoretically, by licensed acupuncturists. This could create further usage of acupuncture supplies by the physical therapy profession and being portray as just another modality to further enhance the Dry Needling technique. By allowing other health care professionals who practice Dry Needling to be able to go through Dr. Ma's buying account to me is not ethnical or professional to the profession of Acupuncture and those who have gone through Acupuncture School and the licensing process. It is a long and arduous process to make sure that those who practice acupuncture are qualified to do so.

Thank you for your time and patience in addressing my concern with the physical therapy profession of Massachusetts pushing to make Dry Needling as a legal scope of practice without appropriate hours of training and licensure coming from an Allied Health Care Professional; Licensed Athletic Trainer and Licensed Physical Therapist, and Licensed Acupuncturist.

Sincerely,

George Leung, M.Ac., L.Ac., L.ATC., PTA., CK

1) CPT

Current Procedural Terminology (CPT) is a system developed by the American Medical Association for standardizing the terminology and coding used to describe medical services and procedures. It is a systematic listing and coding of procedures/services performed by US physicians; a physician-related procedure identification system that serves as the basis for health care billing; CPT coding assigns a 5-digit code to each service or procedure provided by a physician.ⁱ

It has been stated that

“...anyone who bills an insurer must use CPT Codes. The AMA's CPT Code book specifies in its beginning pages that the clinician must use the code which *exactly* describes the technique they perform, not one which comes closest. If a clinician is using a technique which is not *exactly* what is stipulated in the CPT Code description, the instructions tell them to use a code for Unlisted Procedure...”ⁱⁱ

2) Acupuncture is a skilled invasive medical intervention that uses filiform needles to penetrate the skin and stimulate underlying tissues for therapeutic purposes. According to the American Association of Acupuncture and Oriental Medicine (AAAOM):

1. **Acupuncture as a technique** is the stimulation of specific anatomical locations on the body, alone or in combination, to treat disease, pain, and dysfunction.
2. **Acupuncture as a technique** includes the invasive or non-invasive stimulation of said locations by means of needles or other thermal, electrical, light, mechanical or manual therapeutic method.
3. **Acupuncture as a field of practice** is defined by the study of how the various acupuncture techniques can be applied to health and wellness.ⁱⁱⁱ

The filiform needle used in acupuncture is a solid-bore needle with a handle, a shaft, and a finely rounded tip designed to penetrate the skin without damaging skin cells or underlying tissues.

In 2004 The American Medical Association (AMA) assigned 4 Current Procedural Terminology (CPT) codes for acupuncture:

97810 Acupuncture, one or more needles,; without electrical stimulation,; initial 15 minutes of personal one-on-one contact with the patient;

97811 Each additional 15 minutes of personal one-on-one contact with the patient, with reinsertion of needle(s)

97813 Acupuncture, one or more needles,; with electrical stimulation,; initial 15 minutes of personal one-on-one contact with the patient;

97814 Each additional 15 minutes of personal one-on-one contact with the patient with re-insertion of needle(s)

Dry Needling

In Washington State, Labor and Industries (L&I) defines “dry needling” in the WAC

“...as a variant of trigger point injections..., dry needling is a technique performed by physicians who insert a needle directly into trigger points (sometimes with medication)... . The department allows such a procedure to be billed under the trigger point (injection) CPT codes, limiting the injections to 3 with written justification required if an additional 3 injections are to be administered.

The codes assigned to dry needling are:

20550: Injection of single tendon sheath, or ligament, aponeurosis,

20551: Single tendon origin insertion

20552: Injection(s); single or multiple trigger point(s), 1 or 2 muscles

20553: single or multiple trigger point(s), 3 or more muscles^{iv}

The term “dry needling” is derived from the use of hypodermic or “wet” needles to penetrate the skin for a therapeutic procedure that does not use an injectant, hence the term “dry”. It should be noted in the above that “dry needling is a technique performed by physicians” and is not authorized for use by Physical Therapists.

Dry Needling by Physical Therapists

The PTWA (Physical Therapy Association of Washington) describes Dry Needling as:

“...A skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments.”^v

According to the PTWA, the dry needling tool is a filiform needle. When used by Physical Therapists, the filiform needle is currently being called a “dry needle” and its use is being called “Dry Needling.” This is misleading and could be considered a source of confusion for legislators, policy-makers, and the general public. When using a filiform needle, dry needling is a *form* of acupuncture; and the term “Dry Needling” is just another *name* for acupuncture.

CPT Coding for Filiform-needle Dry Needling

As of this writing (July 2016), **there are no CPT codes for filiform-needle dry needling.**

However, since 2011, Physical Therapists have been using the CPT code for manual therapy, 97140, to code for dry needling.

97140 "Manual therapy" is defined as: "[a] collection of techniques in which hand movements are skillfully applied to mobilize joints and soft tissues."^{vi}

PTs have been taught to use **97140 (Manual Therapy)** by Jan Dommerholt, PT, DPT, MPS, DAAPM of **Myopain Seminars**. Dommerholt states in an online exchange with other practitioners:

“I believe that the best code for dry needling is 97140...There is controversy about how to bill for dry needling. Suggestions have included neuromuscular education, therapeutic activity, and others...I am not sure that dry needling should be considered as a separate billable item...but more as a technique within manual physical therapy practice.”^{vii}

In the online discussion, Dommerholt is contradicted:

“To me, dry needling is billed under 97799 (Unlisted Modality) until the American Medical Association (AMA) comes out in a CPT Assistant publication and tells me, you, and others otherwise... Just because you billed dry needling under 97140 and were paid for it does not mean you were supposed to be paid for it.”^{viii}

To which Dommerholt responds:

“...Dry needling should always be part of other manual procedures and as such is folded into the manual therapy code...dry needling is not a billable procedure as there is no specific code for dry needling...**Dry needling is not a modality that requires a CPT code.** Dry needling is just a treatment technique...”^{ix}

Contrary to this, the American Physical Therapy Association states that:

“...the use of CPT code 97140 for the performance of dry needling should not be utilized...**Currently, there is no CPT code that describes dry needling.**”^x

Dry Needling and (Gunn)-IMS

Gunn-IMS is a technique for the treatment of myofascial pain syndrome based on a comprehensive diagnostic and therapeutic model that identifies the etiology of myofascial pain as neuropathic...Gunn-IMS does not differ from dry needling (DN) in much of its technique, or the “how”...(except that) treatments occurring concurrently should...be discouraged...it is contraindicated to have joint manipulation immediately after Gunn-IMS...Gunn-IMS must be seen as a method to encourage normal function within the neuromuscular unit rather than a tool that loosens a muscle in order to allow for other mechanical treatments such as manipulation...Treat the patient once per week for the duration of symptoms using 30 minute appointments.^{xi}

How is this compatible with Physical Therapy? How is this the same as “...always be part of other manual procedures...”? Gunn-IMS is simply another form of deep-needle acupuncture designed to release neuropathic tension in the paraspinal muscles: “By using a needle, the clinician makes use of an ancient technique for stimulating the body. The ancient practice of acupuncture is credited with the discovery of the effects of

stimulation on the body.”^{xiii} Gunn just reinterpreted acupuncture from the point of view of Western Scientific terminology and interpretation: it’s still acupuncture. Thus, dry needling and IMS are both forms of acupuncture dressed up as a “new” modality. There are no CPT codes for these procedures. Technically, they’re more experimental than Traditional Chinese Medicine, and certainly not covered by health insurance.

Conclusion:

- 1) If there are no means (or CPT codes) by which to bill for dry needling and IMS, how can “dry needling” by Physical Therapists be of any cost savings? The cost of the procedure will be borne by the patient by way of an additional cash-paid intervention.
- 2) The term “dry needling” as described by the applicant is just another name for acupuncture. “Dry Needling” by PTs not a form of injection therapy. Dry Needling uses the same tools, filiform needles, for therapeutic purposes.
- 3) In light of this, the applicants fail to demonstrate that the proposal will provide the most cost-effective option to the public.

ⁱ McGraw-Hill Concise Dictionary of Modern Medicine. © 2002 by The McGraw-Hill Companies, Inc.

ⁱⁱ <http://www.remedyspot.com/content/topic/4412122-re-how-are-you-charging-for-dry-needling/>

ⁱⁱⁱ American Association of Acupuncture and Oriental Medicine (AAAOM) Position Statement on Trigger Point Dry Needling (TDN) and Intramuscular Manual Therapy (IMT), May 17 2011

^{iv} <http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/MARFS/Chapter16/default.asp>

^v Applicant Report: Dry Needling in PT Scope of Practice June 1, 2016

^{vi} Medical Dictionary, © 2009 Farlex and Partners.

^{vii} <http://www.remedyspot.com/content/topic/4412122-re-how-are-you-charging-for-dry-needling/>

^{viii} <http://www.remedyspot.com/content/topic/4412122-re-how-are-you-charging-for-dry-needling/>

^{ix} <http://www.remedyspot.com/content/topic/4412122-re-how-are-you-charging-for-dry-needling/>

^x http://www.iamt.org/wp-content/uploads/2014/04/APTASTatement_DryNeedling-2014.pdf

^{xi} Chapter 14: Intra-Muscular Stimulation (IMS) pp209-228“Trigger-Point Dry-Needling” J. Dommerholt and C.F. Fernandez-de-las-Penas 2013 Elsevier Ltd.

^{xii} Chapter 14: Intra-Muscular Stimulation (IMS) pp209-228“Trigger-Point Dry-Needling” J. Dommerholt and C.F. Fernandez-de-las-Penas 2013 Elsevier Ltd.

Comments by Jessica Martens, MSA, CCHM, EAMP

To the Washington State Department of Health
On the proposal to add dry needling to the
physical therapy scope of practice

Please accept these written comments as part of my submission before the Department of Health on the issue of expanding the scope of practice of physical therapists to include dry needling. My remarks focus on the application's treatment of safety. Indeed, protecting the public from harm is one of three key criteria to gauge whether an expansion of scope is warranted. It is a foundation of State policy.

I am licensed as an East Asian Medicine Practitioner (EAMP), and I have been in practice 10 years. I studied for 3 years to attain a Master's degree, with an additional 2 years of education in Chinese Herbal Medicine, and I passed the national examination of competence in needling/acupuncture administered by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM).

Safety Standards

Because penetrating human tissue with a needle is potentially dangerous, state law specifies training and competence standards to be met before medical professionals are allowed to needle their patients. The minimum legal standard to allow therapeutic needling in Washington State is licensure as an EAMP.¹ Licensure requires attaining specific, quantitative levels of theory and clinical training in both western and Asian medicine.² Gaining a license requires passing a national, accredited examination.³

Doctors of chiropractic and naturopathic physicians are very well-trained in their professions. When they want to add therapeutic needling, state policy directs them to add licensing as EAMPs. State law recognizes their western medical training, giving them one year of credit toward licensing as EAMPs.⁴ Physical therapists' training in the basics of western medicine matches that of chiropractors and naturopaths. The application fails to demonstrate why PTs should be allowed to bypass the training in needling theory and practice that DCs and NDs receive. There is no basis given in the application or materials for establishing an exception to meeting this well-established minimum standard of dual licensure.

State law and regulation specify that training should occur in state-approved programs⁵ and in accredited schools.⁶ In contrast, this proposal would set up a separate collection of standards and training for needling. It fails to demonstrate that it meets the established standard for educating people to needle human beings – licensure as an EAMP.

¹ Medical doctors, whose scope of practice includes using hypodermic needles, have even higher standards for needling. If an MD wants to add dry needling, which is acupuncture, s/he takes additional classes in "medical acupuncture." More on this below.

² RCW 18.06.050 and WAC 246-803-100 through 240

³ WAC 246-803-240

⁴ RCW 18.06.050(2)

⁵ RCW 18.06.060

⁶ WAC 246-803-110(3)

Recommendations from other Professions

At its fundamental level, this request asks if physical therapists should set up their own separate standards and regulations for an acupuncture procedure that already has existing statutory standards and regulations. The Washington East Asian Medicine Association says no, and we join the following professional organizations that say no.

- The American Medical Association,^{7,8} whose 2016 resolution states that dry needling should be performed only by licensed physicians and acupuncturists.⁹
- The American Academy of Physical Medicine and Rehabilitation,¹⁰ which observed that some professions do not routinely use needles; its position is that dry needling should be performed only by licensed acupuncturists or licensed medical physicians.
- The American Academy of Medical Acupuncture,¹¹ which pointed out that non-physicians must have over 2,000 hours of clinical and didactic training before needling patients in most states. Its policy, adopted unanimously by its Board of Directors, is that only licensed acupuncturists and physicians should be allowed to perform dry needling.
- The World Health Organization published guidelines containing the most basic levels of training for health professionals wishing to add therapeutic needling. They would require 2,000 hours of training for non-physicians.

There's a reason these professional associations and certifying bodies set high standards. They recognize the importance of specific, deep training in what and where and why points are needed. Dry needling/acupuncture is an invasive practice and potentially harmful. Society has determined that 2,000 hours of training for non-physicians is the standard for those who needle.

In contrast, the application would allow PTs to needle after 54 hours of instruction. The applicant report is based on an introspective listing of what PTs thought should be included. Nowhere does the application compare 54 hours with 2,000 hours of training – or even the 300 incremental hours of education which MDs take.

⁷ RESOLVED, That our American Medical Association recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.

⁸ From the AMA news release, accessed July 11, 2016: "The AMA adopted a policy that said physical therapists and other non-physicians practicing dry needling should – at a minimum – have standards that are similar to the ones for training, certification and continuing education that exist for acupuncture.

"Lax regulation and nonexistent standards surround this invasive practice. For patients' safety, practitioners should meet standards required for licensed acupuncturists and physicians," AMA Board Member Russell W. H. Kridel, M.D." <http://www.ama-assn.org/ama/pub/news/news/2016/2016-06-15-new-policies-annual-meeting.page>

⁹ Physicians wishing to be certified as "medical acupuncturists" undertake an additional 300 hours of training, including supervised clinical work.

¹⁰ AAPM&R Position on Dry Needling, adopted June, 2012

¹¹ AAMA Policy on Dry-Needling, adopted December 9, 2014

The application also fails to compare its vague standard for assessing competency to such well-established standards as those of the AAMA and NCCAOM.

Safety Record of Dry Needling

PTWA included in its submission on safety an article by Brady *et al.* which describes incidents self-reported by 39 physiotherapists over nine months in Ireland. Although Brady's limited report received no reported incidents of significant or severe outcomes, four other researchers reported 5,000 significant adverse events and 11 serious adverse events, including 4 pneumothorax cases.

I have included a summary of a systematic review, published in 2015 by Physiotherapy Alberta,¹² entitled "FAQ: Dry Needling Adverse Events." Although most of the adverse events reported were not severe, the rate of events was significantly higher for dry needling than for acupuncture – almost twice the rate in one study (the least), and twenty times the rate in another study.

Looking beyond the single Brady study, a deeper and broader review of literature reveals the following:¹³

- "Dry needling is likely to result in an increased incidence of serious risks, particularly pneumothorax, due to the short training courses and deep needling techniques which typify the practice."¹⁴
- The authors [Ernst] observe that all deaths would likely be avoided with adequate acupuncture training.¹⁵
- [From a different literature review]: Adverse events would be avoided if all acupuncturists were trained to a high level of competency.¹⁶
- [From an Australian study]: Adverse event rates for practitioners with 0–12 months of CAM (complementary and alternative medicine) education were significantly higher than for those with 37–60 months education.¹⁷

The submission in support of dry needling fails to demonstrate that the proposed 54 hour training will protect the public from harm. All of the studies cited here provide evidence that Washington's minimum standard for training – licensure as EAMPs – should apply to physical therapists wishing to add acupuncture/dry needling to their practice.

¹² Physiotherapy Alberta is the organization responsible for regulating the practice of physiotherapy in the province.

¹³ Reported in Janz S and Adams J. Acupuncture by Another Name: Dry Needling in Australia. *AUST J Acupunct Chin Med* 2011;6(2):3-11.

¹⁴ Janz *ibid.*

¹⁵ Ernst E. Deaths after acupuncture: A systematic review. *International Journal of Risk & Safety in Medicine* 2010;22:131–6.

¹⁶ Ernst E, Lee MS, Choi T-Y. Acupuncture: Does it alleviate pain and are there serious risks? A review of reviews. *Pain* 2011;152(4):755–64.

¹⁷ Myers SP, Cheras PA. The other side of the coin: safety of complementary and alternative medicine. *Medical Journal of Australia* 2004;181(4):222–5.

Conclusion

Washington State has established a minimum standard for training and competence in needling patients: licensing as East Asian Medicine Practitioners. Chiropractors and naturopaths acquire dual licenses when they add needling to their practice.

Other medical professions have reviewed dry needling by physical therapists and recommended that only those licensed as physicians or acupuncturists be allowed to needle. The WHO has set basic standards similar to Washington standards for EAMPs.

Options exist for physical therapists who believe their patients would benefit from dry needling/acupuncture: they can refer patients to fully trained and licensed EAMPs, or they can follow established policy and gain dual licensure, as numerous naturopaths and chiropractors have done.

In contrast, the application seeks to bypass the established path to safe needling practice – dual licensure. However, it fails to demonstrate that its proposal will protect the public from harm – one of the three elements that are required if increasing a scope of practice. It also fails to describe accurately the problems associated with needling patients without full training.

For these reasons, I urge to Department of Health to find that the application, as written, does not meet the statutory criteria to increase the scope of physical therapy. It should be denied.



Introduction

Dry needling is associated with risks that can lead to adverse events. Physiotherapists are legally obligated to ensure they obtain informed consent from their patients. The dry needling informed consent process requires material risks and special risks of treatment be disclosed to patients.¹⁴

Research into adverse events related to dry needling is continually evolving. There are wide variations in research design including differences in the classification of adverse events which, for physiotherapists, makes interpretation and comparison between studies difficult, thus adding to the complexity of the risk disclosure process.⁸

Prior to 2014, only large scale studies examining adverse events related to acupuncture were available.^{4,5,10,12,18,19-22} Brady et al are the first to publish a prospective study of adverse events related to trigger point/IMS dry needling.¹

To support physiotherapist's communication with patients about the risks of dry needling, questions about adverse events associated with acupuncture and trigger point needling are answered.

1. What types of adverse events are related to dry needling?

White et al used the following system to classify adverse outcomes associated with acupuncture combining several reports including a prospective study examining 31,822 treatments.^{19,21}

- Mild (minor) - short duration, reversible, does not inconvenience the patient.
- Significant - requires medical intervention or interferes with patient's activities.
- Serious - requires hospital admission with potential persistent or significant disability or death.

Mild (Minor)	Significant	Serious
<ul style="list-style-type: none"> • Bruising • Bleeding • Pain during treatment • Pain following treatment • Aggravation of symptoms followed by improvement • Feeling relaxed/energized • Feeling tired/drowsy • Feeling faint • Dizzy • Nausea • Sweating 	<ul style="list-style-type: none"> • Prolonged pain at site • Extensive bruising • Profuse sweating • Severe nausea • Vomiting • Fainting • Headache • Extreme fatigue • Severe emotional reaction • Gastrointestinal disturbance • Skin irritation • Slurred speech • Forgotten needle/patient • Seizure 	<ul style="list-style-type: none"> • Pneumothorax • Puncture of other vital tissue • Systemic Infection • Broken needle

[#] Adapted from White 19-21, MacPherson 10 Witt 22

Dry needling includes acupuncture, intramuscular stimulation, trigger point needling and other forms of needling with a solid filament style needle (i.e., Gohavi technique, motor point needling).

Adverse event: An unexpected and undesired incident directly associated with the care or services provided to the patient; an incident that occurs during the process of providing health care and results in patient injury or death; or an adverse outcome for a patient, including an injury or complication. The act of puncturing the skin comes with a number of predictable adverse events (bruising or bleeding, pain during or following treatment) which commonly occur and are mild in nature. A physiotherapist may consider these normal side effects of treatment. However, from the patient's perspective they may be considered adverse particularly if the patient has not been educated about the risks associated with their dry needling technique.

Other prospective acupuncture safety studies describe similar events but may group the mild and significant events differently.^{5,10,12,18,23} Between studies there is general agreement as to what constitutes a serious adverse event.

Brady et al studied adverse events in 7,629 dry needling/trigger point treatments and found that the types of adverse events that occurred are similar to that experienced with acupuncture.¹ A limitation of this groundbreaking study is the number of treatments is relatively small compared to acupuncture studies. All adverse events were classified as mild with the most frequent being bleeding, bruising, pain during treatment and pain after treatment.

Physiotherapists who perform needling are expected to regularly scan the literature to ensure their knowledge of probability and severity of risks associated with the dry needling technique they perform is current.

2. Are all significant or serious adverse events discussed in the information above?

No. For example cases of cardiac tamponade have been reported twice in the literature but in the large-scale prospective studies did not occur.^{4,20} Only conditions that occurred more frequently in the large studies were listed herein.

3. How frequently do adverse events occur?

The European Commission Classification System for medicinal products⁷ has been used to discuss adverse events related to dry needling.^{1,22}

Very Common	Common	Uncommon	Rare	Very Rare
>1/10 people treated	1-10/100 people treated	1-10/1000 people treated	1-10/10,000 people treated	< 1/10000 people treated
≥10%	≥1-10%	≥0.1% - 1%	≥0.01% - 0.1%	<0.01%

The Health Quality of Council of Alberta compared dry needling adverse events across studies⁸ and found that:

- Minor adverse events occur more frequently.
- Serious adverse event are very rare (0.04/10000 treatments).
- Pneumothorax is the most common serious adverse event and is very rare (0.01/10000 treatments).

Number of adverse outcomes reported in prospective research studies				
Research Study	# of treatments	Minor Adverse Outcome	Significant Adverse Outcome	Serious Adverse Outcome
White et al 2001	31,822 treatments	2,135	43	0
MacPherson et al 2001	34,407 treatments	10,920	43	0
Melchart et al 2004	760,000 treatments (97,733 patients)	6,936		6 (includes 2 pneumothorax cases)
Witt et al 2009	2.2 million treatments (229,230 patients)	1,976	4,963	5 (includes 2 pneumothorax cases)
Brady et al 2014	7,629 treatments	1,463	0	0
Total	3,033,858 treatments			11 serious events includes 4 pneumothorax cases

Case studies describing singular events of pneumothorax following dry needling indicate that patients were seeking treatment for a wide variety of conditions such as tension headaches, asthma, chronic cough or other breathing problems pain in the shoulder, neck, or low back regions, and complex regional pain syndrome.^{4,5}

4. Are there differences in occurrence of adverse events between acupuncture and trigger point needling?

Yes.

Acupuncture Adverse Event Rates

- Acupuncture studies report varying adverse event rates ranging from 0.9% to 11.4% (0.9%¹⁰, 0.14%²³, 7%²¹, 8.6%²², 11.4%⁵).

- Acupuncture adverse event rates in 2.2 million acupuncture treatments performed by physicians.²²
 - 19,726 of 229,230 (8.6%) patients reported experiencing at least one side effect of acupuncture.
 - Adverse events requiring treatment occurred in 2.2% of patients.
 - 39.4% of events occurred during treatment.
 - 60.6% of events occurred after treatment.
- Adverse events ranked in order of frequency of occurrence were:
 - Minor bleeding and haematoma (6.1%)
 - Pain during treatment (0.21%)
 - Pain any type (2.04%)
 - Vegetative (i.e., adverse autonomic nervous system) symptoms (0.7%)
 - Inflammation (0.31)
 - Nerve irritation/injury (0.26%)
- Adverse events due to negligence such as forgotten needle, pneumothorax comprised 0.1% of all events.
- There were no acupuncture-associated deaths or permanent injuries associated with the acupuncture treatments.

Trigger Point Dry Needling Adverse Event Rates¹

- Based on 7,629 trigger point needling treatments performed by physiotherapists.
- 1,463 adverse events were reported (19.18%).
- Adverse events ranked in order of frequency of occurrence were:
 - Bleeding 7.5% (7.55/100)
 - Bruising 5% (4.65/100)
 - Pain during treatment 3% (3.01/100)
 - Pain after treatment 2% (2.19)

Key points

- Using the European Commission Classification system,^{1,7,22} adverse events are:
 - A common occurrence when performing acupuncture.
 - A very common occurrence for trigger point dry needling.
- Most adverse events are mild in nature.
- When comparing studies on adverse events associated with acupuncture and with trigger point needling there are similarities and slight differences in the side effects patients experience.
 - Bleeding, bruising and pain are the top three side effects for dry needling and are mild in nature.

- Pain during needling occurs more frequently with trigger point needling than with acupuncture.
- Pain (during and following treatment) occurs more frequently with trigger point needling than with acupuncture.
- Serious adverse events from dry needling are very rare.
- Pneumothorax is the most common serious adverse event associated with dry needling and is very rare.

5. How do I apply this information to the disclosure process?

- When informing patients about dry needling risks, you do not have to quote statistics from the research reports. Disclose the material and special risks related to your practice context meeting your patient's informational needs.
- Bear in mind, the information provided herein provides an overview of dry needling risks from published studies. It paints a broad overview of dry needling risks. Rates of adverse events will vary from practitioner to practitioner as exemplified in Brady's study¹ which identified a subgroup of physiotherapists who had higher rates of mild adverse events than the overall group. You may be missing factual information about the rates of adverse events in your practice. As such your challenge is to combine the research information with your rate of adverse events occurrence and apply this to your disclosure process.
- Analyze your practice to gain a sense of how frequently adverse events occur. Use this information to inform the disclosure process.
 - Can you adapt the classification system for European Medicinal Products to analyze the number of adverse events that occur in your practice?
 - How frequently do your patients experience mild adverse events?
 - Are the frequency of risks reported here the same for your practice?
 - Can you use your practice data in the risk disclosure process?
- When discussing risks with patients:
 - Most physiotherapists will be able to say with confidence that they have never had a patient with a serious adverse event and defer to the research that there is a very rare risk of pneumothorax.
 - Other physiotherapists may have experienced significant or serious dry needling adverse events at rates greater than reported literature and should defer to their own practice data when discussing dry needling risks.
 - The fact that one has never experienced a serious patient safety event in their practice does not predict that one will never experience one in the future.
- Remember consent is an ongoing process. In subsequent dry needling treatments it is prudent to remind patients about the risks of dry needling and, when appropriate, educate patients on self-management of adverse events when they occur.

References are listed in the Dry Needling Resources Reference List.

Physiotherapy Alberta regulates and leads the practice of physiotherapy in Alberta. Contact us for more information on this or other practice guidelines.

780.438.0338 | 1.800.291.2782
 info@physiotherapyalberta.ca
 www.physiotherapyalberta.ca



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
PO Box 47852 · Olympia Washington 98504-7852

August 1, 2016

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Sunrise Reviews
P. O. Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas:

The members of the Washington State East Asian Medicine Advisory Committee would like to express their concerns regarding the sunrise proposal to add dry needling to the physical therapy scope of practice.

Listed below are our specific concerns with the sunrise proposal:

- There is a grave concern of dry needling not being regarded as acupuncture, as there is no meaningful distinction to be made between dry needling and acupuncture;
- Fifty-four (54) hours of clinical training is woefully inadequate and it does not include supervised clinical hours; and
- There needs to be communication and collaboration between the Washington East Asian Medicine Association (WEAMA) and the Physical Therapy Association of Washington (PTWA.)

The committee does not support this sunrise proposal. If you have any questions or need additional information, please contact our Executive Director, Trina Crawford, at 360-236-4890 or email at trina.crawford@doh.wa.gov. Thank you for your consideration of our comments and your support of public safety.

Sincerely,

Jacob Godwin, Vice-Chair, DAOM, EAMP
East Asian Medicine Advisory Committee

Physical Therapy Dry Needling Sunrise Hearing
Written Comments Received After Public Hearing
August 16, 2016

For the past twenty years I have had the honor of serving in the US Armed Forces, the last four as a physical therapist for an Air Force Special Operations unit. Five years ago I was trained and credentialed in dry needling, which I have since safely performed on many of my patients. Not only have I found it to be an extremely effective treatment, but it has had a tremendous impact on reducing the treatment time necessary to get my military patients better. This is vital because I often had only a few days to treat my guys before they were gone again. Many of them were used to sucking it up and driving on, much to their own physical detriment. Once they found that I could help them get better and do it quickly, they were my best advocates to others that were injured. Special Operations is a tough crowd in which to gain credibility. I've had patients with chronic low back pain from four years of jumping out of airplanes bend over and pick up 300lbs from the floor without pain. I've had multiple patients that couldn't lift one or both arms over shoulder height get off of my treatment table and immediately raise their hands over head without pain. Over the last four years, I successfully reduced the overall rate of chronically injured personnel by 60% and my ability to use dry needling played a crucial role.

Needles are a tool, not restricted to any one function or profession. Dry needling is a targeted procedure used to restore muscle function and accelerate pain reduction. It is based in a western medical understanding of anatomy, neurology, and physiology. Just as hospitals were once the only places to find defibrillators, we now find it more advantageous to patients to have increased access to this tool. Emergency defibrillators are now found in schools, in theatres, and in churches, because access to this tool HELPS people. The same can be said of dry needling. This is a tool that is not available to our patients in need of treatment. It is our duty to assure that our Washington citizens have access to every safe available resource to increase and maintain their quality of life.

On March 20, 2015 the physical therapist for the Seahawks sat here and testified about the significant positive impacts that the safe practice of dry needling had on his practice. In fact, his players wrote letters attesting to that fact. Since then, he has ceased using this tool. Of note both of this year's Super Bowl contenders come from Colorado and North Carolina, states in which dry needling is legal for physical therapists to freely and safely utilize in the care and treatment of their patients.

Jon C Neumann, PT, Major, Retired, US Air Force

Please find attached a letter from a client who has received dry needling in the state of Iowa and wished it was available from Physical Therapists here in the state of Washington. Please submit as evidence of support in the Sunrise Review case for Dry Needling.

Thank you! Erik Moen PT

On February 7, 2015, in Duque Iowa I sustained bilateral calcaneus fractures in a skiing accident. My left calcaneus was shattered and had to undergo reconstructive surgery and my right was badly fractured.

One of the major barriers I faced during my recovery in Iowa was effective myofascial release. Under the effective, safe, and professional care of my physical therapist I was treated with very effective, and very specific dry needling techniques. These treatments were extremely effective in providing the myofascial release I needed to continue to improve.

Furthermore, the results of such treatments (which were nearly 10) proved to be a *very* effective, safe, professional, and very critical component to aiding the healing and restoration of my feet, ankles, and legs.

Due to the severe nature of my injuries I am still recovering and rely upon the aid and assistance of a professional physical therapist. My family and I moved to Washington State on June 15th, 2016 and am grieved to discover dry needling is not an option, currently.

As a responsible, intentional and healing patient, who is still recovering from a severe accident, I request that dry needling is immediately made available to all current (and future patients), including myself, who need the help this treatment provides.

Stephan Peck

I testified at the physical therapy sunrise review committee on August 2, 2016. At that hearing, I presented evidence of serious adverse events/injuries and harm caused by physical therapists inserting acupuncture needles through the skin and into patients' bodies, contrary to the applicant's claim that are no serious adverse events caused by physical therapists performing acupuncture under the term dry needling.

Because of time constraints, I was not able to read the entirety of my statement, but submitted the written version, along with documented examples and sources for those injuries. Attached please find the letter (PDF) of Emily Kuykendall, a high school biology teacher who received dry needling from a physical therapist in Maryland in 2013. The physical therapist who performed the treatment punctured a nerve in Ms. Kuykendall's leg, causing serious pain and suffering which necessitated drug therapy. Ms. Kuykendall describes her ordeal and the nature of her injury in detail in this letter, along with a photo of site of the injury.

Please accept this documentation as a supplement to my written comments. I respectfully ask that this letter be entered into the official record of these proceedings. If you require further information regarding serious adverse events/injuries and harm caused by physical therapists inserting acupuncture needles through the skin and into patients' bodies, please contact me and I will be happy to assist you.

John Moore, EAMP, LAc

I am a 24-year-old woman who other than vulvodynia was perfectly healthy and now I am in a worst state after a first & last "dry needling" experience meant to just help with inner thigh muscle tightness associated with vulvodynia—diagnosed at Johns Hopkins in Baltimore, Maryland this past spring. My primary doctor believes that the location of the 2 inch "dry needling" bruise shows where the "dry needling" physical therapist hit a particular nerve-- between the knee and bend of the leg, inner left thigh where the seam of a pants leg would be-- which hit would explain the pain down my legs and up my spine. I have had sharp & dull pain from head to toe--literally from my both jaws to both feet. Please see attached of a bruise, approximately 2 inches in diameter on my upper inner left thigh near my knee. My acupuncturist, Dr. Tiru Liang, who has been practicing for over 35 years, examined the bruise on

Friday, October 5th—she was appalled by the bruise left by the physical therapist, Ms. Dionne Hawkins, who does not have a medical degree and who has not been practicing “needling” nearly as long as she has.

I would like to share the specific details with you, because I would like to prevent this kind of incident from ever happening to anyone else in the state of Maryland; hopefully, this will come to light somehow at the national level.

As mentioned in the previous email, I have found it more difficult this weekend to reverse in order to park safely (I think that this comes in part from my back stiffening on the patient table, bracing from the excruciating “dry needling” on Thursday, October 4th, and from the stress of repeatedly crying and yelling “stop” to the physical therapist).

Unlike other teachers, a high school science teacher has added legal responsibilities to ensure the safety of adolescents during laboratory experiments. On Friday, October 5th, my primary doctor gave me two prescriptions to help alleviate the sharp and dull pain which I am experiencing literally from head to toe (left foot to left jaw—please note my bruise on my left leg, the “dry needle” caused immense “electrical” pain around my left knee cap—a pain I have never experienced in my whole life and I wish to never experience again). I am still experiencing sharp and dull pain even with Cymbalta for my muscular/neural pain, over-the-counter Aleve, and prescription Naproxen. Dr. Diener also gave me Alprazolam to help to calm me down from the “dry needling” pain, but I am still very emotionally distressed. I feel that the combination of prescriptions has made me very lethargic and less observant about my surroundings. As a high school science teacher, I need to be very sharp and on my toes constantly from the time the bell rings at 7:20am to 2:10pm—ready for any kind of medical emergency which may arise from using various chemicals or tools in the lab. I cannot simply call in for a substitute teacher easily, because substitute teachers do not have the necessary safety certification and substitutes would be a liability for the school system. I have already lost a week of work and may lose more time in order to see various neurologists.

Growing up in a household with a father who has a PhD in microbiology, I used Western medicine most of my life—until this past year. Since August, I have seen a wonderful acupuncturist and doctor, Dr. Tiru Liang in Clarksville, Maryland. Since the first time which I

saw her, I have had incredible positive results. I have experienced less pain and anxiety associated with the pain. I think very highly of her. Every time I see her, she asks me how I am doing on multiple levels—physically and emotionally. Once she administers the acupuncture needles, I hardly feel them (because she’s that good)—the only thing that I feel is the slight burn of the alcohol, which is completely understandable to prevent any kind of infection. I know that I can count on her for a “same day” emergency appointment. I recommend Dr. Tiru Liang to various fellow co-workers, including my principal, assistant principal, retired board of education member, and my vulvodinia specialist at Johns Hopkins. In other words, I understand how “needling” should be done, because of my exceptional experience with an acupuncturist and medical doctor. That has acted as a baseline for comparison—the traumatizing “dry needling” experience with physical therapist Dionne Hawkins on Thursday, October 4th, 2012 at 6:30pm (who does not hold a medical degree).

Since October 4th, I have had a range of physical symptoms—sharp & dull pain from head to toe, “pins & needles” sensation down my legs, and numbing sensation down the legs and lower spine. I thought that the sharp pain was scary, but the numbness is terrifying. I will never forget the look of my students' faces as I sat stiffly in the front of the classroom that Friday, bawling in pain from the "dry needling," looking for substitute afternoon coverage, so I could have emergency visits with my doctors. My freshman gifted and talented biology students looked like they were about to cry--they were scared for me. I am in a position of authority. I am supposed to be the strong one for them.

I have been having horrible dreams since the "dry needling" incident and I do not know if they can be attributed to the prescriptions to deal with the "dry needling" or simply the anxiety behind the incident. I have had a dream that the "dry needling" was happening all over again and woke up terrified in the middle of the night. I think that the dream was caused by actual physical pain which felt like pricks of those needles in my right thigh--and the pain which I was actually feeling when I woke up was somehow manifested or integrated into the dream itself. I have also had a dream that my feet were turning blue in the emergency room of Howard County General Hospital and they had to call my neurologist in the middle of the night to come in. I woke up terrified that I wouldn't be able to move. Logically, though, I knew that I had had a dream. I was scared before I had gone to bed last night, because I went to our local Giant grocery store and I felt like I was walking with heavy shoes on as I was going down the aisles, because of the numbness sensation in my feet, legs, and bottom. Right before I had gone to bed, I told my parents that I was scared about the numbness progressing overnight as it rapidly as it had throughout the day yesterday and I did tell them that I was scared about not being able to move much in the morning. The anxiety before bed last night about the

numbness may have contributed to the horrible dreams. Usually, I don't remember most of my dreams and usually, I hardly ever have nightmares. These dreams have truly scared me.

This is really taking a physical and emotional toll on me. **There is almost not a minute in the day that goes by that I wish that I had not gone to see Ms. Hawkins.** Almost every day I have cried either at home or work or both--and I look forward to the opportunity after doctors, and nurses, and specialists, and lawyers, when I can just go home and crawl in bed and rest my from this new pain after such a long day.

Medical director & neurologist Dr. Gerwin (and well-known proponent of “dry needling”), concluded that I had been “violated” by physical therapist Ms. Dionne Hawkins—causing physical & emotional damage from the “dry needling.” The appointment was nearly 3 hours long. He conducted a very thorough examination of me from head to toe, took very thorough notes on his laptop computer, and provided a lengthy medical explanation for my pain from head to toe--he is one of the best doctors I have ever meet--I can clearly see why he is a medical director. He said that he had consulted with his co-director Mr. Dommerholt, the first physical therapist to teach “dry needling” in the U.S. prior to my appointment. Dr. Gerwin is typing up a formal report, which he said that I can disseminate to whomever I wish, including Executive Director Curry of the Maryland Board of Physical Therapy Examiners.

I understand that Dr. Tracey Adler in Richmond, VA specializes in pelvic pain AND “dry needling.” In her article, [“Trigger-Point Needle Helps Relieve Chronic Pain” \(PDF\)](#), in the July 26, 2008, *Richmond Times Dispatch*, Dr. Adler said, **“Inserting the needle doesn't hurt...and although patients may be sore afterward, their chronic pain is gone** because the pain is treated at the source.” Dr. Adler assisted me in getting an appointment with medical director Dr. Gerwin. Logically, it seems that a tool which has the potential to be extremely beneficial to patients, also has the potential to be very detrimental if put into the wrong hands—I am still having sharp & dull pain weeks after my “dry needling” appointment despite taking Cymbalta, Naproxen, Alprazolam, Acetaminophen, Flexeril, Gabapentin, and taking a B12 supplement.

If you need the Physical Therapy Board to listen, here is an actual patient complaint of injury. There may be others out there who are not in the same position that I am in; others who may not have the financial resources/capital or knowledge to know how to be a self-advocate and/or find a legal advocate. There may be some in the medical field who are afraid to speak out—afraid of the possible repercussions to their medical career. As a public school science teacher and member of various science teacher organizations and associations at the local and national level, I believe in making the general public more knowledgeable in the field of science. It is a matter of individual safety and safety of their loved ones. “Dry needling” is an issue which not only Maryland citizens need to receive further education about, but also American citizens as a whole nationwide need to be better informed and protected. How many people will need to be hurt for the Board of Acupuncturists and the Board of Physical Therapists to agree upon the vague wording and misinterpretations of “dry needling” with respect to physical therapists? Change needs to happen now.

Please feel free to contact me by email with questions or concerns. Thank you for your time.

Miss Emily Kuykendall, M.Ed., Biology Teacher – Regular, Honors, Gifted & Talented
Ellicott City, MD

I am writing to object in the strongest terms possible to the issue of SB 6374 / HB 2606 that expands the scope of physical therapists to include acupuncture, which they label as “dry needling.”

So-called “dry needling” with a minimum of 54 hours of training is a boiled-down, simplified, cartoon version of acupuncture. We acupuncturists do what we do because it works, but we have trained infinitely longer and in more depth than the bare minimum requirements for physical therapists to do something

that mimics—badly—what we do. Meanwhile, we acupuncturists are not practicing physical therapy on anyone and calling it “Chinese Medicine Body Manipulation” or “Asian Physio” and charging for that as a modality ... because that would not make sense (plus PTs would not stand for it)! That is, acupuncturists are not co-opting what PTs do, because they are the ones trained in that! We often refer people for physical therapy; we don’t suddenly decide that in addition to acupuncture and Chinese medicine we should also start evaluating and treating people with our own brand of “physical therapy.” They are two separate fields, each requiring extensive and lengthy training.

I am a master’s degree graduate of the New England School of Acupuncture, the country’s oldest school of acupuncture and Chinese medicine. I attended school for 3.5 years and then passed the rigorous multi-part national board exam given by the National Certification Commission for Acupuncture and Oriental Medicine. I have been in practice for 20 years, with the last 12 in Washington state.

When I moved to Washington from another state I simply assumed that my education at a renowned school plus eight years of private practice assured me of encountering no problems with transferring my license. I discovered that the Washington State Department of Health has extremely stringent requirements for licensure that caused me to have to back up my credentials with plenty of documentation and detailed course descriptions. While I was dismayed by the extra hoops, at the same time I was impressed with the thoroughness of the DOH’s examination of my claims to competence. This is as it should be! It spoke highly of the level of professionalism I would come to know in the field of acupuncture in this state.

I would urge that this same level of stringency, caution, and scrutiny be applied in the matter of physical therapists desiring to co-opt from acupuncturists the insertion of needles into people as a modality in their scope of practice. There are numerous news articles and anecdotal reports about injuries—some of them serious—and painful experiences via PTs using needles without proper training or background knowledge. In the 3.5 years of acupuncture schooling, we were constantly being shown proper and safe use of needles to prevent injuries—we first practiced on ourselves, then each other, and then many hours in closely supervised clinical settings with volunteer patients. Physical therapists inserting needles after only 54 hours of what is basically a cookie-cutter kind of training of trigger points is counter to all that we acupuncturists learned, studied, practiced, and took to heart about the body and about safe-needle protocol.

There is no room for overlap, nor a reason for overlap! Inserting needles in someone is serious business, and this is why schools of acupuncture and Chinese medicine in this country train students long and hard in the high standards of safety required to prevent injuries and in the theories behind point selection. It’s not a matter for a week-long class. I vehemently urge the rejection of this bill.

—Nancy, MAc, EAMP

I am a primary care doctor in Seattle. I have been in practice for 15 years. I would like to express my concern for the current plan to allow physical therapists to perform dry needling with minimal training. When I started practicing 15 years ago, there was a very different attitude in the medical community around treating chronic pain. The mantra I learned in medical school was that if patients said they were in pain, you needed to believe them, and treat the pain aggressively—even if that meant using escalating doses and long-term use of opiates. We learned about patients suing doctors for failing to adequately treat pain.

This misguided attempt to ease pain, in turn, created the opiate epidemic. I saw personally what happened to my patients on high-dose opiates. They didn’t get better, they were still in pain, and they became addicted to opiates.

Now, as a medical community, we know better and use opiates much more cautiously. We, now more than ever, need other effective ways to treat pain. I refer patients to PT for physical therapy and I refer

patients to licensed acupuncturists for acupuncture. I am concerned that if PT's perform dry needling without the extensive training that acupuncturists/medical acupuncturists undergo, patients won't improve. If they experience dry needling that doesn't work during PT, referring them to an acupuncturist will be a harder sell. This could cause us to lose an important modality in treating chronic pain.

Finally, I think there can be something empirically healing in the process of seeing acupuncturist--in tapping into the mind-body connection. It may be placebo but it seems to work. I have had patients who get acupuncture in medical acupuncture settings say they didn't like it because it "was too clinical." I fear putting in a few needles at the end of a PT session won't have the same healing effect.

In summary, I think acupuncture is an important modality in treating chronic pain in today's opiate epidemic. I would hope that physical therapists or any other medical provider would have comparable training as a licensed acupuncturist if they are going to be performing that treatment, even if it has a different name.

Jessica Rongitsch MD

I attended the sunrise review on the topic of dry needling earlier this week and really appreciated the opportunity to learn from the many different perspectives shared on this issue. Hearing how open minded, respectful, and interested board members seemed in wanting to learn about all perspectives on this issue made me want to write today to share my own as a physical therapy student. I am just finishing my second year of the physical therapy program at University of Washington and will begin 9 months of clinical internships beginning this September before graduating June 2017.

Through the last two years of classes and clinical experiences, I have worked very hard in and outside of my classes to develop the skills and knowledge necessary to feel like I can provide the best care to my patients when I graduate. I have had extensive coursework in topics of anatomy and physiology, neurology, patient examination, patient care, and differential diagnosis, as well as clinical experiences allowing me to practice examination and treatment skills and think critically about whether specific treatment techniques can be safely used on each patient given their specific presentation. I have developed confidence in my knowledge of anatomy and physiology that I have worked so hard to gain during this program and after researching the procedure of dry needling, I feel with this knowledge and additional training on the specific technique of dry needling that my colleagues and I would safely and effectively be able to use this technique in order to provide the best care for our future patients. I want to feel like when I start my career as a physical therapist, I will be able to have an extensive toolbox of safe and effective techniques for musculoskeletal conditions available to me that I can access based on an individual patient's presentation and what they will benefit the most from. In our program, we are being trained to be experts on the musculoskeletal system and I do not think it should be considered outside our scope of practice to be able to use a musculoskeletal technique physical therapists have safely and effectively performed for years that will optimize our patients' recovery and function. I feel that dry needling should be included in the physical therapist scope of practice.

Thank you so much for your consideration of this topic.

Anne Ziegler, SPT, University of Washington, Physical Therapy Program 2017

I am writing to contend that dry needling can be performed safely by physical therapists. This is contrary to the view voiced by the American Association of Acupuncture and Oriental Medicine (AAAOM). The objection raised by supporters of this view is that physical therapists do not receive equivocal training in acupuncture including dry needling. This is based on information from AAAOM, 2011. I reject this claim because while acupuncturists receive 1,490 hrs of education, this is not all specific to dry needling and physical therapists must receive specific intensive training in dry needling techniques to safely use this modality. This is based on information from Rogel, 2012.

Furthermore, there are three strong reasons to support my view that dry needling can be performed safely by physical therapists. The first reason is that physical therapists receive instruction on the human body, screening, interventions and 10 months of apprenticeship that provide an extensive foundational knowledge of the anatomy that they can impact with dry needling techniques, since physical therapists learn 86% of the knowledge needed to safely apply dry needling in their basic education and advanced or specialized training is only needed for 16/117 needling specific knowledge requirements. This is based on information from Caramagno, 2015. In addition, this reason is supported by the fact that due to foundational DPT instruction only 64 hours of additional training were needed to safely perform dry needling techniques without significant adverse events. This is based on information from Brady, 2013.

The second reason is the obvious view that needles are used safely by physical therapists for other modalities/studies including EMG, NCSs and electrical stimulation. In Washington State, physical therapists are permitted to perform needle EMGs upon referral from a health care practitioner and “upon demonstration of further education and training in electroneuromyographic examinations...” This is based on information from R.C.W. 18.74.010 and 18.74.160(4).

Finally, it is clear that dry needling can be performed safely by physical therapists given significant adverse effects of dry needling by physical therapists are rare. This is based on information from Sarah, 2013. This reason is supported by the contention that with 64hrs of training, physical therapists had an estimated upper risk rate for significant adverse effects of less than or equal to 0.04% whereas higher rates of reactions to acupuncture found in literature include 11.4% in a prospective acupuncture study by Ernst et al. which were not classified into mild or significant. This is based on information from Brady, 2013.

I restate my contention that dry needling can be performed safely by physical therapists. I urge you to also adopt this view. Write your law maker supporting legislation for the use of dry needling by physical therapists.

Yours sincerely,

Oliver Brown, SPT

University of Washington Doctorate of Physical Therapy Program Graduating in 2017

I am writing in regards to the inclusion of Dry Needling in the physical therapist practice act for the state of Washington. I am a physical therapist that has been practicing in the state of Washington for the last year, and in Colorado for 2 years before that. In Colorado, dry needling is commonly used by physical therapists and I have worked with numerous physical therapists that utilize the technique.

During my time in Colorado, I would frequently refer my patient's to my co-workers that dry needle when appropriate, and I have seen many remarkable improvements. One patient in particular had a significant trigger point in the gluteal muscle. Despite weekly massage therapy and regular massage therapy, we could not get this muscle to release. Within 2 sessions of dry needling, the trigger point was gone. The patient had significantly reduced lumbar pain (which is what we were treating), she had improved ability to reach overhead, and she was eternally grateful for the technique. I personally experienced the technique as a patient having been treated for headaches and cervical pain, and to me from the side of a patient it is amazing how immediate I got relief. I have tried acupuncture many years ago and the experiences are very different.

One of the main arguments I have seen against physical therapists performing this technique is our level of education. I would agree that to perform the technique you need an intense understanding of anatomy, and physical therapists absolutely have that. I have a 4 year Bachelor's degree in Health & Exercise Science, and as a pre-requisite to physical therapy school I had to take 2 semesters of biology, 2 semesters of chemistry, 2 semesters of physics, anatomy, physiology, psychology, and statistics. Then in physical therapy school I took 2 very intense semesters of anatomy and was required to assist with dissecting human cadavers each time. I was required to learn nearly every muscle in the body including their bony attachments, muscle action, blood supply, and nerve innervation. We learned how nerves from the spinal cord relate to muscles and sensation. My particular school had medical students that helped TA our

anatomy labs and many of them commented how much more we had to know about the musculoskeletal system than they did in their medical program. We are truly experts in this system. Taking a dry needling course following physical therapy school, you are given a review of this anatomy and how to safely place needles. We are not learning anatomy and safety from scratch. We are adding on to an already intense knowledge of the musculoskeletal system.

I would like to be able to perform dry needling in addition to my current physical therapy practice because my priority is finding the best techniques to get my patients better faster. I would never claim to do full acupuncture, and I would not use dry needling on every single patient. I think dry needling is a powerful tool that physical therapists are very well trained to use safely and appropriately. Please consider allowing it to be added during the next sunrise.

Megan Bell, Doctor of Physical Therapy

I am writing in support of physical therapists being able to perform dry needling in the state of Washington. It is a safe and effective tool in the treatment of neuromuscular and musculoskeletal conditions, and as a future clinician I would love to have such a tool at my disposal with which to help my patients.

Personally, I have found the application of dry needling to be immensely helpful. Before moving to the state of Washington and beginning my coursework at the University of Washington, I lived in Atlanta, Georgia as I worked towards fulfilling my prerequisite coursework and accruing volunteering hours ahead of applying to physical therapy graduate programs. During this time, I hurt my back while lifting weights - it was so painful that barely made the short bicycle ride back to the apartment that my wife and I shared. I remember laying down on a frozen steak for relief from the pain. I was fortunate to be volunteering at a local physical therapy clinic where the clinic director had just finished receiving his certification to perform dry needling. My anxiety regarding needles was quickly overpowered by the continuing pain that I felt, and I quickly accepted this clinician's offer to experience dry needling firsthand. I had a needle placed into both sides of my lower back and!

after a few minutes I felt a large measure of relief. I felt that the dry needling had in a way "unlocked" my back, and I could at that point start a comprehensive rehabilitation protocol.

Dry needling is a safe and effective intervention in the hands of physical therapists: a 2013 study published in *The Journal of Manual and Manipulative Therapy* found that the risk of adverse events occurring due to dry needling by physical therapists is less than 0.04%, which is lower than the risk of adverse events when using a common medication like ibuprofen. As a clinician, the efficiency of the intervention is admirable - much as I experienced with my own back injury, the ability to perform dry needling can be the difference between one session of dry needling (which can take as little as a few minutes) compared to working at the same problem using alternative interventions over the course of multiple treatment sessions that can span weeks.

I am in full support of physical therapists performing dry needling, having received dry needling as a patient and now throughout my education as a future healthcare provider. It is a safe, effective, and efficient tool, and one that I am hopeful that physical therapists and their patients will have available to them in the near future.

Samuel M Huie

Division of Physical Therapy, Department of Rehabilitation Medicine, University of Washington

I am a physical therapy student in the doctorate program at the University of Washington. I would love to share my thoughts and experiences with dry needling in regards to the recent review of dry needling by physical therapists and acupuncture practice. As a second year student I will be completing my internships over the next nine months and then proceed to enter the field of practice as an individual clinician.

I entered this field of work because I love to help people, I love to work closely with patients and help them to achieve their goals, regain function, and generally feel better. Physical therapists are the experts on movement, within the practice there are several avenues to restore optimal movement. Many movement disabilities are caused by muscular structures that have trigger points within them, causing dysfunctional movement in that muscle and also the surrounding structures and muscles. There are many techniques to alleviate trigger points, but none as effective as the direct technique of dry needling. What a dry needle can do in a matter of seconds can take ten or more minutes to release using soft tissue techniques with the hands.

I have been exposed to dry needling in observation of a physical therapy clinic. The patients receiving the treatment had much more success in the release of their trigger points and pain relief than patients that were not comfortable with receiving the needling treatment and required soft tissue work by hand.

I believe physical therapists with proper training are well qualified to perform dry needling treatments on patients. It is used in conjunction with several other interventions which would be focused on restoring their function and reducing pain. As a student, I hope to be able to include this in part of my future practice and have the opportunity to help patients through dry needling, if they require it.

Kelly Donaldson

My name is Scott Anderson and I am a DPT student at The University of Washington. I will be graduating in June, 2017 and I am writing you today in regards to physical therapists using the dry needling technique. I know this topic is under review and I want to voice my support for the use of this technique for the best treatment of our patients. I know there was great testimony on both sides of the topic last week, and I would like to offer some testimony of my own. First, I would like to mention that with physical therapy listed as a specialty the patient is exposed to a higher copay. Why do I bring this up? I bring this up because dry needling decreases the amount of time needed to release trigger points compared to the manual therapy needed to release the same point. This means that the patient could potentially get the treatment they need to recover in less sessions if dry needling could be incorporated. This ultimately would decrease the cost on the patient and increase !

the quality of care provided. These are the outcomes that should be held highest by our health care system and by our clinicians, and if we can meet these goals with dry needling we owe it to the patient to incorporate it into the physical therapy scope of practice.

Scott Anderson, SPT

My name is Jianjun Wang. I am an Acupuncturist working in Issaquah and Renton area for over 18 years! I was a medical Doctor in China for 20 years before I immigrants to United state! I have been western medical education in China and Chinese medical education in USA. I know that how much acupuncture treatment do the wonderful job for my patients than the medication I did! Needles is doing amazing work for people who are in the severe pain! It is why PTs want to use "dry needle" to help their patients! They are doing wrong things! Because the needles are belong to acupuncture who are in high education for the job! Every professional provider need to do their job in the FIELD! Just like that we all knows that when a patient has pneumonia , the Antibiotic is the best medication to healing, but the acupuncturist or PTs are can do it because it is medical Doctor job!

Please call me if you have any question about this letter!

Thank you so much for your hard work!

Best wish!

Jianjun Wang , L Ac

I am emailing the Department of Health to voice my support of physical therapists performing dry needling as a means of treating their patients. As a current student in the Doctor of Physical Therapy program at the University of Washington, I believe it is important for physical therapists to be able to

utilize the benefits of dry needling in order to help their patients reach optimal outcomes. Dry needling is both an efficient and effective therapeutic intervention tool that is used in conjunction with other physical therapy interventions to improve movement and function in patients. It falls well within the knowledge, skill and education of a physical therapist. Dry needling is safe when performed by physical therapists. In a study published in the Journal of Manual and Manipulative Therapy in 2013, researchers reported that the risk of adverse effects of dry needling performed by physical therapists is less than 0.04 percent - lower than for common over-the-counter pain medication such as ibuprofen (.137 percent).

Thank you for your support.

Catyann Parker, Student of Physical Therapy, President of Class of 2017 University of Washington

I'd like to express my concern about the proposal for physical therapists to add 'dry needling' to their scope of practice.

I am an EAMP in Seattle and have been practicing for 15 years. I have a very strong referral network that includes physical therapists. I regularly refer to and receive referrals from approximately six different physical therapists. We find that our patients benefit through our collaborative efforts because the specificity each of us provides is not duplicated by the other. It is enhanced by working together. Not one of the physical therapists I work with perform dry needling. Their discipline overflows with precise strategies to achieve their goals. 'Dry needling' is not a necessary tool for them.

There is no doubt in my mind that a physical therapist can learn to perform 'dry needling' safely and accurately with appropriate training and respect for this invasive procedure. It should be limited to the locations known as trigger points. These locations should be clearly defined. Dry needling is a dangerous technique if employed incorrectly. There are locations in the body where 'dry needling' is contraindicated. One such location is the anterior neck at a location on the medial border on the sternocleidomastoid (SCM) muscle. I witnessed the bruising and adverse effects of the 'dry needling' technique applied by a PT incorrectly on this acupuncture point. It was detrimental to the patient and ineffective as a treatment.

EAMP's and PT's overlap in a few areas of treatment. It is understandable that PT's would like to perform 'dry needling'. The assertion that 'dry needling' is not acupuncture is incorrect. Dry needling is an acupuncture technique. There are definitely times when the patient would benefit from the application of dry needling at one or two specific locations during a treatment. It is true that the patient's recovery may be enhanced by its application during a PT treatment. It is understandable that PT's are fighting hard for the inclusion of this technique into their repertoire.

The current proposal is not adequate in training hours. The curriculum does not outline supervised practical training. The proposal should describe specific locations and points on the body that the technique is limited to.

Collaboration between EAMP's and PT's should be required in order to develop a proposal for the residents of Washington state. We are fortunate to live and work within a highly collaborative and respectful medical community which benefits all.

Thank you for your time and attention while reviewing this proposal.

Inderjeet Ramgotra, MSc EAMP NCCAOM dipl OM
Inner Renewal and the Healthy Path

I have been in practice as an EAMP since 2009, prior to that I practiced Massage Therapy for 20 years. I find it a bit hard to swallow that you are even considering allowing PT's to pretend to practice Chinese medicine with only 54 hours of education. Dry needling is basically practicing acupuncture and it is an injustice to my profession that you might consider granting PT's dry needling license. There are many factors in East Asian Medicine for treating pain that 54 hour of education could not cover.

Like these question that guide our treatment plans:

Is the pain:

blood stagnation

phlegm stagnation

dull (deficient)

dryness pain

damp pain

Shi pain: worse with pressure

Xu pian Better with pressure

Moves around (wind):

shu wind pain

xu wind pain

Cold pain

hot pain

deficient heat

deficient cold

etc.

Acupuncture is a complete medical system, that can not be reduced to a simple 54 hours of education for pain. Please DO NOT give Physical Therapist the license to practice Chinese Medicine with out the proper training. When they are not successful, this patient will never again try acupuncture because "it did not work". When if fact a real EAMP practitioner might well have been able to solve the problem with the above diagnostic education that we receive with three years of training as East Asian Medicine Practitioners.

Julienne Battalia LAc,
East Asian Medicine Practitioner

I am entering my third and final year of the Doctor of Physical Therapy program at the University of Washington. I often receive messages from friends and family about their experiences with physical therapy. I was recently contacted by a close friend who moved from Seattle, WA to Nevada three years ago. In this recent conversation she enthusiastically told me about some sever pain she has had in her hip for the past 5 years and the full relief she experienced after a single treatment of dry needling. This friend is a dance instructor and yoga teacher. Movement is essential to sustaining her career and she has been limited in functional mobility for the past 5 years. Although she has received some pain relief with treatment from doctors, acupuncturists, and chiropractors, receiving dry needling from a skilled physical therapist was the only treatment that has fully relieved her symptoms in just a single treatment. It was difficult for me to explain to her why she would not be able to receive this effective treatment if she moved back to Seattle. Dry needling, when indicated, is one of the most effective and efficient treatments within the physical therapy scope of practice. Dry needling can reduce the number of visits a patient needs which reduces national health care costs. Dry needling also helps quickly return patients to work and to full participation in their lives. I did 7 years or preparatory work to enter the field of physical therapy because I am passionate about improving the quality of life of people in my community. I wish to have access to the use of dry needling in my future practice in Washington to help patients recover as quickly as possible, just as my friend did in Nevada.

Thank you for your time,
Megan

I wanted to respond following the Sunrise Review regarding Dry Needling as part of the scope of practice for physical therapists. As a Doctor of Physical Therapy student currently at the University of Washington, it is important to me that I be able to provide techniques, such as Dry Needling, that will help me provide quality patient-centered care in an effective and efficient manner. It sincerely concerns me that my ability to practice Dry Needling is being contended because, as a future practitioner, I feel it is important for me to be able to make my own clinical decisions and judgments regarding what the best course of treatment is for a patient and have the ability to include Dry Needling as a potential part of my practice. Research regarding any adverse events related to physical therapists practicing Dry Needling is lacking and does not currently provide any substantial evidence that we as practitioners are placing our patients at any increased risk. The efficacy of Dry Needling practice can be seen both through patient outcomes and testimonials and in by no means suggests that physical therapists would be affecting the acupuncturist practice in any way. Our only aim is to protect our profession and ensure that we are enabled to provide the best care we can for our patients using techniques we know to be effective as part of our treatments. With that said, I believe that Dry Needling should be included as part of the physical therapy scope of practice.

Shelina D. Martinez, SPT, Department of Rehabilitation Medicine
University of Washington School of Medicine

I am writing to in response to the Sunrise Review on Dry Needing to contend that dry needling, as a practice, is safe for physical therapists to perform with appropriate standards for education and training. This is contrary to the view voiced by Acupuncturists within the state of Washington. A few reasons to support my view that dry needling as a practice is safe for physical therapists to perform are as follows: 1) Dry needling is a separate technique and separate from the history of acupuncture, 2) research has found the percentage of severe adverse affects from physical therapists conducting dry needling is exceptionally low at 0.04% and is lacking overall to show any evidence at all the dry needling performed by physical therapists is dangerous and 3) that the practice has been specifically affirmed as within the scope of physical therapy practice by at least 24 states and the District of Colombia in this country.

In addition, much of the core education provided by the Doctor of Physical Therapy programs would be considered fundamental to the basis of dry needling practice. With completion of the additional training hours, physical therapists would be more than qualified to perform safe and effective dry needling practice.

I restate my contention that dry needling as a practice is safe for physical therapists to perform with appropriate standards for education and training. I urge you to also adopt this view, and to work with the Washington State Board of Physical Therapy to formalize the necessary standards. As a current Doctor of Physical Therapy student at the University of Washington, it is extremely important to me that I will have the ability in my future practice to make decisions about what I deem to be important for patient treatment and to be able to perform the most efficient and cost effective treatments. Thank you for your time.

Shelby Bell

I would like to present my testimonial of a very favorable outcome from receiving acupuncture treatments from Dr. Xia Che, a TCM acupuncturist.

I received about 8 acupuncture treatments from her last year. Before the treatments commenced, I was barely able to drive my car and was in a lot of pain from chronic lyme disease. Just after the 8 treatments,

I felt well enough to pack, singlehandedly, all of my belonging and drive myself to a new home I bought in another county. Such is the power of my treatments with her. Unfortunately, because I had too far away from her clinic, I was not able to continue treatments with her.

Emma Applegate

Thank you for inviting our opinions. My resume includes:

- Core Massage Faculty and Co-Chair of Shiatsu Department at The Swedish Institute, NYC, 1987-1989
- Core Massage Faculty at the Seattle Massage School, Seattle and Fife Campuses, 1990-1994
- Adjunct Faculty teaching Shiatsu at Heide Brenneke Massage School. 1992-1995
- Adjunct Faculty at NIAOM, Northwest Institute of Acupuncture and Oriental Medicine, 1992-1995
- Core Faculty at Bastyr University, Acupuncture and Oriental Medicine Department, 1994-2001
- Gig Harbor Acupuncture, Owner and Practitioner, Gig Harbor, WA, 1994-1998
- Healing Arts Acupuncture, Owner and Practitioner, Seattle, WA, 1994-1998

I was dually licensed in both massage and acupuncture, but having retired, I have let my massage license lapse. It is as a formerly dual-licensed practitioner that I am responding to the Physical Therapists wishing to add DRY NEEDLING to their scope of practice.

As both a practitioner and teacher I am always thrilled when any practitioner of any modality wants to expand their treatment vocabulary. I understand this well because I went back to school for three additional years to add acupuncture to my hands-on massage/shiatsu skills. I particularly like the concept of a wide treatment vocabulary because that permits one to accommodate the individual needs of a patient rather than meeting them with only a single approach.

With invasive techniques such as the use of acupuncture needles (because those are precisely the tools PTs are proposing to use), the safety of the patients requires both adequate training (no shortcuts) plus adequate supervised practice in a clinical setting under professional supervision.

For any PTs who care enough about their patients to do the extra studying and practice I have only compliments and applause. For those who want to alibi that somehow they have training they do not have, I think that is contemptible and casts real doubt as to (the PTs) motives.

With acupuncture I have additional concerns. America has lagged behind the rest of the civilized nations of the world in recognizing East Asian medicine as genuine. When I first started my acupuncture education, the FDA was still designation acupuncture needles as 'experimental devices.' (Thank goodness they have revised that label to 'medical tools' and/or 'medical instruments.'

I can imagine no explanation other than MEDICAL RACISM for dismissing a 5,000+ year old medicine with 2,500 years of classic medical texts and documentation of practice in this insulting manner.....but when acupuncture first arrived here in America it was labelled 'fraudulent' and those that saw results claimed that, of course, these were due to 'placebo effects.'

I do not think any medicine from any Caucasian culture has been treated with such disrespect and disregard. To my mind, by the PTs insistence that they somehow transcend the need for current legislated standards of training and clinical supervision, the Physical Therapists are continuing this American medical tradition of MEDICAL RACISM. This saddens me and I sincerely hope that my beloved State of Washington is not going to be guilty of allowing this.

In your review of the Physical Therapists' demand for adding DRY NEEDLING (trigger point acupuncture) to their scope of practice, please consult the recognized acupuncture schools across the country as to what they consider responsible and safe training for those who will employ these medical instruments. My concern is both for the safety of patients and for the reputation of acupuncture which should not be affected by lack of results or medical malpractice due to insufficient training and practice under supervision.

Please do not hesitate to contact me if you have any questions or if I can be of any further help.

Naomi R. Rhoads, EAMP, MFA (and former LMP)
Previously Secretary of the Acupuncture Association of Washington

I'm a physical therapist licensed in our state. I support the application to identify dry needling as a part of physical therapy scope of practice with qualifications under a licensure endorsement process.

Please allow me to offer evidence that 1) the history of physical therapy practice in our state has included invasive procedures such as needle insertion through the skin and into muscle tissue and 2) dry needling and trigger point therapy are not acupuncture.

1) On May 29, 1975 the WAC 246-915-010 was updated to include: "(1) The "performance of tests of neuromuscular function" includes the performance of electroneuromyographic examinations."

Since 1975, physical therapists have performed nerve conduction studies and needle electromyography (NCS/EMG) in our state. Needle electromyography is the insertion of a monofilament fine wire electrode through the skin and adipose layers into muscle tissue where the bioelectric potentials are analyzed on an oscilloscope in real time. The PTs performed these studies after post-licensure education and training. It was the responsibility of the PT to recognize the boundaries of his or her own professional competencies and use only those in which he or she can prove training and experience (WAC 246-915-190(4)). During this forty year time frame, there were no complaints of patient harm to the Board of Physical Therapy or to any malpractice insurer. Tens of thousands of patients had nerve conduction studies and needle electromyography performed by physical therapists in this time span.

In 2005, the state legislature passed and the governor signed into law that "A physical therapist may perform electroneuromyographic examinations for the purpose of testing neuromuscular function." This law set parameters for obtaining a licensure endorsement in needle electromyography. In spite of rigorous debate in opposition from the state Medical Society, the wisdom and power of the Legislature and Governor prevailed because they both recognized the prerequisite knowledge, skills and abilities obtained from physical therapist education and training provided a solid basis for practice of NCS/EMG and that the public was well served by a statute permitting it's practice.

2) At the Sunrise Review Hearing many opponents stated that dry needling is acupuncture. The law doesn't support this statement.

The Legislature updated the law pertaining to acupuncture practice in 2010. This included a name change to East Asian Medicine Practitioner, because the legislature recognized that this field covered more than acupuncture (RCW 18.06.005). This updated scope of practice law lists the varied interventions that East Asian Medicine Practitioner may provide (RCW 18.06010). The terms: "dry needling" and "trigger point therapy" are not on this exhaustive list.

Dry needling is a Western Medicine technique that is practiced by physical therapists safely and effectively across the country and the world. Please support the application to include dry needling as part of physical therapy scope of practice. Thank you.

Elaine Armantrout, PT, DSc
Board Certified Clinical Electrophysiologic Physical Therapy

I am a student of Physical Therapy at the University of Washington, and I am writing today in support of keeping Dry Needling within the scope of practice for Physical therapists in this state. Not only has research shown that the chance of injurious outcome is basically zero, dry needling provides immediate relief for patients whom would otherwise have to go to several rehab visits to remediate. So, it's an effective rehabilitation technique and it saves patients (and Insurance companies) money.

Research also shows that the two practices – Dry needling and Acupuncture – are different modalities, requiring different skill sets. Physical therapists have the necessary skills to perform dry needling in a safe, effective manner, just as PTs can perform other modalities (Ultrasound, E-stim, etc.).

I feel it is rather unfortunate that this issue has become so politicized. Acupuncturists and Physical Therapists are two branches of the same tree – Patient care. If we maintain that we are “patient centered” then worrying which group gets to get paid for practice seems counter-intuitive. Further, scare tactics and misinformation seem to be the weapon of choice for those opposed to dry needling, whereas supporters are attempting to maintain an “evidence-based” approach. Please consider this email another voice in support of dry needling being within Physical therapists’ scope of practice.

Thank you for your time and consideration.

Mark W. DeBourke, SPT, Division of Physical Therapy, Department of Rehabilitation Medicine
University of Washington

I am a second year doctor of physical therapy student at the University of Washington. After examining the sunrise review entitled “Physical therapy scope of practice sunrise – dry needling,” I would like to express my strong support in favor of keeping dry needling within the scope of physical therapy practice in the state of Washington.

I have been the recipient of acupuncture and have had the privilege to observe the practice of dry needling in the physical therapy setting, and I feel that they are quite different treatments. While not only is the theory behind the two practices different, the process of receiving the two is also different.

When receiving acupuncture, the needle is placed into one of the 2,000 points on the human body. Traditional acupuncturists tend to leave the needle(s) for 20 minutes or more. This is vastly different than trigger point release through dry needling, which is what is being practiced by the physical therapists. This treatment involves placing the needle at a dense point in the affected muscle that re-produces the person’s pain. Once the needle is placed into this point, which is also known as the trigger point, a twitch is elicited and the needle is removed. The process as a whole takes less than 30 seconds. If one were to place two patients receiving acupuncture and dry needling side-by-side, the treatment sessions would appear vastly different.

Additionally, I have seen the instantaneous affects that dry needling in the physical therapy setting can have in the treatment of pain. When observing dry needling, I witnessed more than 20 patients who experienced a significant decrease in pain and improvement in function as a result of the technique. The impact that this technique had in the treatment and recovery of these patients was significant. Because of this, I have chosen to include dry needling in my future practice.

If the bill is not passed and dry needling is not considered within the physical therapy scope of practice in the state of Washington, I will be leaving the state of Washington. As a physical therapist, I do not want to feel limited in my ability to treat my patients.

Caitlyn Michno, SPT, University of Washington Doctor of Physical Therapy Program

Please protect patients/pain relief consumers in WA state from the potential adverse risks of DN through PT. As a patient with chronic pain for at least 9 years and actively seeking long-term solutions to staying pain free with various medical providers and alternative healers, I write to encourage you to take responsible measures and deny physical therapists from administering dry needling to patients without proper training.

I have had a discussion in my PT's office about DN, what it is, and what it would do. At the time, in a tremendously frustrating moment of pain, I remember asking her to just do it if she believes it would help me. A few times, I remember suddenly tearing up and breaking down in front of her as I spoke with her about my progress, and I felt like I was back to a hopeless place from many years ago, and I didn't know where the light would be if there is the end of the pain tunnel. She has practiced DN when she was at another state that allowed PTs to use DN, so when she told me how it has assisted others in relieving pain, I was on board, because why would anyone in pain refuse pain relief? And that was it, because all I wanted was pain relief. I had no other questions at the time about anything else, just that if she could do it, then I would like the service offered.

I was not in a state of mind to question the potential risks of administering needles at the inappropriate meridian or nerve point, or anything else that pertains to a fuller knowledge of the human system, one that is taught from the Eastern medicinal practices and takes many many years to master and implement safely for patients. I did not have long-term solutions in mind, and therefore I had no questions about temporary pain relief or what would happen if the "wrong" point was needled, and whether she would know how to fix it along with any other potential negative consequences.

Having seen various acupuncturists in my seek for pain relief, I am amazed and impressed by the depth of knowledge that is required of acupuncturists in their determination and consideration of administering treatment for a particular patient - customized fully to a patient's health history, condition, and elaborate contexts that apply to how the needles would be inserted. I have no confidence in a PT's ability to master the knowledge of acupuncturists. The way acupuncturists evaluate and assess pain is quite different from the perspective of PTs. They also have had much longer and elaborate training about the human body and energy systems, in order to get to safely administering needles on patients.

I believe if PTs see the immense value and benefit in acupuncture, they should team up and work with acupuncturists to deliver a collaborate treatment plan for their patients, rather than take a sub-category technique from acupuncture and try to brand their technique, and in the process, insults the East Asian acupuncture community by being hypocritical about what it is really that they are trying to do, for themselves, and for their patients. If a PT cannot tell a patient what other conditions might come to the surface with the point they would like to apply DN, then they are unable to handle a disaster recovery procedure.

Acupuncture is as powerful as a doctor's knowledge, and it has the ability to turn a person's life around. It also has the ability to temporarily make a person feel worse, depending on what's being done and how the troubles are addressed. I have had various acupuncture experiences and none of them are the same, because the practitioner carries different knowledge and perspective about what it is that my body requires in order to assemble its priorities that would lead to (hopefully) recovery and healing, rather than spinning a useless cycle of pain or lethargy (or any other issues the patients are dealing with). Acupuncturists can administer needles to reverse negative symptoms as reported by a patient, or it can fully cure the root of a patient's health problem. Yes, it can relieve pain, very fast, and is very powerful when the correct points are found and treated (the real problem isn't always at the pain site, and PTs would not see it that way, and would not know what is causing the real problem and what is being bullied).

Eastern Asian Medicine is very highly respected because of the tremendous amount of training and clinical guidance that practitioners go through in order to practice. I have no issues with acupuncturists administering needles because THEY KNOW WHAT THEY ARE DOING, as they should. They will need to tell me why I am feeling a certain way after treatment, and how long the sensations are expected

to last, and what that means for me on a variety of levels. That demonstrates understanding of their practice, which is both an art and science, through a much more extensive medical training compared to what is being proposed by the PT community in their desire to use DN.

DN is not in the scope of practice of PTs and should not be simply because the site of the pain is NOT WHERE THE REAL PROBLEM IS, and PTs must know the full scope of impact and consequences at the nerve, muscular, and energy levels if they are to adopt this practice and forego their collaboration with the acupuncture professionals that already resolve issues for their patients. There are things that PT can do that acupuncture cannot do, and vice versa, and DN would not only blur the boundaries, but it would also lead to accountability concerns.

If PTs are to practice DN, can the scope of practice be laser-focus defined so there are no questions about whether a PT is doing DN vs. acupuncture? Are there demonstrable measures to protect patients who are stuck in the mindset of simply getting rid of their pain without any broader foresight into the potential risks and health harm as a result of DN by a PT without adequate broader training? I would have no problems if these serious questions are addressed, but until they are properly and adequately addressed, please make the responsible decision and decline passing this bill for WA state, for the protection and highest good of patients suffering and not knowing a thing about long-term vs. short-term relief, and for those who may not have had the privilege of being educated better about this intramuscular manual therapy (which does not accurately capture the many other layers that are affected and impacted).

I also urge you to review the reasons behind the opposition from the other states that have denied DN their state. Thank you for your consideration.

Christina Wang

I most strongly recommend the Health Department not endorse or recommend to the Legislature, any procedure that resembles Acupuncture, to be performed by Physical Therapists on the public and to not endorse or recommend, any change to the Physical Therapist Scope of Practice that would include the procedure of “Dry Needling”.

Physical Therapists in this state would like to add “Dry Needling” to their Scope of Practice. Dry Needling is unequivocally, just another name for Acupuncture. As such, Acupuncture requires years to master, as evidenced by the state requirement for current Acupuncturists (East Asian Medicine Providers) to be licensed to practice, only after fulfilling didactic and supervised clinical training requirements, to include successful completion of the National Certification Commission for Acupuncture and Oriental Medicine’s complex board examinations.

The American Medical Association (AMA) agrees that Dry Needling is not distinguishable from Acupuncture as cited in a AMAWire article entitled, “Physicians take on timely public health issues”, dated 6/15/2016, 1:00 PM. This article stated:

(“Ensuring patient safety is paramount for physicians. To that end, delegates adopted new policy that recognizes the procedure of dry needling as invasive.

Physical therapists are increasingly incorporating dry needling into their practice. Dry needling is indistinguishable from acupuncture, yet physical therapists are using this invasive procedure with as little as 12 hours of training, while the industry standard minimum for physicians to practice acupuncture is 300 hours of training.

Delegates agreed that the practice of dry needling by physical therapists and other non-physician groups should include—at a minimum—the benchmarking of training and standards to already existing standards of training, certification and continuing education that exist for the practice of acupuncture.

The policy also maintains that dry needling as an invasive procedure should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.

“Lax regulation and nonexistent standards surround this invasive practice,” AMA Board Member Russel W.H. Kridel said in a news release. “For patients’ safety, practitioners should meet standards required for acupuncturists and physicians.””)

Medical Doctors (M.D.’s) that attended my Acupuncture and Oriental Medicine School were required to complete a minimum of two (2) years of didactic and supervised clinical internship work in order to graduate. The M.D.’s then became eligible to sit for the National Certification Commission for Acupuncture and Oriental Medicine board examinations for Acupuncture. Upon successful completion of coursework and supervised clinic internship (no less than 1 year supervised clinical internship of 500 hours duration, consisting of 400 patient treatments performed on 100 different patients) combined with passing the national board examinations and a background check, these very same Medical Doctor’s would then be eligible to be granted a license by the state to practice Acupuncture on the public. Why would less stringent requirements be made for any different profession?

Allowing Physical Therapists to perform advanced Acupuncture techniques without adequate supervised training and master level expert instruction and demonstrated proficiency, is akin to allowing a Medical Doctor perform heart surgery when they have only been trained in Dermatology or for that matter, allowing an Acupuncturist (East Asian Medicine Practitioner) to set broken bones (reduction) with little or no training. It does not make sense, is illogical and more importantly, extremely unsafe.

Lastly, by allowing Physical Therapists to perform Acupuncture, under the guise of “Dry Needling”, the Health Department and Legislature would immediately place practicing East Asian Medicine Practitioners (EAMP) at an economic disadvantage, because EAMP’s are not currently authorized to bill Medicaid, Medicare, L&I or TriCare for services performed, as Physical Therapists currently are. Additionally, there are currently no CPT Codes (AMA approved Procedure Codes) designated for Physical Therapists to perform “Dry Needling”. There is a reason for this. It is because Dry Needling is Acupuncture.

Please do not endorse or recommend any Acupuncture procedure to be performed by inadequately trained or supervised professionals, except by board certified, East Asian Medicine Practitioners, the only professionals qualified to perform Acupuncture safely.

Douglas L. Daniels, M.Ac., Dipl.Ac., (NCCAOM), East Asian Medicine Practitioner

To whom it may concern, I sent this to the Washington State Legislature in early 2015 and would like to present this to the sunrise review committee. Restricting dry needling by qualified physical therapists would be a horrible mistake. I greatly appreciate and regularly visit acupuncturists, but they're lobbying without knowledge here.

Last year, I interviewed Rep. Cody regarding the numerous serious problems with health insurance regulations and marketing for this Crosscut piece (Five ways your medical insurance defines deductible <http://crosscut.com/2014/07/five-ways-your-medical-insurance-defines-deductible/>).

I hope that you've read it.

Today, I'm not reporting but am writing in with my experience as a patient in regards to the dry needling bill (HB 1042 - 2015-16). This bill would ban PT's in Washington State from practicing dry needling.

I've been an acupuncture patient for more than 15 years and continue to go regularly. The past two years I've also received dry needling, mostly from a PT but also on one or two occasions from an MD. Both these modalities have tremendous merit. And, in my experience as an extremely body aware person (I have 600+ hours of yoga teacher training), acupuncture and dry needling are very different.

Acupuncture generally works on energy meridians and can affect the body in many subtle ways. I believe that it reorganizes energetic patterns in the body and activates the parasympathetic nervous system, which aids healing.

Dry needling in my experience (as performed by my PT) focuses on releasing bound up trigger points within muscles and affecting dysfunctional muscle patterning. I've had dry needling treatments from my PT numerous times over the past two years following a surgery and related complications. I've had treatments on the knee and hip, low back and neck & shoulder. It's been tremendously helpful. And, frankly, when I've asked my acupuncturist to perform similar treatments she's not understood what I'm talking about. I've found dry needling to be extremely beneficial to my healing and care. The type of dry needling that my MD did was actually less sophisticated than that done by my PT.

While his treatment was helpful, I did not experience the same level of positive benefit as I have from my PT's dry needling.

I would be harmed by passage of the Senate equivalent of HB1042 as I would not be able to receive dry needling from my PT any longer.

As I wrote for Crosscut, there are significant serious issues that could be addressed this term by you and your colleagues with regard to health insurance rules, regulations, pricing and marketing. Please focus your energy there.

I think the passage of the HB1042 equivalent by the Senate would be a terrible mistake. Please allow my PT to continue dry needling.

Please feel free to reach out if you have questions.

Jeff Reifman

My name is Ed Eichelsdoerfer, and I am a 2nd Year Doctor of Physical Therapy Student at the University of Washington. I am writing to voice my support in favor of the inclusion of dry needling into the state practice act for physical therapists in Washington. There is some opposition to this idea from acupuncturists and Eastern Medicine licensing boards. However, my support for this issue stems from 2 core beliefs: the first being that physical therapists are well-equipped to handle this treatment modality, and the second being that acupuncture is not the same as dry needling.

Upon my graduation next June, I will have completed 163 credits as well as one year of clinical training in order to help my practice as a physical therapist. All of this time in the classroom and clinic includes hundreds of hours in training in anatomy and physiology, treatment modalities, and understanding of pathophysiology of numerous disease processes. This training sets us up to handle musculoskeletal trigger points and their treatment using many interventions in a safe, efficacious manner. The use of dry needling is one of these many interventions, and it is both efficient and safe. (One systematic review found that the incidence of adverse effects from PT-led dry needling is 1/10 as common as adverse effects from taking ibuprofen!) With the appropriate training in needle use and handling by trained professionals, physical therapists are well-equipped to perform dry-needling and avoid adverse outcomes.

The second reason arises from the fact that despite claims to the contrary, dry needling is not the same as acupuncture. There are enough inherent differences between the practice of acupuncturists and physical therapists to warrant the use of needles by both professions. This is because physical therapists can use trigger point dry needling for pain reduction, whereas acupuncturists use "dry needling" for treatment of other systemic conditions such as nausea. A study by Smith, Crowther, and Beilby found that traditional acupuncture can successfully treat nausea better than sham acupuncture (needling in non-chi points) or no treatment, based off 593 pregnant women. Dry needling performed by physical therapists never claims to treat nausea, and it is only used in a local area of musculotendinous dysfunction. Studies such as this one

solidify the differences in application of acupuncture compared to dry needling. Dry needling used by physical therapists focuses on specific

trigger point release related to a localized injury following western medicine principles, whereas acupuncturists "treat holistically or systemically over a longer period of time, following the principles, tenets, and theories of Chinese medicine". This difference in application and definition was actually asserted by the American College of Acupuncture and Oriental Medicine's, as that definition is from their own website.

As a physical therapy student with past patient care experience, I believe that quality care necessitates diversity of treatment practices so that patients and doctors can choose individualized treatments. This is a commonly held belief throughout the healthcare system, and it is the basis for patient-centered care. In this paradigm, the patient's values, beliefs, and decisions are in the center of all health decisions. Some patients may not believe in the value of acupuncture as a practice, but would still benefit from dry needling as performed by a physical therapist for the treatment of a localized trigger point. In order to accommodate these types of patients, it is best practice to allow them some degree of freedom in choosing their own treatments, rather than only allowing them to go to acupuncture which they see no value in.

Thank you for your time in reviewing my feedback. Have a good day.

Ed Eichelsdoerfer, 2nd Year DPT Student, University of Washington

My name is Kyle Mark and I am a third-year Doctor of Physical Therapy student from the University of Washington. I am writing you today to implore you to consider permitting physical therapists to use dry needling as a treatment modality in the state of Washington. I'm sure you have already been educated on the evidence supporting dry needling as its own separate modality from acupuncture. Dry needling is a modality that can have vast improvement on patient outcomes by addressing muscle trigger points in a fraction of the time it takes to resolve them using manual therapy. In addition to cutting time and subsequent healthcare costs, dry needling has the potential to decrease opioid dependence and prevent development of chronic pain and its sequelae. Though the fear of many East Asian Medical Practitioners is that physical therapy's use of dry needling will take away business from the acupuncture profession, the informed individual should know that acupuncture and dry needling

have very different medical applications, meaning there is little overlap between patient populations seen by each respective profession.

The physical therapy curriculum taught in PT school and through clinical experiences is grounded in the biological sciences, anatomy, and clinical patient care. This provides physical therapists with the necessary tools to learn more about and apply dry needling safely and effectively for our patients. As a soon-to-be graduate in the field of physical therapy, I want to be equipped with the most effective treatments for my patients. From the perspective of my personal development as a practitioner, I want to be the most efficient and effective practitioner I can be. Being allowed to practice dry needling fits into my view of doing no harm and providing the best outcomes for my future patients.

Please consider the extensive medical education that qualifies physical therapists to undergo further training for safe administration of dry needling. Please consider the different medical applications of dry needling vs. acupuncture and furthermore the little impact that dry needling application by physical therapists will have on the acupuncture business. Please consider the potential of dry needling application by physical therapists to prevent long-term disability and opioid dependence for countless patients, leading to quicker, better functional outcomes. Thank you for your time.

Kyle Mark, SPT

University of Washington Doctor of Physical Therapy Program | 2017 Department of Rehabilitation Medicine | University of Washington School of Medicine

My name is Chunlin Gao and I am a licensed acupuncturist since 1999 in the state of Washington. I am originally a physician graduated from Shanghai Medical School in 1975. I was also a professor at Qinghai Medical School specializing in OBGYN within the western medical system. I since relocated to Seattle, WA and received my master's degree from Northwest Institute of Acupuncture and Oriental Medicine. I've been practicing Chinese Medicine and Acupuncture integrating my western medical background from China since 1999.

I am qualified to state boldly that practicing Acupuncture requires many years of education in both western anatomy, physiology as well as the Chinese Medical channel theory and diagnosis in order to be successful and effectively treating patients.

It is appalling to me that Physical Therapists are attempting to practice acupuncture under the guise of a different name (i.e. "dry needling"). In my home country, China, there are only two types of needling, "wet" and "dry". Wet needling is injection of medicine into acupuncture points. Dry is needling on its own, which in United States, we call Acupuncture.

PT argues they would like to utilize needles in order to enhance their practice of pain treatments. However, with only 54 hours of training, this puts the public in danger. Why would Acupuncture schools need to undergo rigorous accreditation by the Department of Education in order to provide schooling to qualified individuals to be in intensive training for over 4 years in didactic and clinical settings? Why are the graduates of these schools required to take multiple national exams and meet individual state requirements before they are legally able to insert a needle into another person? One simple reason is, safety. A large part of the education is training students in needling techniques because this is an invasive technique.

Another reason that PTs would like to ignore is the fact that each point on the body represents a larger system that connects to the physical organs. Therefore, their "trigger points" that relieve "pain" on the surface level is actually having a greater impact on the entirety of the person. Because PTs do not have the background or education in Chinese Medicine, they would never understand what impact they are actually having. This is dangerous.

As well, PTs would like to believe that they "discovered" these "trigger points" but actually, for thousands of years, in Chinese Medicine it has been called "Ashi" points.

PTs also argue that acupuncturists treat the whole body so PT should be able to treat local areas of pain. This very statement shows their ignorance and lack of understanding of how every part of the body is connected and integrated, therefore, there is no treating only the local area. This is another reason why PTs practicing acupuncture "dry needling" is dangerous to the public. Essentially they have no theoretical or practical understanding of what exactly they are doing when they insert a needle into someone's body. This is just as ridiculous as acupuncturists proposing to perform surgery after two weekend trainings. Surgery isn't within our scope. Just as acupuncture "dry needling" is not within PT's scope. Chinese Medicine is a complex system that has existed for thousands of years in which acupuncture is one technique. Physical Therapy has existed for the last 100 years, there is no comparison.

Chunlin Gao, LAc

I'm writing in favor of physical therapists being able to practice dry needling. I know much of the controversy around dry needling rests within the question of how closely dry needling relates to acupuncture, but I feel this is not the real issue at hand. Instead I think this becomes a question of monopoly and the disablement of consumer rights.

Journey with me if you will. As physical therapists in Washington state, we saw the chiropractic profession try to monopolize on manipulation. Now we have the profession of acupuncture doing the same with the use of needles. Next comes the personal trainers staking a claim at exercise prescription,

then doctors wanting all relevant diagnostic information to be theirs alone, physiatrists wanting sole ownership of ultrasound, and the list goes on and on. I'm using a slippery slope fallacy in speaking this way, but the fact remains that many professions overlap in their abilities and skills. Choosing to distinguish one field as the sole provider of a technique creates a healthcare environment that leaves not only the consumer at risk, but also leaves little room for accountability.

Incorporating dry needling into physical therapy practice is not incorporating acupuncture into physical therapy practice. Including this one technique in physical therapy practice is simply that, including one technique that may or may not have actual overlap with acupuncture techniques. In the end is that so terrible? Is having a similar technique, that in both professions requires education and skill a bad thing? Is having a similar technique that is aimed at patient care and better functional outcomes an awful choice? I think the answer is clear that by allowing physical therapists to practice this one technique we continue to address patient health, patient outcomes, and create a system in which our primary concern is still the patient.

Serena Fiacco, SPT

University of Washington Doctor of Physical Therapy Program | 2017 Department of Rehabilitation Medicine | University of Washington School of Medicine

I am writing to advocate for the legislative proposal SB 6374 which would allow physical therapists to perform dry needling. I am a current physical therapy student at the University of Washington with only one year left of internships before I graduate next spring.

Having completed the entire extensive academic portion of the curriculum, it is frustrating to me to know that even with all my foundational knowledge of anatomy, I am not able to legally perform dry needling, a technique that can add immense value to patient treatment. Most physical therapy students in the country are not met with this same frustration, as in 19 states physical therapists are permitted to perform dry needling with no additional education/training specific to the technique. Meanwhile, in 13 other states physical therapists are able to perform dry needling following the completion of additional education and training.

In Washington, we do not have this same opportunity to perform dry needling, even if we seek out additional education. This is particularly disheartening in light of the information generated by an independent report commissioned by the Federation of State Boards of Physical Therapy that was published in 2015. This report stated that entry-level DPT programs were found to provide more than four-fifths (86 percent) of the relevant knowledge requirements needed to be competent in dry needling. With only 14 percent more training I could be performing a technique that has been found to be both efficient and safe for patients.

This restriction of the physical therapy scope of practice does not allow me and my fellow physical therapy students to best utilize our education and it deprives patients of a treatment technique that can be more effective and efficient than other methods to increase their function and decrease their pain.

I urge you to consider how this expansion of the physical therapist scope of practice could enhance patient care and allow for full utilization of treatment techniques to the benefit of both the patients and the therapists. Thank you for your time and consideration.

Rachelle Boettcher, SPT, University of Washington, Doctor of Physical Therapy 2017

This letter provides public comment in reference to the proposal to add dry needling to the physical therapist scope of practice.

I request the WA State Department of Health to recommend adding dry needling to the physical therapy scope of practice. The following is provided in response to the requirements set forth in RCW 18.120.030:

Pain causes people to do harm to themselves and others in the quest to reduce the agony. They take NSAIDs which raises the risk of coronary artery events by ~30%. They take Tylenol which is known to cause kidney damage. They take narcotics which are known to be addictive. These addicts fill our emergency rooms and doctors offices daily in their demands for pain medication. When they can no longer obtain prescriptive narcotics they frequently turn to alcohol, illegal drugs or legalized marijuana. It's obvious that pain has caused a lot of damage to our society and economy.

- I am a patient with a damaged heart and damaged knees. I am not allowed to take NSAIDs because of the increased risk of cardiac events. One knee needs to be replaced but cannot be replaced because of my weakened heart. I am relatively young and have, perhaps, decades of excruciating pain. Dry needling is a technique proven to reduce/remove pain without risking further heart damage. My health insurance plan was chosen to support my in-network health care providers – heart transplant team, cardiologists, orthopedic surgeons and physical therapists. Very few Washington State acupuncturists are in network for my health insurance plan which is aligned to Western Medicine.
- My elderly mother herniated a disc in her spine @ L4 last year then experienced multiple fractures to her pelvis due to osteoporosis early this year. She spent a week in the hospital and was released in the same level of pain that she had when she entered the hospital. She was in terrible pain – long term pain. Back surgery was deemed too risky and the pelvis fractures needed time to repair. The back surgeon recommended acupuncture. I spent weeks calling acupuncturists in Snohomish County – dutifully leaving messages and hoping for a return call. Sadly, few returned the calls which indicate a lack of compassion/caring. Most of the local acupuncturists are out of network for my mothers' Med-advantage plan, resulting in frequent commutes into Seattle which was contra-indicated for her health condition. She could not remain in her apartment if she took narcotic pain medicine, so she chose – at 87 years of age – to utilize only Tylenol and NSAIDs for months of extreme pain during the healing process. She would have had a better quality of life if her physical therapist had been allowed to perform dry needling. Medicare costs would be reduced and the government metrics for re-hospitalization would improve.

It is simply ridiculous that any patient be required to travel out of state or out of country to seek pain relief and healing from physical therapists that are licensed to provide dry needling!

There has been a lot of discussion and debate revolving around dry needling in the past few years. I have never personally experienced the benefits of this treatment, but I have encountered many people that have, and there is consistently resounding positive response.

Physical therapy is based on movement sciences to address specific musculoskeletal and neurologic issues. The tools to enhance movement at our disposal are currently soft tissue work, therapeutic exercises and activities, and manual techniques all of which are dictated to some degree by patient discretion. When it is up to the patient to determine their type and quality of care, they should be given all the options of treatment from an equally qualified provider in the study of the body and trigger points. At a Combined Sections Meeting lecture this past February there was a case presented in which a teenager with cerebral palsy attended physical therapy each week to have dry needling performed to his quadriceps muscles. He returned each week and truly looked forward to these sessions because it was the only time he was able to receive some relief and increased motion in his legs.

Acupuncturists and physical therapist both study the body, and both have the necessary skills to provide dry needling; however, the approach is different. Physical therapy takes a more direct approach the

alleviate pain to the involved muscles whereas acupuncturists take a more holistic approach of the entire body to address one particular issue. The treatment areas they address may not even be near the site of pain. With these different techniques and the ideal outcomes from therapists that have used dry needling, this practice should not be limited by the state's governmental process. The Physical therapists complete a rigorous academic workload and clinical rotations before being allowed to sit for the boards, thus ensuring their competency. We are Doctors in rehabilitation medicine who spend lengthy hours studying the human anatomy and evidence based practice; we are well-equipped clinicians and should be able to perform the treatment of dry needling.

Alexis Bonny, SPT, University of Washington, Department of Physical Therapy Rehabilitation Medicine

I support the proposal to add dry needling to the PT scope of practice.

Deb Schaack

I STRONGLY OPPOSE physical therapists having dry needling under the scope of their practice.

Sarah Collins

My name is Rose Leavens, and I am a 2nd-year physical therapy graduate student at the University of Washington. I am writing today to ask for your support in adding dry needling to the physical therapy scope of practice. In January, I was diagnosed with a disc herniation in my neck, at which point I started both acupuncture and 4 months of physical therapy for treatment. Both treatments were extremely helpful, however it was for very different reasons. Acupuncture helped increase circulation and oxygenation of my tissues through meridians, a process that is outside of my knowledge base and understanding. Physical therapy facilitated muscular balance of length and strength through the release of trigger points and targeted exercises for me to perform at home. My physical therapist spent multiple sessions working on release of my trigger points, which was one of the biggest pain relievers for me. It was only after these trigger points had been released that I was able to successfully perform activities that were meaningful to me, such as lifting and carrying any object greater than 5 pounds. Should my therapist have been allowed to perform dry needling on me for the release of trigger points, I am confident we would have been able to progress more quickly to functional activities and postural training, and thus discharge me from physical therapy sooner. This is because it would have only taken a single appointment to release trigger points with dry needling and move forward to more meaningful activities, rather than spending 4-5 visits working on releasing the muscles that were so irritated they were preventing me from moving properly.

Both physical therapy and acupuncture are wonderful treatment options for individuals with musculoskeletal problems. However, they are vastly different and each use a unique approach to treatment based on only the same anatomy, not the same medical principles. The only similarity between a physical therapist performing dry needling and an East Asian Medicine Practitioner performing acupuncture is the needle itself. This similarity alone is not enough to deny physical therapists including the use of needles in their scope of practice. Medical doctors did not prevent us from using stethoscopes or reflex hammers, and massage therapists did not deny our inclusion of soft tissue manual therapy techniques in our practice. All of us as healthcare professionals are doing our part to improve patient care and address our patients' medical concerns as efficiently and effectively as possible. The prevention of one modality being used by multiple disciplines will hinder this patient care process.

Please support the physical therapist's desire to include dry needling in our scope of practice.

Rose Leavens, SPT, Co-President | University of Washington Doctor of Physical Therapy Class of 2017

My name is Carley Rissman and I am a current student in the Doctor of Physical Therapy program at the University of Washington. I support the current proposal by PTWA to include dry needling within the scope of practice of physical therapy via an endorsement on the physical therapy license.

As a student, I have participated in advocacy activities concerning physical therapy services and professional issues – including dry needling. Additionally, I was able to attend the recent Sunrise Review hearing (though I arrived after the sign in sheet was removed). I am proud to be a lifelong resident of Washington State and plan to continue working and living here after I graduate and become a fully licensed physical therapist. As such, I hope to be able to practice in ways that maintain high standards of patient safety, provide value to my patients, allow me to use good clinical judgement based on patient need, and are within both my knowledge base and scope of practice. Based on the anatomy, physiology, palpation, and other elements of my physical therapy education, I feel that dry needling should be a part of that future practice when applied appropriately and completed safely after additional specific training on dry needling. In many states, the standards within t!

he Doctor of Physical Therapy education are enough to allow dry needling practice without additional education or requirements. However, as our professional association encourages physical therapists to work not just within their scope, but their knowledge base, many physical therapists obtain additional education in order to use best current practices.

The current proposal by PTWA goes above and beyond what most states require – the additional endorsement would ensure that only qualified practitioners are able to actually practice dry needling. The endorsement for dry needling practice can be likened to the spinal manipulation endorsement which was recently added to the physical therapy scope of practice – a compromise between physical therapy and chiropractic professions which provided and ensured a place for both in Washington State. I feel that the current proposal is an analogous compromise which respects the differing history, traditions, and practices of the acupuncture and physical therapy professions.

Carley Rissman, SPT, Division of Physical Therapy, Department of Rehabilitation Medicine
University of Washington

I am writing in regards to the Washington State issue on physical therapists performing dry needling, HB 1042. As I complete my second year of PT school at the University of Washington, I am excited to begin my three clinical rotations. It is upsetting to me, however, to know that one particular intervention isn't going to be part of my learning experience. That is dry needling. Due to lawsuits against PTs using the practice and legislation making it illegal for PTs to perform dry needling, I won't have the benefit of learning first-hand how this intervention is used to improve patient care.

As a reminder, dry needling is a practice using a solid filament needle without medication through skin into underlying tissue to treat neuromuscular conditions, pain, movement impairments and disability. It is based on modern scientific studies of the neuromusculoskeletal system including anatomy, physiology, histology, biomechanics, neuroscience, kinesiology, pharmacology, and pathology. PTs are skilled practitioners in these systems, having more than four-fifths of the relevant knowledge requirements needed to be competent in dry needling already at the time of graduation from an established DPT program. In addition, in order to perform dry needling, PTs would be required to complete advanced, post-doctorate continuing education which would include 55 hours of psychomotor training relating to needle technique, palpation, selection and placement taught by MDs or PTs in a medical institution or established clinic.

This practice is not meant to stand in place of acupuncture. Rather, it is to be used in conjunction with other PT interventions to improve movement and function in an efficient and effective manner. For example, if a patient has limited mobility and impaired movement patterns due to muscles with excessive tension, the PT could spend 60 minutes doing manual therapy to try to calm those muscles down. More likely, the PT will refer the patient to a massage therapist with specific instructions and see the patient once that issue is resolved, because it isn't worth the patient's time or money for the PT to spend 60

minutes on one issue. However, dry needling is effective after several minutes. If the PT could use this intervention, they could then incorporate this into the treatment and address the movement and functional impairments within the same session, saving the patient time and money.

I appreciate you taking the time to read this email and I hope that you can see the benefits of PTs using dry needling. Please do not hesitate to ask for more information to better understand the issues.

Helen Dailey-Fallat, SPT, University of Washington Doctor of Physical Therapy Program | 2017
Department of Rehabilitation Medicine | University of Washington School of Medicine

I am writing to you today to advocate for the approval of dry needling to be in the scope of skilled practice for physical therapists in Washington State. I am a second year student in the Doctor of Physical Therapy program at the University of Washington. In addition to instilling the values of evidence based practice in our profession, the University of Washington has been exemplary in providing us students with the latest research in interventions that will greatly benefit our patients in our future practice. One of these interventions is trigger point dry needling. I believe that including dry needling within the scope of physical therapy practice will greatly advance patient care.

Dry needling stimulates myofascial trigger points in order to improve pain and reduce muscle tension. Like any intervention that we use with a patient, we follow up with home exercise programs so that patients are empowered to maintain the gains achieved in our session. For example, after performing a trigger point release in the quadriceps muscle on a patient, we provide the patient with skilled stretching and manual techniques so that they can maintain pain free motion and take charge of their own bodies. This is what I love about the profession that I am entering. We not only use skilled interventions to improve patient function, we also empower patients to stay healthy instead of encouraging them to continue to seek physical therapy treatment indefinitely.

Dry needling is one of the most effective techniques to provide quick relief to a tense and painful muscle for our patients. Unlike acupuncture, which uses "meridians" or "chi" to guide treatment, dry needling focuses on well established trigger points in our musculoskeletal system. As such, knowledge of the nervous system as well as the musculoskeletal system is key in order to accurately perform dry needling. Our physical therapy curriculum has given us extensive knowledge of these systems and we are well equipped to provide patients with this intervention.

I see enormous promise in my field for providing excellent and evidence based care to patients. Including dry needling in our scope of practice will be an asset to future patients.

Johanna Leader, Doctor of Physical Therapy Student, University of Washington | Class of 2017

My name is Jianfeng Yang and I am an EAMP and L.Ac. in Washington State. I graduated from Chengdu University of Traditional Chinese Medicine (TCM) and started to my practice since 1970. I taught Acupuncture and Chinese herbal medicine 19 years in China and 11 years in USA. In TCM Universities or Schools, for all acupuncture students, they need to go through three quarters training for basic acupuncture techniques and one more quarter for advanced course training, and then they are allowed to use needles to puncture human body points. If PTs want to use needles to treat patients, for the safety purpose, they must know the angle and depth of needle insertion, location of points, body constitutions, emotions and spiritual status very well, otherwise, they could hurt internal organs causing severe accidents, severe damage of blood vessel or/ nerves or/ needling sharks or/ needling broken And they also need to know how to handle these accidents once happening. To be a qualified acupuncturist, it needs at least 5 year training in China and 3-4 years training in USA. All PTs need to go to qualified acupuncture schools on universities to get normal training and get license if they want to practice

acupuncture. For public health concerns, all PTs should not be allowed to do acupuncture with only 54 hours training.

Please look at the following statement, which maybe helpful to understand what PTs called dry needling is actually acupuncture.

February 22nd, 2016

**Statement of World Federation of Chinese Medicine Societies:
Dry Needling is within the Scope of Acupuncture and Moxibustion of
Traditional Chinese Medicine**

It is known that some practitioners are applying a method of treatment, called dry needling, in their medical practices. This method of treatment refers to puncturing trigger points in the myofascial tissue with acupuncture needles, so as to release statues, such as pathological muscle tension, and to treat diseases, such as myofascial pains. These trigger points are actually channel points, extra points and Ashi points in acupuncture and moxibustion of traditional Chinese medicine. Besides, puncturing manipulations and needles of dry needling are the same as those of acupuncture and moxibustion of traditional Chinese medicine. Therefore, dry needling is actually 're-discovery' of acupuncture and moxibustion of traditional Chinese medicine, and is a component of different kinds of traditional and modern acupuncture therapies.

World Federation of Chinese Medicine Societies acknowledges that, dry needling is a component of the therapy of Chinese acupuncture and moxibustion, and it cannot be developed independently without medical principles of Chinese acupuncture and moxibustion.

World Federation of Chinese Medicine Societies advocates, in the course of utilizing the achievement of acupuncture and moxibustion of traditional Chinese medicine, practitioners should respect the fact that dry needling is within the scope of acupuncture and moxibustion of traditional Chinese medicine, respect acupuncture theories and traditional culture of acupuncture and moxibustion of traditional Chinese medicine, so as to promote the worldwide development of acupuncture industry in a healthy and orderly way.

I am currently a DPT student at the University of Washington, and I was also a patient who received dry needling for neck pain. My neck pain affected me on and off for about 5 years, with the shortest "off" phase lasting about 2 weeks. I was working with a physical therapist for my neck pain and I had reached a plateau in my recovery, where I was unable to complete my exercises effectively enough to reduce my neck pain. At her urging, I went to a physiatrist who performed dry needling to have this type of treatment done, to see if we could make more headway in my therapy. I went for 2-3 dry needling treatments, spaced several weeks apart, while I also continued with physical therapy.

With the help of dry needling, my neck pain and headaches have resolved, and I have been symptom free for almost 2 years. I believe I would have wasted a lot of physical therapy visits trying to get better if I had not received dry needling treatment. It was unfortunate that I had to go to another professional to receive this procedure. I feel if my physical therapist had been allowed to perform dry needling, I would have saved money and time by only going to one provider. My physical therapist had the background knowledge about me and my body to send instructions to the physiatrist to indicate which muscles should be targeted to best facilitate my recovery. Based on my personal experience with dry needling, and as a physical therapy student about to enter the medical field, I strongly feel that physical therapists have the knowledge, background and patient history to be able to perform dry needling safely, effectively and efficiently, for the benefit of the patient and to help

keep costs low in our current inefficient medical system. As a future physical therapist, I look forward to being able to using every tool available to fully assist in a patient's recovery.

Thank you for your time,

My name is Tae Sun Krishnek and I am a 2nd year DPT student from the University of Washington. I wanted to put forward some thoughts I had about physical therapists using dry needling:

One argument against physical therapists (PTs) practicing dry needling is the suggestion that trigger point dry needling is the same as acupuncture and physical therapists are not licensed to perform acupuncture. An objection to this claim is that dry needling is, in fact, a unique intervention based on modern western ideas about anatomy and neurophysiology. This view is supported by Stephen Birch, one with expertise in the area, who writes that trigger points occur proximate to the site of dysfunction or within a referred region while acupoints addressed by acupuncture can occur distant to the site of symptoms. In conclusion, the two practices are discrete and treat different points using dissimilar theory and background.

Another argument against PTs practicing dry needling is that it may be unsafe. A study performed by Brady in 2013, however, showed that serious adverse effects (more than bruising or pain) are uncommon and occurred in only 0.04% of dry needling treatments.

An important consideration is that dry needling fits within PT's scope of practice. This argument is supported by the claim that dry needling involves the use of what the American Physical Therapy Association refers to as "mechanical devices" (needles) and the knowledge of neurology and anatomy to treat neuromusculoskeletal impairments that PTs are trained in. This view is shared by Douglas Gansler, the attorney general of Maryland.

Lastly, PTs should practice dry needling because it is an effective intervention for treating neuromusculoskeletal pain and movement impairments, which is the clinical expertise of the field of physical therapy. Dry needling has been proven to be effective in treating pain in patients with myofascial pain syndrome in a 2013 study by Kietrys et al.

Overall, I believe that physical therapists have the knowledge and skills to safely and effectively perform dry needling and that they should be allowed to employ this intervention for the well-being of those with musculoskeletal pain and movement impairments. I appreciate your time.

Tae Sun Krishnek, SPT, University of Washington Doctor of Physical Therapy Program | 2017
Department of Rehabilitation Medicine | University of Washington School of Medicine

My name is Nichole Cleland and I am writing in regards to the "dry needling" discussion.

I have been a patient of a traditional acupuncturists for several years and have had great success because of the knowledge of my practitioner Xia Che (<http://www.everetti-chingacupuncture.com/xia-che/>). She has extensive education and training and I would not feel safe and secure in her care otherwise. To allow someone to earn the right to do such a delicate and complex treatment while only having basically a weekend of training is scary: scary to what could possibly go wrong and scary because of the damage to the reputation of actual, quality acupuncturists as the lesser trained ones cause injuries and eventual law suits.

It will taint the practice to allow poorly trained "techs" (essentially) to be able to use the title of a licensed acupuncturists.

As a patient, I cannot stress how bad of an idea to allow this "dry needling" to happen.

Nichole Cleland

I am a physical therapist who was at the Sunrise hearing on August 2nd. I was one of the contributors to the written Sunrise Report submitted by the PT's. Though I didn't sign up to speak, I wish I would have just to address some of the comments/questions that were voiced by the board and some of the points brought up by the opposition. I would like to address some of those points of confusion and hopefully add some clarity.

One of the questions that came up a number of times was regarding medical acupuncture training, the 300 hours required for that, and how that compares to the PT training of dry needling. It was also mentioned in many of the comments from the opposition that if PT's want to do dry needling, they should follow a similar pathway as the naturopaths (ND) and chiropractors (DC) when they are training for an acupuncture certification. I contributed to the education section of the Sunrise Report and addressed this specific issue. The main point to be made here is that all of these training pathways are training for acupuncture (an Eastern medicine based philosophy and practice), not dry needling (a western medicine based modality). Dr. Dammerholt did a good job of explaining the difference between acupuncture and dry needling and how they overlap in some ways, but are based on two very different schools of thought, and therefore are used differently as treatment approaches, and are frequently described by those having received both as being very different experiences. I further emphasized these points in the Sunrise Report by looking very specifically at the medical acupuncture training curriculum and breaking it down by what PT's have already learned in school, what they do not need to learn, because it has to do with the practice of acupuncture, and what we need to learn in further schooling in order to safely treat using dry needling. I believe you can clearly see how much of the curriculum in the medical acupuncture training, and likely ND and DC acupuncture training, is irrelevant or repetitive for PT training for dry needling. A better comparison would be the course that many MD's take in order to perform dry needling or intramuscular stimulation (IMS), very different than medical acupuncture. The most notable local course is in Vancouver BC by one of the founders of IMS, Chan Gunn. He has been practicing and teaching since the 70's. I included that course information in the report as well. The curriculum for that course spans a couple weekends and is open to many different kinds of practitioners including both MDs, NDs, DCs, and PTs. Again, this is for dry needling (named IMS by this school), very different from medical acupuncture.

One other point that I wanted to make based on many of the questions asked regarding the training as it exists now for dry needling is in regards to the testing during that training. Safety and needle technique is one of the highest priorities during the training. I included a chart in the report that shows this to more clarity, but I wanted to emphasize that most courses rigorously test the course participants at the end of each course. This testing includes written and practical exam. Also, in the Kinetacore training, level one is focusing on basic needle technique and is taught on muscles that are easy to treat and very low chance of risk (either of hitting significant blood vessels or pneumothorax). Level two teaches some of the more advanced techniques and trickier muscles to treat. Before someone can advance to level two, they have to document 200 treatment/patients using level one techniques/muscles. They must document the symptoms experienced by the patient, the muscle treated, the response in the muscle, and the outcome.

Finally, on a more personal note, I am a PT who works closely with many acupuncturists and received treatment myself. I am a strong believer in acupuncture as a successful treatment. However, it is different than dry needling done by a PT. I had bilateral hip replacements due to severe arthritis because of congenital dysplasia. Before my replacements, I was in quite a bit of pain and many of my muscles were turned off or overactive because of my pain. Though acupuncture addressed the pain, it wasn't until I was in CO and received dry needling there, that I truly saw a lasting benefit from the needling. Before surgery, my pain relief and level of function dramatically improved after one session of needling, and would last for a month. Whereas any pain relief from acupuncture would last at most a week. After surgery, I could continually make gains in strength and mobility that would last after one session of dry needling followed by exercises and stretches that I could continue to do to teach my body to retain what was gained in the needling session. This is a very different approach than acupuncture. As a PT, I still will refer to acupuncturists, as I believe their services are invaluable, but the only person I can refer to now to needle is a physiatrist, who is more expensive and more difficult to get in to see than a PT. Plus, I don't get to follow up with those patients right away to help retrain those muscles that have been needed,

and I find the results don't last as long.

Thank you for your review of the report, comments, and the hearing. I hope this has helped open your eyes to the benefit for needling done by PTs and how it is different than acupuncture and is a much needed service for our patients.

Carrie Helminger

My name is Olivia Nielson, and I am a soon-to-be third year physical therapy student at the University of Washington. I'm writing this letter to express my thoughts about the use of dry needling in the physical therapy profession. Dry needling is the insertion of a thin needle into painful and palpable nodules of skeletal muscle known as myofascial trigger points, which improves blood flow and reduces pain in the area where the needle is inserted. It is a safe and effective technique to alleviate soft tissue impairments in order to restore proper muscular functioning. Although there are other manual therapy techniques to restore soft tissue functioning, dry needling can release myofascial trigger points in less time and with less effort in comparison to these other manual techniques. Therefore, the efficacy and efficiency of dry needling allows physical therapists to spend more time on other necessary treatment interventions, which leads to better patient outcomes and !
higher quality care.

All treatment interventions have the risk of adverse events, however, dry needling has proven to be a consistently safe intervention for the past 20 years. There is no existing literature that suggests that physical therapists cause any serious harm with dry needling, and the Federation's Disciplinary Database has no record of a physical therapist causing harm from dry needling. Physical therapists are equipped with an entry-level doctorate education, and with continuing education will be able to safely utilize dry needling in their practice.

On a personal note, I find it frustrating that after two years of extensive education on the subjects anatomy, physiology, neuroscience, pathology, clinical reasoning, evidence-based practice, manual therapy, body systems and more, I would not be allowed to practice the technique of dry needling. It is a safe and beneficial intervention for my future patients, and I want to be able to utilize this intervention because it will optimize my patients' care. Therefore, I urge the Board to recognize that dry needling is a part of the physical therapy scope of practice.

Olivia Nielson, SPT, University of Washington Doctor of Physical Therapy Program · 2017

This letter submitted by a number of patients and health care providers:

I rely on my health care professionals to be fully trained by accredited institutions and licensed by the State of Washington. The proposal by the Physical Therapy Association of Washington to perform "dry needling" is woefully inadequate. It does not adequately address harm, assurance of professional ability, or cost-effectiveness. By their own descriptions, what they describe is acupuncture.

There are many dual licensed practitioners in the state of Washington, who hold multiple licenses to practice multiple disciplines. This is important to protect the public health and safety of the health care consumers in Washington State. The Department of Health should require that physical therapists complete the training and licensure to become EAMPs as is required under RCW 18.06.

Please deny the Physical Therapy Association of Washington's application in its entirety.

Brian Tang, Debra Marsten, Fong Freeman, Hayden Hamilton, Helen Chan, Iris Song, James Waugaman, Jodie Underwood, Johnson Chen, Ka Ting Tsoi, Lance Hornback, Michael Garcia, Nicole Keenan, Shu Chu Wang, Tak Li, Gary Abrahams, Yuelin Fan, Yun Xiao, Yuncai Su, Zhaoqing Lu, Yongfei Zhang, Xianqin Ban, Hai Fegn, Dr. Chancellor, , Xianguong Pu, Wenayang Huong, Jasmin Shun, Fengshan Zhu, Polina Angeringer, Angela Wu, Brianna Noach, Duncan Clark, Jing Yang, Yanmin Tan, Jason Yip, Jo

Ann Railton, John Reynolds, Susanna Reynolds, Diana King, Mike VanNuland, Mary VanNuland, Paul Renyolds, Jimmy Leung, Jieling Lu, Patrick Li, Maggie Kong, Shmuel El-Ad, Amin Lakha, GuoHua Si, Shirley Collins, Laura Puailihau Newton, Tiansong Wang, Carol Maa, Ellen Fetchiet, Gayle Taylor, Annie Tamburro, Dee Backiel

I am finishing my last week of academics before heading off to my clinicals at the University of Washington's Doctor of Physical Therapy Program, it is within the UW's School of Medicine in the Department of Rehabilitation. These past two years have been foundational not only in my development of knowledge of the human body and it's movements and processes but also in the development of my critical thinking. Our department has stressed from Day 1 the importance of Evidence Based Practice (EBP). This has become my credo as a new (almost graduated) student of physical therapy: I will not only use the literature, evidence, and clinical cases to help decide the most appropriate and effective route of treatment for my patients, but also critique the literature and evidence and how data is presented.

I truly believe that critical thinking and EBP can be and should be standard practice. With these beliefs I ask you to look at the evidence provided by both physical therapists and acupuncturists on the physical therapists' use of dry needling.

With the evidence out there, what dry needling is, PTs background and scholastic training, as well as how PTs apply it to our patient base, I do not see why we should be barred from using this incredible, effective technique. I have gone to acupuncture for many years and received quality treatment, however, having been a patient and knowing how PTs intend to use dry needling; I cannot see that they are one and the same thing. The technique varies as does the intention and goal.

Not only will our patients benefit from this type EBP, but I feel that I as a therapist with hypermobile joints will benefit from it. Instead of using my hands as my tools and potentially shortening my career by putting my hands through more work than they need, OR potentially not preforming a trigger point release on a patient that needs in it order to save my hands, by having this technique neither my patients nor my hands will suffer.

Algerae Bergstrom, SPT, University of Washington Doctor of Physical Therapy Program | 2017
Department of Rehabilitation Medicine | University of Washington School of Medicine

I, speaking on my own behalf, and speaking as a licensed Physical Therapist in the state of Washington for 23 years, and speaking as a Physical Therapist who does not perform intramuscular stimulation (dry needling) and won't do so in the foreseeable future. I am speaking as a professional who thinks that a profession should be able to direct and include effective practice methods to its practice that fall within the scope of practice and the laws that govern its practice. I get seriously concerned when an opposing practice group essentially uses scare tactics with the public and public officials to try and disallow us to use a method an effective treatment technique that is effective for a limited scope. I get seriously concerned when an opposing practice group equates a simple, limited technique to their broad medical base approach to treating everything. I get seriously concerned when an opposing practice group tries to bring forth safety concerns for our practice, but was unable to state their own safety concerns that describe their practice.

For the purposes of this remaining document, I will refer to the acupuncturists as East Asian/Oriental Medicine practitioners. The national accrediting body for Washington state's East Asian Medical Practitioners is the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM).

The East Asian/Oriental Medicine practitioners were not able to produce safety records of their own practice at the Sunrise review. I looked to the common scientific literature to survey the safety record of acupuncturists. I primarily looked at the reports from China. I did this as our Washington East

Asian/Oriental Medicine practitioners have stated their strong gravitation to the history and lore of Chinese based acupuncture/medicine in their practice and defense thereof. The following article reviews adverse events in Chinese acupuncture from 1980-2009. This does not represent the full history of Chinese medical practice.

Bull World Health Organ. 2010 Dec 1; 88(12): 915–921C.

[Junhua Zhang](#),^a [Hongcai Shang](#),^a [Xiumei Gao](#),^a and [Edzard Ernst](#)^b

Acupuncture-related adverse events: a systematic review of the Chinese literature

[Go to:](#)

Introduction

Acupuncture is popular in most countries, but nowhere more than in China. Because its use is so widespread, safety is an important issue that deserves close attention. Serious adverse events resulting from acupuncture, including pneumothorax, cardiac tamponade, spinal cord injury and viral hepatitis, have been identified in previous literature reviews.^{1–4} Prospective surveys to determine the frequency of acupuncture-related adverse events have been conducted in Germany,^{5,6} Norway⁷ and the United Kingdom of Great Britain and Northern Ireland.^{8,9} These studies have shown an incidence of mild, transient acupuncture-related adverse events that ranges from 6.71% to 15%. The most common adverse events of this type were local pain from needling (range: 1.1–2.9%) and slight bleeding or haematoma (range: 2.1–6.1%). In a prospective observational study of 190 924 patients, the incidence of serious adverse events (death, organ trauma or hospital admission) was about 0.024%.⁵ Another large-scale observational study showed a rate of adverse events requiring specific treatment of 2.2% (4963 incidents among 229 230 subjects).⁶ Studies such as these have shown that in extremely rare cases acupuncture can lead to serious, sometimes life-threatening complications, in addition to mild and transient adverse events.

Because most reports on the safety of acupuncture have been published outside China, the objective of this article was to summarize the Chinese literature on the subject of acupuncture-related adverse events and determine the possible reasons that such events occur.

[Go to:](#)

Methods

Inclusion/exclusion criteria

In December 2009 we searched the following electronic databases: Chinese Biomedical Literature Database (1980–2009), Chinese Journal Full-Text Database (1980–2009) and Weipu Journal Database (1989–2009). The search terms were: (*acupuncture* OR *needle*) AND (*induce* OR *cause* OR *adverse event* OR *adverse reaction* OR *side effect* OR *complication* OR *harm* OR *risk* OR *mistake* OR *infection* OR *injury* OR *fainting* OR *haemorrhage* OR *bleeding* OR *death* OR *pneumothorax* OR *pain*). We searched for these terms (in Chinese) as free text in the title or abstract, and we also hand-searched the reference lists of all reports located through the electronic searches.

Case reports, case series, surveys and other observational studies were included in the review if they reported factual data on complications related to acupuncture. Review articles, translations and clinical trials were excluded. The search was limited to Chinese-language papers.

Different types of acupuncture can lead to different adverse events. To present clear results, we only included reports on traditional needle acupuncture, defined as a procedure in which stainless steel

filiform needles are inserted into acupoints – acupuncture points located throughout the body that are associated with specific therapeutic effects – and manipulated in place. Other types of acupuncture, such as electroacupuncture, laser acupuncture and auricular acupuncture, were excluded.

Two authors (Zhang and Shang) independently examined the titles and abstracts of all papers found through the search to determine if they fulfilled the inclusion criteria outlined above. The full texts of potentially relevant articles were retrieved for detailed assessment. Disagreements between the two authors were resolved by discussion.

Information on author, patient, acupuncturist, acupuncture site, adverse event, treatment and outcome was extracted from the primary articles and entered into a pre-formulated spreadsheet. Acupoints were described by *pinyin* name (i.e. the Latinized spelling of traditional Mandarin Chinese names) and code according to a standard nomenclature developed by the World Health Organization.^{10,11} These data have been summarized in three tables according to the type of adverse event.

[Go to:](#)

Results

Our inclusion criteria were met by 115 articles (98 case reports and 17 case series) ([Fig. 1](#)). We noted no clear trend in the frequency of reports of acupuncture-related adverse events over the past 30 years.

[Fig. 1](#)

Flow diagram for systematic review of the Chinese-language literature on adverse events related to traditional needle acupuncture, 1980–2009

In total, 479 cases of acupuncture-related adverse events were reported. Patients ranged in age from 2 to 73 years. The first authors of the papers were members of medical departments, court jurisdictions and police departments. Only 20% of these authors were the acupuncturists who performed the procedure that caused the adverse event. The reported acupuncture-related adverse events were classified into three categories: traumatic ([Table 1](#), available at: <http://www.who.int/bulletin/volumes/88/12/10-076737>), infectious ([Table 2](#)) and “other” ([Table 3](#)).

Body site and reference ^a	Adverse event (no. of cases ^b)	Acupoint (code ^c or site)	Outcome
Spinal cord and neighbouring tissues			
Bao LP, Gao CT. Subarachnoid haemorrhage after acupuncture at Fengchi and Yamen points in 3 cases. <i>Jilin Med J</i> 1993;4:45–6. Bao F, Zhang XL, Tian SP. Acupuncture at Fengchi point	Subarachnoid haemorrhage (35 cases)	GB20, GV16, GV14, BL10	3 deaths, 32 recoveries

[Table 1](#)

Traumatic events after acupuncture, as identified through a systematic review of the Chinese-language literature, 1980–2009

Reference ^a	Cases ^b (age in years and sex)	Reason for acupuncture	Acupoint (code ^c or site)	Adverse event	Outcome
Zhang XJ. Acupuncture caused buccal space abscess. <i>Med J Chin People's Armed Police Forces</i> 2007;18:778.	23, male	Toothache	Buccal region	Buccal space abscess	Recovery
Wang YJ. Acupuncture	52, male	Toothache	Buccal region	Temporal	Recovery

[Table 2](#)

Case reports of infection after traditional needle acupuncture, as identified through a systematic review of the Chinese-language literature, 1980–2009

Table 3
Acupuncture-related adverse events other than trauma and infection, as identified through a systematic review of the Chinese-language literature, 1980–2009

Reference ^a	Cases ^b (age in years and sex, or no. of cases)	Reason for acupuncture	Acupoint (code ^c or site)	Adverse event	Outcome
Liu CB. Acupuncture-related syncope in 4 cases. <i>J Clin Acup Manipulation</i> 2001;17:51.	34, 45 & 50, females	Low back pain; shoulder pain		Fainting	Recovery
Li YZ. <i>Chin J Acupunct</i> 1997;19:11.	42, female	Shoulder pain	Shoulder site	Fainting	Recovery

[Table 3](#)

Acupuncture-related adverse events other than trauma and infection, as identified through a systematic review of the Chinese-language literature, 1980–2009

Traumatic events

Traumatic injuries were reported in 87 articles (73 case reports and 14 case series) and totalled 296 cases. The events were classified into seven subgroups according to the type and site of the injury.

Arachnoid and spinal dura mater

Nine cases of spinal epidural haematoma (in the cervical, thoracic and lumbar spine) were reported. No further information was provided.

Subarachnoid haemorrhage was reported in 35 patients, 3 of whom died. The others recovered after 1 to 8 weeks of treatment. One of the deceased patients had a history of hypertension and

cerebral haemorrhage and died 10 days after the acupuncture. The other two patients died within 30 minutes of having undergone the acupuncture, perhaps as a result of injury to the medulla oblongata.

The acupoints most frequently involved in cases of subarachnoid haemorrhage and spinal epidural haematoma were Fengchi (GB20), Yamen (GV15), Fengfu (GV16), Dazhui (GV14) and Tianzhu (BL10). In several cases, the needles were inserted to a depth of 4 to 5 cm below the skin's surface, and such deep insertion is suspected to have led to injury.

Thoracic organs and tissues

With a total of 201 cases, pneumothorax was the most frequently reported acupuncture-related adverse event. Four patients died from it and the others recovered after 2 to 30 days of treatment. One patient was a 70-year-old woman with a history of chronic bronchitis, emphysema, cor pulmonale and heart failure who died from pulmonary infection, heart failure and pneumothorax. Two more women died after not receiving timely treatment for pneumothorax caused by needling at the Jianjing (GB21) and Tianding (LI17) acupoints. The fourth patient died from tension pneumothorax but no further information was provided.

The acupuncture sites in these cases were primarily in the shoulder and scapular regions (64%) and in the chest (24%). In two cases, the Tianding (LI17) point in the neck area had been needled. The most frequently used acupoints were Jianjing (GB21; 30%), Feishu (BL13; 15%), Quepen (ST12; 10%) and Tiantu (CV22; 10%). Other acupoints were Ganshu (BL18), Shenshu (BL23), Tianding (LI17), Jiuwei (CV15), Juque (CV14), Jianzhen (SI9), Quyuan (SI13) and Dingchuan (EX-B1).

Chylothorax was reported after needling at the Feishu (BL13) point in a 21-year-old man with a malformed thoracic duct. Right ventricular injury was reported in four cases, two of which recovered

after surgical treatment. The other two patients died from right ventricular puncture complicated by cardiac tamponade and multiorgan dysfunction syndrome. One case of aortic artery rupture was reported after needling at the Qimen point (LR14) at a depth of 4 cm; the patient died within 15 minutes. Coronary artery injury with cardiac tamponade was reported in a man who treated himself for chronic bronchitis and lost the needle at the Zhongfu point (LU1).

Abdominal organs and tissues

Injuries of abdominal organs and tissues were reported in 16 patients, all of whom recovered after surgery. These instances included perforations of the gallbladder, of the bowels and of the stomach, frequently complicated by peritonitis. A 2-year-old boy suffered intestinal wall haematoma with intestinal obstruction after acupuncture treatment for diarrhoea.

The acupoints associated with such adverse events were Tianshu (ST25), Zhongwan (CV12) and Qimen (LR14). Most of the patients underwent acupuncture for abdominal pain, attributable mainly to appendicitis or cholecystitis. Deep needling accounted for most of the abdominal injuries.

Neck area

Six cases of injuries in the neck region were reported, including neural injuries (4), a false aneurysm of the carotid artery (1) and thyroid haemorrhage (1). One patient died after acupuncture at the Tiantu point (CV22); the needle had been inserted to a depth of 6 cm.

Eyes

Five articles reported injuries to the eyes, including orbital haemorrhage (3), traumatic cataract (1), injury of the oculomotor nerve (1) and retinal puncture (1). One case of optic atrophy accompanied by haemorrhage and traumatic cataract resulted in visual impairment.

The acupoints in the above cases were Jingming (SL1), Qiuhou (EX-HN7) and Chengqi (ST1). When needling acupoints in the area of the orbital cavity, bleeding is difficult to avoid, even for the experienced acupuncturist. Deep needling can also injure the oculomotor nerve, the retina and neighbouring tissues.

Peripheral nerves, vessels and other tissues

Three cases of haemorrhage were reported after acupuncture on the cheeks and the hypoglottis. One case of calf haematoma complicated by diabetic foot was caused by needling at the Tiaokou (ST38) and Chengshan (BL57) acupoints.

Four cases of peripheral motor nerve injuries and subsequent motor dysfunction were reported. Three children suffered adductor muscle fibrosis and adduction deformity of the thumb as a result of local vascular and muscular injuries from needling at the Hegu point (LI4).

The acupoints most frequently involved in the injuries were Taiyang (EX-HN5), Neiguan (PC6) and Hegu (LI4). Forceful needle manipulation at these points, which are quite superficial, can cause injury to peripheral nerves, capillaries and muscle fibres.

Needling site pain and broken needle

Four cases of pain at the needling site were reported in two articles. An intra-abdominal lump turned out to be caused by an acupuncture needle fragment that had broken off 15 years earlier.

Infectious events

Nine cases of bacterial infection and two cases of viral infection were reported. All patients recovered after appropriate treatment.

Infections were mainly due to poor sterilization of acupuncture needles. Acupoints on the head became infected most often, perhaps because hair makes it difficult to implement aseptic technique. Two cases of facial abscess may have been caused by acupuncture to relieve toothache.

Other adverse events

A total of 172 acupuncture-related adverse events that were neither due to trauma nor to infection were reported. Local allergic reactions occurred after acupuncture in four patients with an allergy to metal needles.

In our review, fainting was the most common adverse event associated with acupuncture, and it occurred primarily in patients receiving acupuncture for the first time. In total, 150 cases of fainting were reported. In one report of 82 cases, 60% (49) of the patients fainted during the first treatment. Of these 49 fainting spells, 83% occurred when acupuncture was being applied to the head or neck.

Stroke after acupuncture was reported in five patients (aged from 58 to 73 years). One case of stroke occurred in a 72-year-old woman who received acupuncture on her arm. The other four patients had a history of stroke and hypertension. Three patients died from cerebral haemorrhage that was considered to be causally related to the acupuncture.

Other adverse effects included cardiac arrest, pyknolesy (epileptiform attacks resembling petit mal), shock, fever, cough, thirst, aphonia, leg numbness and sexual dysfunction. However, the existence of a causal link between acupuncture and these adverse events is uncertain.

[Go to:](#)

Discussion

Many types of acupuncture-related adverse events have been identified in the Chinese literature. Injuries and infections appear to be related to inappropriate technique, whereas other types of adverse events are not. Fainting is vasovagal in origin and minor bleeding is sometimes inevitable.

Infections result primarily from poor aseptic procedure and insufficient knowledge on the part of acupuncturists, who often disinfect reusable acupuncture needles with alcohol instead of sterilizing them. The use of disposable sterile acupuncture needles and guide tubes is strongly recommended.¹²

Most traumatic events are caused by improper manipulation in high-risk acupoints. The depth of needle insertion is crucial. The lung surface is about 10 to 20 mm beneath the skin in the region of the medial scapular or midclavicular line.² This may explain the high incidence of pneumothorax during needling in this area. Other traumatic complications, such as subarachnoid haemorrhage, cardiovascular injuries or perforation of the gallbladder, can also be caused by excessively deep needle insertion.

The patient's condition also needs to be considered. Cardiovascular trauma occurred most frequently in patients with cardiomegaly. Patients with abdominal pain that has no clear diagnosis are at increased risk of trauma or infection from acupuncture at abdominal acupoints. Symptomatic treatment of abdominal pain with acupuncture can also delay effective therapy.

During needling at peripheral acupoints on the legs, arms and face, manipulation should be carefully executed to avoid damaging nerves and blood vessels.

Some adverse events are inevitable but could be minimized through preventive measures. Fainting, which is a reflex caused by vagal excitation, is the most common adverse event during acupuncture.¹³ Its incidence can be reduced by preparing patients and positioning them properly; the patient should not be hungry or tired and should preferably be placed in the supine, lateral or prone position.

Of the 87 articles reporting traumatic events, 59 (70%) provided information about the acupuncturists. Of these 59 articles, 68% (40) indicated that the acupuncturists were practising in village clinics or rural hospitals when they performed the procedures that caused the traumatic events. All infections reported were caused by acupuncturists in rural areas. In China, acupuncturists in rural and urban hospitals have a great disparity in clinical skills. Acupuncturists practising in rural hospitals, township health centres or

village clinics rarely receive formal education in medical colleges. It follows that training for the practice of acupuncture needs to be unified and improved.

Several serious adverse events were identified through a review of case reports,¹⁴ but very few were found in surveys⁷⁻⁹ or prospective observational studies.^{5,6} This suggests that serious acupuncture-related adverse events are rare. Bleeding and pain during needling are reported less often in the Chinese-language than in the English-language literature, perhaps because practitioners in China consider such events too trivial to report. Infections (primarily hepatitis) after acupuncture are reported frequently in the English-language literature¹ but relatively rarely in the Chinese-language literature, even though non-disposable acupuncture needles are still used in China. It is possible that in China acupuncture-related infections are underreported.

Of the 87 articles reporting traumatic injuries, 72 (about 70%) were authored not by the acupuncturists themselves, but by the physicians who treated the adverse events. None of the articles reporting infections were authored by the acupuncturists, as opposed to 16 of the 20 (80%) reports of adverse events other than trauma or infection. Again, we suspect that underreporting of such events in the Chinese-language literature is much higher than in the English-language literature.

Our review has several limitations. Although our search strategy was comprehensive, we cannot guarantee that all relevant articles were identified. Many of the reports lacked detail, so that cause-effect relationships are often uncertain. In the absence of a denominator (i.e. the total number of acupuncture treatments practised over the study period), the reported adverse events do not lend themselves to generating incidence figures. There are 2688 hospitals of traditional Chinese medicine in China.¹⁵ If we assume, for instance, that each hospital receives 50 to 100 visits for acupuncture per day (a conservative figure), the annual number of acupuncture treatments would total from 50 to 100 million. This would suggest that the incidence of acupuncture-related adverse events is negligible. However, the true incidence remains unknown and cannot be accurately estimated. Collectively these factors limit the conclusiveness of our findings.

[Go to:](#)

Conclusion

Various types of acupuncture-related adverse events have been reported in China. Similar events have been reported by other countries,¹⁻⁹ usually as a result of inappropriate technique. Acupuncture can be considered inherently safe in the hands of well trained practitioners. However, there is a need to find effective ways to improve the practice of acupuncture and to monitor and minimize the health risks involved.

[Go to:](#)

Acknowledgements

The authors thank YY Xu, X Zhang and WK Zheng for their help with the literature search.

[Go to:](#)

Competing interests:

None declared.

[Go to:](#)

References

- Norheim AJ. Adverse effects of acupuncture: a study of the literature for the years 1981–1994. *J Altern Complement Med.* 1996;2:291–7. doi: 10.1089/acm.1996.2.291. [[PubMed](#)] [[Cross Ref](#)]
- Peuker ET, White A, Ernst E, Pera F, Filler TJ. Traumatic complications of acupuncture. Therapists need to know human anatomy. *Arch Fam Med.* 1999;8:553–8. doi: 10.1001/archfami.8.6.553. [[PubMed](#)] [[Cross Ref](#)]

- Yamashita H, Tsukayama H, White AR, Tanno Y, Sugishita C, Ernst E. Systematic review of adverse events following acupuncture: the Japanese literature. *Complement Ther Med.* 2001;9:98–104. doi: 10.1054/ctim.2001.0446. [[PubMed](#)] [[CrossRef](#)]
- Ernst E, Sherman KJ. Is acupuncture a risk factor for hepatitis? Systematic review of epidemiological studies. *J Gastroenterol Hepatol.* 2003;18:1231–6. doi: 10.1046/j.1440-1746.2003.03135.x. [[PubMed](#)] [[CrossRef](#)]
- Endres HG, Molsberger A, Lungenhausen M, Trampisch HJ. An internal standard for verifying the accuracy of serious adverse event reporting: the example of an acupuncture study of 190,924 patients. *Eur J Med Res.* 2004;9:545–51. [[PubMed](#)]
- Witt CM, Pach D, Brinkhaus B, Wruck K, Tag B, Mank S, et al. Safety of acupuncture: results of a prospective observational study with 229,230 patients and introduction of a medical information and consent form. *Forsch Komplementmed.* 2009;16:91–7. doi: 10.1159/000209315. [[PubMed](#)] [[CrossRef](#)]

□ **Norheim AJ, Fønnebo V. Acupuncture adverse effects are more than occasional case reports:** Results from questionnaires among 1135 randomly selected doctors, and 197 acupuncturists. *Complement Ther Med.* 1996;4:8–13. doi: 10.1016/S0965-2299(96)80049-5. [[CrossRef](#)]

- White A, Hayhoe S, Hart A, Ernst E. Adverse events following acupuncture: prospective survey of 32 000 consultations with doctors and physiotherapists. *BMJ.* 2001;323:485–6. doi: 10.1136/bmj.323.7311.485. [[PMC free article](#)] [[PubMed](#)] [[CrossRef](#)]
 - Macpherson H, Scullion A, Thomas KJ, Walters S. Patient reports of adverse events associated with acupuncture treatment: a prospective national survey. *Qual Saf Health Care.* 2004;13:349–55. doi: 10.1136/qshc.2003.009134. [[PMC free article](#)] [[PubMed](#)] [[CrossRef](#)]
 - A proposed standard international acupuncture nomenclature: report of a WHO scientific group. Geneva: World Health Organization; 1991.
 - WHO standard acupuncture point locations in the Western Pacific Region. Geneva: World Health Organization; 2008.
 - Guidelines on basic training and safety in acupuncture. Geneva: World Health Organization; 1999.
 - He J, Tang QF, Zhuang LX. Clinical analysis of the therapeutic effect of fainting during acupuncture and preliminary study of the mechanism. *Chin Acu Moxibustion.* 2004;24:553–5.
 - Lao L, Hamilton GR, Fu J, Berman BM. Is acupuncture safe? A systematic review of case reports. *Altern Ther Health Med.* 2003;9:72–83. [[PubMed](#)]
 - Ministry of Health of the People’s Republic of China [Internet]. Beijing: Ministry of Health; 2010. Available from: <http://www.moh.gov.cn> [accessed 11 August 2010]. Chinese.
- The references of this article may help you reflect on the current safety record of Chinese-based Oriental Medical practitioners. Oriental medical practice is apparently (stated in testimony) what the East Asian/Oriental Medical practitioners model their practice from for the purposes of Washington state law.

In light of this article, I find it interesting that Mr. Moore filed a complaint against a Physical Therapist in Benton county for creating a superficial hematoma with the practice of dry needling. According to the research paper above, Chinese Oriental Medical practitioners often view this as a non-event, or “too trivial to report”.

The definition of East Asian/Oriental Medical practice (refer to the National Certification Commission for Acupuncture and Oriental Medicine) and the definition of what we are asking for in a simple, trainable technique (refer to the American Physical Therapy Association practice model) are significantly different. We are finitely asking to treat active trigger points with a filament. We are not asking to treat as practitioners of medicine. Our practice of Physical Therapy is defined by the WACs modeled from APTA’s model practice language which includes the use of filaments for intramuscular stimulation. Muscular stimulation is also treated with manual techniques and physical modalities. We don’t have a “laundry list” for these techniques in our practice act. If this precedence is allowed, ... what next? Massage therapists saying we cannot use “massage” techniques to stimulate muscle?

Physical Therapists know their scope of practice. They do not claim to practice medicine. The simplistic definition of medicine from Wikipedia is as below.

“**Medicine** (British English **i**/'mɛdɪsm/; American English **i**/'mɛdɪzɪsm/) is the **science** and practice of the **diagnosis**, **treatment**, and **prevention** of **disease**.^{[1][2]} The word *medicine* is derived from **Latin** *medicus*, meaning "a physician".^{[3][4]} Medicine encompasses a variety of **health care** practices evolved to maintain and restore **health** by the **prevention** and **treatment** of **illness**. Contemporary medicine applies **biomedical sciences**, **biomedical research**, **genetics**, and **medical technology** to **diagnose**, treat, and prevent injury and disease, typically through **pharmaceuticals** or **surgery**, but also through therapies as diverse as **psychotherapy**, **external splints and traction**, **medical devices**, **biologics**, and **ionizing radiation**, amongst others.^[5]

Medicine has existed for thousands of years, during most of which it was an art (an area of skill and knowledge) frequently having connections to the **religious** and **philosophical** beliefs of local culture. For example, a **medicine man** would apply herbs and say **prayers** for healing, or an ancient philosopher and **physician** would apply **bloodletting** according to the theories of **humorism**. In recent centuries, since the **advent of modern science**, most medicine has become a combination of art and science (both **basic** and **applied**, under the **umbrella** of **medical science**). While stitching technique for **sutures** is an art learned through practice, the knowledge of what happens at the **cellular** and **molecular** level in the tissues being stitched arises through science.

Prescientific forms of medicine are now known as **traditional medicine** and **folk medicine**. They remain commonly used with or instead of scientific medicine and are thus called **alternative medicine**. For example, evidence on the effectiveness of **acupuncture** is "variable and inconsistent" for any condition,^[6] but is generally safe when done by an appropriately trained practitioner.^[7] In contrast, treatments outside the bounds of safety and efficacy are termed **quackery**.”

Summary

Physical Therapists and Physiotherapists around the world are using thin filaments to provide intramuscular stimulation as a form of their licensed practice. This technique is for the limited scope of a Physical Therapists’ practice of treating hypertonic, dysfunctional muscle tissue. It is based in Western medical theory and research. It is intended for our patient/client base. It is not competitive with the practice of East Asian/Oriental Medical practice.

The comparative safety records of both practices are similar with the exception that East Asian/Oriental Medicine practitioners have demonstrated greater complexity in the serious outcomes (including death). The practice of East Asian/Oriental Medicine includes a more invasive use of filaments around more sensitive tissues in their treatment attempts of pathologies outside of the scope of Physical Therapy. The Physical Therapists use of filaments is within a limited scope. It does not include the medical treatment of conditions such as, insomnia, high blood pressure, cancer, malaria, smoking cessation, hyperthyroidism, autism spectrum disorder, macular degeneration, hot flashes,..etc.

In addition, Physical Therapists do not include concepts of East Asian/Oriental medicine, including use of herbs or subcutaneous injection there of (recent 2016 Legislative/WAC request).

We are simply and safely stimulating muscle in a technique that effectively creates an “control-alt-delete” stimulus. The improved state of treated muscle structures then allows a Physical Therapist to retrain normal muscle function (lengthening, shortening in a coordinated manner and improving the muscle to achieve a more normal state of muscle relaxation). Intramuscular stimulus is just part of effective intervention on dysfunctional muscle tissue. It is not an aspect that is trained in East Asian/Oriental Medical practice. In our national healthcare quest to take the emphasis off of a society to

quickly use opioids to modulate pain,..this technique, used by Physical Therapists is a safe and simple way to manage muscular pain/dysfunction. East Asian/Oriental Medicine practitioners have their unique role as well.

If the East Asian/Oriental Medicine practitioners are concerned about safety,..there are minimal differences in comparative literature, if anything, East Asian/Oriental Medicine practitioners hold greater in their interventions due to the breadth of their desired scope of practice. It is inherently different than the Physical Therapists scope.

East Asian/Oriental Medicine practitioners may have concerns about market competition. I am positive that Physical Therapists have a narrow scope for the use of this technique for existing clients in Physical Therapists practices. We do not attempt to emulate the full medical practice of oriental medicine that uses acupuncture as part of its medical practice. If East Asian/Oriental Medicine practitioners are confident in their practice,..they should essentially be without competition for their scope of practice. Physical Therapists have respect for the practice of East Asian/Oriental Medicine. There is precedent for Physical Therapist referring to East Asian/Oriental Medicine practitioners as part of their responsibility as an autonomous practitioner. On the contrary, I personally have never received a referral to Physical Therapy from an East Asian/Oriental Medicine practitioner in my 23 years of practice.

I would ask you to carefully consider the literature and scopes of practice. I am always available for your further questions. Thank you.

I am emailing to express my objection to Acupuncture being encroached upon by the Physical Therapy profession's new modality of needling into trigger points called "Dry Needling".

PTs throughout the country are attempting to include Acupuncture therapies in their scope of practice by changing the nomenclature to circumvent existing licensing requirements. The Physical Therapists attest that by not incorporating traditional elements of East-Asian Medicine practice such as Channel Theory and Tongue and Pulse diagnosis, and by re-termining the procedures as "Dry Needling," they have the right to practice Acupuncture within the scope of a Physical Therapy license. Yet Acupuncture and Dry Needling share the same materials, needling locations and technical procedures.

In 1991, The World Health Organization defined trigger point needling as a subset of Acupuncture points. An important three part study, *Trigger Points and Classical Acupuncture Points*, by Dr. Peter T. Dorsher of the Mayo Clinic and Dr. Johannes Fleckenstein of the University of Bern, Switzerland (2009) shows that myofascial trigger point regions were demonstrated to have 93.3% anatomic correspondences with classical Acupuncture points. Trigger point regions and classical Acupuncture points in the treatment of both pain and somatovisceral disorders had ~97% correlation for treating pain conditions and over 93% correlation in treating somatovisceral conditions. They concluded that the strong (up to 91%) consistency of the distributions of trigger point regions' referred pain patterns to Acupuncture meridians provides a third line of evidence that trigger points most likely represent the same physiological phenomenon as Acupuncture points in the treatment of pain disorders. (Please see the attached document below, "CSAP dry needling doc").

As a new practitioner dedicated to the practice of medicine, I can see how enabling a wider range of people to practice Acupuncture therapies could generally benefit public health. While I hold the profession of Physical Therapy in high regard, Dry Needling usurps already regulated East-Asian healing modalities that have been proven to work. There are no solid national regulations for Dry Needling; some states such as New York and Oregon having disallowed needling within the PT scope of practice, while others have allowed it. I am concerned Physical Therapists are not limiting their needling to "trigger points," but have begun to see the benefit of using distal points (away from the problem area), and will, in effect, be performing very poorly trained acupuncture. This is already happening around the country (see image below). Additionally, poor needling technique is painful for patients, who then say "I've had acupuncture (from a physical therapist) and it was painful." I've heard this in my own new practice, from

my own family, and from other acupuncturists as well. This creates a discrepancy that the patient is unaware of, and is a disservice to the skill of trained clinical acupuncturists.

What is most concerning is the broad discrepancy between the amount of education and clinical training required for each modality before these techniques are utilized on patients. As an acupuncture student, I received education in myofascial trigger point location and treatment using manual and needling methods as part of my training in East-Asian Medicine. I completed 1500 hours of graduate level academic instruction (including Western Internal medicine and Western Physical medicine) and *1200 hours of clinical training under the supervision of an experienced Licensed Acupuncturist with at least 10 years of clinical experience*. In order to obtain state licensing, I passed three rigorous board exams to attain certification through the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM). All of these qualifications had to be met before state licensing was granted and I was allowed to begin needling patients unsupervised. Physicians are required to have 300 hours of training before performing Acupuncture. If the expanded scope of practice is passed, Physical Therapists will be allowed to perform Acupuncture (in the form of Dry Needling) with only 54 hours of Acupuncture training.

This stark discrepancy in the lack of Acupuncture technique training for physical therapists practicing Acupuncture (which is being rebranded as Dry Needling) puts the wellbeing of patients and the legality of Dry Needling into question. Additionally, it undermines the integrity of the East-Asian Medicine profession and its State and Federal regulation. Licensed Acupuncturists are best qualified to provide patient care in the field of Acupuncture, which encompasses Dry Needling. As an Acupuncturist, I ask you to please respect and uphold the Laws and Regulations surrounding Acupuncture needling techniques.

Most Sincerely,
Anne Cranston, Lac, EAMP, MAcOM
Washington State Department of Health Licensed Acupuncturist
Colville, WA

A photo of a physical therapist doing “dry needling” for relaxation (image on left) and using acupoints from Stomach, Bladder and Liver channels (image on right):



Attached is the CSAP document, detailing evidence supporting the exclusion of Physical Therapists from performing acupuncture (dry needling):

Attached is a link to video footage of a dry needling instructor puncturing a lung:
https://www.youtube.com/watch?v=EWb69O_NiE&feature=youtu.be

Exploring the Need for “Dry Needling”
[Table of Contents](#)

Introduction	1
Dry Needling is defined as Acupuncture	1
Education	2
Points	3
World Health Organization report	3
The American Physical Therapy Association and the Agency for Health Care Research and Quality	4
Malpractice	4
Safety	5
Efficacy	6
Summary	6

Introduction

The evidence supporting the exclusion of Physical Therapists from inserting needles into the human body without proper acupuncture training and licensure is evident. It is the purpose of this document to address the various realms this issue impacts along with supporting documentation.

Dry Needling is defined as Acupuncture

The National Chiropractic Council (NCC), a federal risk purchasing group which purchases Physical Therapy malpractice insurance on a group basis for its members, has misgivings regarding the whether Dry Needling is infactAcupuncture:

“Proponents of the addition of dry needling to the scope of physical therapy maintain that trigger pointdry needling does not have any similarities to acupuncture other than using the same tool. These same proponents of the technique re-define traditional Chinese medicine as being based on a traditional system of energetic pathways and the goal of acupuncture to balance energy in the body. They emphasize the channel relationship of acupuncture points, de- emphasize or completely exclude the use of ASHI points, and emphasize that acupuncture is based on the energetic concepts of Oriental medicine diagnosis. They therefore define dry needling as different and distinct from acupuncture because it is based on Western anatomy.¹

“However, these proponents fail to recognize that acupuncture schools teach both ‘western’ neurophysiological concepts along with ‘traditional’ meridian concepts. As such, acupuncturists are highly trained within both fields of medicine. In fact, the profession of Chinese medicine utilizes neurophysiological principles. As such, there is no such distinction between ‘eastern’ and ‘western’ [Dry Needling] acupuncture.²

Education

Acupuncturists are educated and trained to perform myofascial and trigger point needling as part of an accredited, graduate level, degree granting program and upon successful completion, are eligible for MA Licensure. Physical Therapists receive no training in needling the body as part of their degree program.

Jan Dommerholt (PT, DPT, MPS and the first Physical Therapist in the United States to teach trigger point dry needling courses³) acknowledges that Physical Therapy education is not designed to teach

Physical Therapists how to insert a needle into patients: “In the United States, dry needling is not included in physical therapy educational curricula.”⁴

He adds, “Accurate needling requires clinical familiarity with Myofascial Trigger Points and excellent palpation skills.”⁵

In assessing the training and subsequent aptitudes of therapists engaging in Trigger Point Dry Needling, Dommerholt, et al in a 2006 OPTP Award for Excellence in a Published Review of the Literature recognized article entitled “Myofascial Trigger Points: An Evidence-Informed Review” writes: “Until very recently, the current scientific knowledge and clinical implications of Myofascial Trigger Points [MTrPs] were rarely included. It appears that orthopedic manual therapists have not paid much attention to the pathophysiology and clinical manifestations of MTrPs [emphasis added]. Manual therapy educational programs in the US seem to reflect this orientation and tend to place a strong emphasis on joint dysfunction, mobilizations, and manipulations with only about 10%-15% of classroom education devoted to muscle pain and muscle dysfunction.”⁶

Licensed Acupuncturists, however, receive education in myofascial trigger point location and treatment at many accredited schools of acupuncture throughout the US. Individuals who attain national Acupuncture certification through the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) undergo a rigorous training program at a minimum standard of three academic years, 1490 hours in Acupuncture, including point location and needle technique. Of the 1490 hours in Acupuncture, 660 hours must be clinical hours, in other words, hours spent practicing Acupuncture, including the insertion of needles, under the supervision of a Licensed Acupuncturist.

Licensed Acupuncturists use Ashi/Trigger Point Acupuncture/Dry Needling in their healthcare practices. The National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), the certifying board for Acupuncture licensure, supports this conclusion. The NCCAOM completed a job task analysis in 2003 and again in 2008. The analysis documented the prevalence of actual use of Dry Needling practices, that is the treatment of trigger points, motor points and/or ashi points with Acupuncture needles, by practicing acupuncturists. In 2003, 82% of acupuncturists surveyed used needling of trigger points in patients who presented with pain. Of the patients who present for Acupuncture treatment, it is estimated that 56% present with trigger point pain.⁷

Points

The word “Acupuncture” (Latin acu) “with a needle” + (English) puncture. Definition: An originally Chinese practice of inserting fine needles through the skin at specific points especially to cure disease or relieve pain (as in surgery).⁸

Travell and Simons’ *Myofascial Pain and Dysfunction, the Trigger Point Manual*, describes the relationship between Trigger Points, Acupuncture and Dry Needling:

“The distinction between TrPs [Trigger Points] and Acupuncture points *for the relief of pain* is blurred for a number of good reasons... There is a high degree of correspondence (71% based on this analysis) between published locations of TrPs and classical acupuncture points *for the relief of pain*.”⁹

Since the use of Acupuncture predates the idea and the term “Dry Needling”, it is appropriate to state that frequently the trigger point selected for the treatment of pain is actually an Acupuncture point. In fact, Dry Needling is a pseudonym for a brief course of study in myofascial acupuncture also known as Ashi Acupuncture and Trigger Point Acupuncture.⁵⁴ Three important studies, Trigger Points and Classical Acupuncture Points, Parts 1,2,3 (P.T. Dorsher, J. Fleckenstein) explore the relationship of Ashi or Acupuncture points to myofascial trigger point regions. In the first part of the study, myofascial

trigger point regions were demonstrated to have strong (93.3%) anatomic correspondences with classical acupuncture points.¹⁰ The second portion of this study examined the clinical correspondences of trigger point regions and classical acupuncture points in the treatment of both pain and somatovisceral disorders, and found they had ~ 97 % correlation for treating pain conditions and over 93 % correlation in treating somatovisceral conditions.¹¹ The third portion of the study concluded that the strong (up to 91%) consistency of the distributions of trigger point regions' referred pain patterns to Acupuncture meridians provides a third line of evidence that trigger points most likely represent the same physiological phenomenon as Acupuncture points in the treatment of pain disorders.¹²

World Health Organization report

The World Health Organization (WHO) defines trigger point needling (Dry Needling) as a subset of Acupuncture points. In 1981, the World Health Organization (WHO) Regional Office for the Western Pacific organized a Working Group for the Standardization of Acupuncture Nomenclature. After 10 years of effort, a consensus on the proposed standard international Acupuncture nomenclature was reached by the Regional Office for the Western Pacific's Working Group and then by the WHO Scientific Group in Geneva. In 1991, *A Proposed Standard International Acupuncture Nomenclature* was published by WHO in Geneva and a revised edition of *Standard Acupuncture Nomenclature* (Part 1 and 2) was published by the Regional Office for the Western Pacific in Manila. Below is an excerpt from *A Proposed Standard International Acupuncture Nomenclature* as pertains to trigger points. Again, please note the hierarchy of coding numbers used. All terms beginning with a code of 5.1 have been determined by the World Health Organization to be a subset of Acupuncture

5.1.225	trigger point	發痛點	a sensitive area of the body which produces a reaction elsewhere in the body when stimulated
5.1.226	trigger point needling	發痛點刺鍼	a type of acupuncture in which the trigger points are needled for therapeutic purposes
5.1.227	tender point needling	壓痛點刺鍼	a type of acupuncture in which the tender points are needled for therapeutic purposes
5.1.228	intramuscular stimulation needling	肌肉刺鍼	a needle stimulating treatment for muscle shortening in deep muscles, especially effective for chronic pain of neuropathic origin, also known as needling myofascial trigger points
5.1.68	ouch point	阿是穴; 天應穴	an acupuncture point with no specific name nor definite location, the site of which is determined by tenderness or other pathological responses, also known as the ashi point
5.1.127	lifting-thrusting method	提插法	a needle manipulation involving lifting and thrusting the needle
5.1.168	intermuscular needling	分刺	an ancient needling method by puncturing directly into the muscle

The American Physical Therapy Association and the Agency for Health Care Research and Quality

The organizations define Acupuncture points and Dry Needling points as the same set of points. The Agency for Healthcare Research and Quality (AHRQ), a division of the National Institutes of Health, in a Technology Assessment published by The U.S. Department of Health and Human Services, Public Health Service agrees: “Acupuncture refers to the insertion of dry needles at specially chosen sites for the treatment or prevention of symptoms and conditions.”^{14,15}

As defined by the American Physical Therapy Association’s Educational Resource Paper, *Physical Therapists & the Performance of Dry Needling* (2012), Dry Needling is an invasive technique used by physical therapists (where allowed by state law) to treat myofascial pain that uses a dry needle, without medication or injection, which is inserted into areas of the muscle known as trigger points.¹⁶

Malpractice

Since Physical Therapists are not actively being taught Dry Needling in their graduate/post graduate education, some insurance companies will not offer malpractice insurance for the performance of Dry Needling by Physical Therapists.

The National Chiropractic Council (NCC), a federal risk purchasing group which purchases Physical Therapy malpractice insurance on a group basis for its members, has misgivings regarding the safety of Dry Needling as performed by Physical Therapists:

“To allow physical therapists to use needles on patients without sufficient training constitutes a public health hazard”. Based on the foregoing, the North Chiropractic Council will not provide malpractice insurance for any physical therapist who inserts needles and/or utilizes the technique of dry needling.”¹⁷

Safety

Licensed Acupuncturists engage in many hours of clinical, safety and continuing education in order to refine their specific clinical skills including the piercing of skin to achieve therapeutic effect and avoid harm.

In Maryland acupuncturist students are required to complete a minimum of 660 hours of supervised clinical training, as well as coursework in safety and infection prevention. In addition, after graduation, licensed acupuncturists in Maryland are required to complete 30 continuing education hours every two years to refine their clinical skills of piercing the skin for therapeutic effect. Many choose to study more than the minimum requirements.

Physical therapists however, have no such training while in school and their non-regulated post-graduate dry needling courses are short (as little as 27 hours¹⁸).

Individuals who attain national acupuncture certification through the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) undergo a rigorous training program at a minimum standard of three academic years, 1490 hours in acupuncture, including point location and needle technique. Of the 1490 hours in acupuncture, *660 hours must be clinical hours*, in other words, hours spent practicing acupuncture under the supervision of a LAc.

In addition, NCCAOM-certified Acupuncturists are required to be certified in Clean Needle Technique and must complete Continuing Education Units in order to maintain their certification.¹⁹

The National Center for Complementary and Alternative Medicine, a division of the National Institutes for Health, states: “Acupuncture is generally considered safe when performed by an experienced practitioner [emphasis added] using sterile needles. Relatively few complications from acupuncture have been reported. Serious adverse events related to acupuncture are rare, but include infections and punctured organs. Additionally, there are fewer adverse effects associated with acupuncture than with many standard drug treatments (such as anti-inflammatory medication and steroid injections) used to

manage painful musculoskeletal conditions like fibromyalgia, myofascial pain, osteoarthritis, and tennis elbow.”²⁰ The World Health Organizations confirms: “In competent hands, acupuncture is generally a safe procedure with few contraindications or complications. Nevertheless, there is always a potential risk, however slight, of transmitting infection from one patient to another (e.g. HIV or hepatitis) or of introducing pathogenic organisms. Safety in acupuncture therefore requires constant vigilance in maintaining high standards of cleanliness, sterilization and aseptic technique. There are, in addition, other risks which may not be foreseen or prevented but for which the acupuncturist must be prepared. These include: broken needles, untoward reactions, pain or discomfort, inadvertent injury to important organs and, of course, certain risks associated with the other forms of therapy classified under the heading of "acupuncture".²¹

“The most important finding from this survey is that there were no serious adverse events associated with 34,407 treatments provided by professional acupuncturists [emphasis added]. We estimate that, with 95% confidence, the underlying serious adverse event lies between 0 and 1.1 per 10,000 treatment episodes.²²

“No serious adverse events were reported, where these were defined as requiring hospital admission, prolonging hospital stays, permanently disabling or resulting in death (95% CI; 0 to 1.1 per 10,000 treatments). This conclusion was based on data collected from one in three members of the British Acupuncture Council. Given that the whole membership delivers between one and a half and two million treatments a year, this is important evidence on public health and safety. When compared with medication routinely prescribed in primary care, the results suggest that acupuncture is a relatively safe treatment modality.”²³

Efficacy

There exists no verifiable research data attesting to the efficacy of Dry Needling as performed by Physical Therapists.

BlueCross BlueShield, when assessing the probability of relief of symptoms as demonstrated by a survey of available clinical research trials investigating the use of Dry Needling by Physical Therapists, concluded:

“Despite the fact that dry needling has been known for years, there have been few published studies measuring the effect on patient outcomes published in the peer reviewed literature. Those studies that are available have design flaws or comprise small study samples so that it is not possible to draw conclusions regarding patient outcomes.”²⁴

In a randomized, double blind, sham-controlled crossover trial comparing Dry Needling, Acupuncture and sham treatment of motion related neck pain, Irnich et al (2002) assessed relative quality of care: “Acupuncture is superior to Sham [treatment] in improving motion-related pain and ROM [range of motion] following a single session of treatment in chronic neck pain patients. Acupuncture at distant points improves ROM more than DN [Dry Needling]; DN was ineffective for motion-related pain.”²⁵

Summary

Since Dry Needling is Acupuncture, no identifiable need exists to expand the scope of Physical Therapy in Maryland to include Dry Needling. Acupuncturists are able, well-trained and amply experienced to fulfill all Acupuncture needs of Maryland residents.

The Federation of State Medical Boards lists guidelines for evaluating the merit/need of scope of practice expansion/change including:

- ✓ Existence of a verifiable need for the proposed scope of practice change;
- ✓ Existing scopes of practice and the effect of requested changes on public health and safety;

- ✓ Formal education and training purported to support scope of practice changes and the existence of a formal process for accreditation;
- ✓ Existing or proposed regulatory mechanisms such as licensure, certification and registration;
- ✓ The advisability of allowing independent practice or requiring collaboration or supervision;
- ✓ The advisability of interaction and cooperation between affected regulatory boards in evaluating issues that involve multiple practitioners, in investigating complaints, and in recommending appropriate discipline;
- ✓ Requirements for full and accurate disclosure by all health care practitioners as to their qualifications to provide health care services;
- ✓ Accountability and liability issues relating to scope of practice changes;
- ✓ Details, rationale, and ethics of any proposals to bypass licensing or regulatory requirements in allowing scope of practice changes, the implications for other practitioners, and the effect on patient safety; and
- ✓ Financial impact and incentives related to and affecting the scope of practice changes.²⁶
- ✓ None of these needs have been considered, reviewed or met.

The Federation of State Board of Physical Therapy in *Changes in Healthcare Professions Scope of Practice: Legislative Considerations*(2006)wrote: “The only factors relevant to scope of practice decision making are those designed to ensure that *all licensed practitioners be capable of providing competent care.*”²⁶

Dry Needling is an Acupuncture practice. Dry Needling is synonymous with Acupuncture and is, in fact,

a subset of Acupuncture. Licensed Acupuncturists are the best equipped, prepared and qualified and therefore the best choice to provide competent care in the fields of Dry Needling, Intramuscular Manual Therapy and Acupuncture.

SOURCES CITED

1

Schroeder, Vice-President and General Counsel, Michael."National Chiropractic Council(TM)."Letter to Kathleen Haley, Executive Director, State of Oregon Medical Board. 18 Nov. 2009. MS

2

Schroeder, Vice-President and General Counsel, Michael."National Chiropractic Council(TM)."Letter to Kathleen Haley, Executive Director, State of Oregon Medical Board. 18 Nov. 2009. MS

3

"Council of Colleges of Acupuncture and Oriental Medicine Position Paper on Dry Needling." *Acupuncture Today Is a Leading Provider of Acupuncture News, Info and Research Information in the World.* Web. 28 Dec. 2011.

4

"Bethesda Physiocare, Resources for Professionals, News." *Bethesda Physiocare: A Jan Dommerholt Company.* Web. 30 Dec. 2011.
<<http://www.bethesdaphysiocare.com/professionals/news.html>>.

5

"Bethesda Physiocare, Resources for Professionals, News." *Bethesda Physiocare: A Jan Dommerholt Company.* Web. 30 Dec. 2011.
<<http://www.bethesdaphysiocare.com/professionals/news.html>>.

6

Dommerholt, Jan. "Myofascial Trigger Points: An Evidence-Informed Review." *Ingentaconnect.*The Journal of Manual & Manipulative Therapy, 2006.Web. 10 Apr. 2012. <http://www.dgs.eu.com/uploads/media/MTrP_an_evidence_informed_review_02.pdf ALSO <<http://www.ingentaconnect.com/content/maney/jmt/2006/00000014/00000004/art00003>>.

7

"Council of Colleges of Acupuncture and Oriental Medicine Position Paper on Dry Needling." *Acupuncture Today Is a Leading Provider of Acupuncture News, Info and Research Information in the World*. Web. 28 Dec. 2011.

<<http://www.acupuncturetoday.com/mpacms/at/article.php?id=32377>>.

<http://www.merriam-webster.com/dictionary/acupuncture>

9

Simons, David G., Janet G. Travell, Lois S. Simons, and Janet G. Travell. Part One: Introduction. *Travell & Simons' Myofascial Pain and Dysfunction: The Trigger Point Manual*. Baltimore: Williams & Wilkins, 1999. Print.

10

Dorsher, MD, Peter, and Johannes Fleckenstein.MD. "Trigger Points and Classical Acupuncture Points." *Elsevier-Germany Online Journals*. Akupunktur. Web. 21 Feb. 2012.

<http://elsevier.isoftmedia.de/inhalt.php?lan~eng/site~journalg/journal~4/name~1_09/article~5800132.html>.

11

Dorsher, MD, Peter, and Johannes Fleckenstein.MD. "Trigger Points and Classical Acupuncture Points." *Elsevier-Germany Online Journals*. Akupunktur. Web. 21 Feb. 2012.

<http://elsevier.isoftmedia.de/inhalt.php?lan~eng/site~journalg/journal~4/name~1_09/article~5800132.html>.

12

Dorsher, MD, Peter, and Johannes Fleckenstein.MD. "Trigger Points and Classical Acupuncture Points." *Elsevier-Germany Online Journals*. Akupunktur. Web. 21 Feb. 2012.

<http://elsevier.isoftmedia.de/inhalt.php?lan~eng/site~journalg/journal~4/name~1_09/article~5800132.html>.

13

"WHO Western Pacific Region - Publications and Documents - WHO International Standard Terminologies on Traditional Medicine in the Western Pacific Region."

WHO Western Pacific Region - Home. World Health Organization. Web. 13 Feb. 2012.

<http://www.wpro.who.int/publications/PUB_9789290612487.htm>.

14

When To Select Observational Studies as Evidence for Comparative Effectiveness Reviews Prepared for: The Agency for Healthcare Research and Quality (AHRQ)

Training Modules for Systematic Reviews Methods Guide www.ahrq.gov Effective Health Care Program.

"The AHRQ Training Modules for the Systematic Reviews

Methods Guide:..." *The AHRQ Training Modules for the Systematic Reviews Methods Guide: An*

Introduction. Ahrq.gov. Web. 06 Feb. 2012.

<<http://www.slideshare.net/AHRQEHCProgram/the-ahrq-training-modules-for-the-systematic-reviews-methods-guide-an-introduction>>.

15

Alberta Heritage Foundation for Medical Research Health Technology Assessment Unit. *Acupuncture:*

Evidence from systematic reviews and meta-analyses 2002

Mar. Used in glossary of "Acupuncture for Osteoarthritis." *Centers for Medicare & Medicaid*

Services. Web. 14 Jan. 2012. <<http://www.cms.gov/medicare-coverage-database/details/technology-assessments-details.aspx?TAId=19>>.

16

American Physical Therapy Association. *Physical Therapists & the Performance of Dry Needling Resource Paper*. Rep. APTA/APTA.org. Web. 27 Jan. 2012.

<[http://www.apta.org/search.aspx?q=American Physical Therapy Association's Educational Resource Paper, Physical Therapists & the Performance of Dry](http://www.apta.org/search.aspx?q=American+Physical+Therapy+Association's+Educational+Resource+Paper,+Physical+Therapists+%26+the+Performance+of+Dry+Needling#s=~_d0!2!1!!1!8!0!1!2!!0!_d1!2!1!3!326!sim%7CMyAll!-360!DqCqtqBquqwppxrsvryrApxrsvrzzrppqwpppsq!_d3!%40APTASource+OR+NOT+%40APTASource!_d0!APTA.org!4!Physical+Therapists+and+the+Performa)

[Needling#s=~_d0!2!1!!1!8!0!1!2!!0!_d1!2!1!3!326!sim%7CMyAll!-](http://www.apta.org/search.aspx?q=American Physical Therapy Association's Educational Resource Paper, Physical Therapists & the Performance of Dry Needling#s=~_d0!2!1!!1!8!0!1!2!!0!_d1!2!1!3!326!sim%7CMyAll!-360!DqCqtqBquqwppxrsvryrApxrsvrzzrppqwpppsq!_d3!%40APTASource+OR+NOT+%40APTASource!_d0!APTA.org!4!Physical+Therapists+and+the+Performa)

[360!DqCqtqBquqwppxrsvryrApxrsvrzzrppqwpppsq!_d3!%40APTASource+OR+NOT+%40APTASource!_d0!APTA.org!4!Physical+Therapists+and+the+Performa](http://www.apta.org/search.aspx?q=American Physical Therapy Association's Educational Resource Paper, Physical Therapists & the Performance of Dry Needling#s=~_d0!2!1!!1!8!0!1!2!!0!_d1!2!1!3!326!sim%7CMyAll!-360!DqCqtqBquqwppxrsvryrApxrsvrzzrppqwpppsq!_d3!%40APTASource+OR+NOT+%40APTASource!_d0!APTA.org!4!Physical+Therapists+and+the+Performa)

nce+of+Dry+Needling!_d5!_d2!!KqGqtFpwpxpHppupxpupypupwppypvvpJpIpEpApBpzpDppCpqvprp
qsq!>.

17

Schroeder, Vice-President and General Counsel, Michael."National Chiropractic Council(TM)."Letter to
Kathleen Haley, Executive Director, State of Oregon
Medical Board. 18 Nov. 2009. MS

18Kinetacore. Level I Course. Applications for Pain Management and Sports Injuries. Web Retrieved
August 14, 2012 from:

<http://www.kinetacore.com/physical-therapy/Functional-Dry-Needling-Level-1-Training/page17.html>

19

"Council of Colleges of Acupuncture and Oriental Medicine Position Paper on Dry
Needling." *Acupuncture Today Is a Leading Provider of Acupuncture News, Info
and Research Information in the World*. Web. 28 Dec. 2011.

<<http://www.acupuncturetoday.com/mpacms/at/article.php?id=32377>>.

20

Simons DG, Travell JG, Simons LS. *Travell and Simons' Myofascial Pain and Dysfunction; the Trigger
Point Manual*. 2nd ed. Baltimore, Md: Williams & Wilkins;
1999.

21

Dry Needling in Orthopaedic Physical Therapy Practice, **Jan Dommerholt, PT, MPS**. Orthopaedic
Practice Vol. 16;3:04

22

MacPherson, Hugh, Kate Thomas, Stephen Walters, and Mike Fitter. "A Prospective Survey of Adverse
Events and Treatment Reactions following 34,000
Consultations with Professional Acupuncturists."

23

MacPherson, Hugh, Kate Thomas, Stephen Walters, and Mike Fitter. CITATION "A Prospective Survey
of Adverse Events and Treatment Reactions following
34,000 Consultations with Professional Acupuncturists." *Acupuncture in Medicine*. BMJ Journals,
2001. Web. 7 Apr. 2012. <http://aim.bmj.com/content/19/2/93.long>

24

BlueCross Blue Shield, and CareFirst. "Medical Policy - 8.01.018 - Dry Needling." *Carefirst.com/Medical
Policy Reference Manual*. BlueCross BlueShield, 19 Mar.

2012. Web. 10 Apr. 2012.

<<http://notesnet.carefirst.com/ecommerce/medicalpolicy.nsf/vwwebtablex/eac9e12f165e256b8525763c004c9350?OpenDocument>>

25

Irmich D., Behrens, N., Gleditsch, J>M> et al (2002): Immediate effects of dry needling and acupuncture
at distant points in chronic neck pain: results of a
randomized, double-blind, sham-controlled crossover trial. *Pain* 99, 83-

9. <http://www.ncbi.nlm.nih.gov/pubmed/12237186>

26

Federation of State Medical Boards. (2005). *Assessing scope of practice in health care delivery: Critical
questions in assuring public access and safety*. Dallas, TX

190. The Federation of State Boards of Physical Therapy. *Changes in Healthcare Professions Scope of
Practice: Legislative Considerations*(2006)

Web. 29 Dec. 2011 <<https://www.fsbpt.org/RegulatoryTools/ScopeOfPractice/index.asp>>.

It has come to my attention that the Physical Therapy Association has applied for a Sunrise Review in an
attempt once again to add "Dry Needling" to their scope of practice. This is a big problem due to
unreasonable discrepancies in training requirements and the undermining of existing regulation.

Acupuncture is a long standing effective form of medical therapy that involves the insertion of filiform needles into specific neuromuscular points of the body for healing benefit. Recognizing this benefit, the Physical Therapy association has attempted to redefine the nomenclature of these already established techniques to circumvent existing licensing requirements. Here is a recent peer-reviewed publication that argues that Dry Needling initiatives are in fact an attempt to bypass Acupuncture standards: <http://online.liebertpub.com/doi/10.1089/acm.2016.0066>

Licensure to practice Acupuncture requires a Master's Degree with over a thousand hours of education and hundreds of hours of supervised practice, as well as successfully completing the NCCAOM national board exams. Compare this to the fewer than 60 hours of education and zero supervised clinical work required to practice Dry Needling and the inequity becomes obvious.

Not only has Dry Needling been voted out of the scope of practice of Washington Physical Therapists twice already, and as recently as last February, the Washington State Attorney General has also ruled that "The practice of dry needling does not fall within the scope of practice of a licensed physical therapist". <http://www.atg.wa.gov/ago-opinions/scope-practice-physical-therapy>

Anyone with half a mind can see the Physical Therapy Association's attempts to incorporate Acupuncture technique are greed driven nonsense, and for the Department of Health to allow "Dry Needling" within the scope of Physical Therapy practice would be a corruption of justice.

I might also add that according to the American Medical Association in regards to Dry Needling:

"Lax regulation and nonexistent standards surround this invasive practice. For patients' safety, practitioners should meet standards required for licensed acupuncturists and physicians". <http://www.ama-assn.org/ama/pub/news/news/2016/2016-06-15-new-policies-annual-meeting-page>

and according to the American Academy of Medical Acupuncture:

"it is inadvisable legally to expand the scope of physical therapists to include dry needling as part of their practice".

Tim Baglio MSAOM LEAMP
Birwood Acupuncture

My name is Alexander Kim and I am a licensed acupuncturist who graduated from Bastyr University, in Kenmore, WA, with my Masters in Acupuncture and Oriental Medicine. Bastyr University is considered one of the best schools in our country for acupuncture and I am fortunate to have studied with some of the best professionals in my field. In addition to my four year intensive graduate program, I had the opportunity to study in China's Chengdu and Shanghai university and observe how they integrate Chinese and Western Medicine together. I am very passionate about this medicine and have dedicated a lifetime of study in this field.

I am writing to urge you to reject the physical therapy scope expansion attempt. First of all, dry needling and acupuncture are indistinguishable from each other from a regulatory and legislative standpoint. "Dry needling" is still a form of acupuncture. What physical therapists call "Dry needling" is using needles to release "trigger points", which is a common technique employed by acupuncturists to release myofascial pain. This "Dry needling/Trigger Point" technique to use needles to release taut bands of tissue is described in the earliest acupuncture texts. Trigger points have been recognized as acupuncture points since the 7th century CE, at the latest. It is NOT a new discovery and just differently LABELED so PTs can add acupuncture to their scope of practice. Furthermore, this technique is already documented as a subset of acupuncture and acupuncture schools teach this technique with an emphasis on musculoskeletal and neurological anatomy.

I would like to remind you that anyone using dry/acupuncture/filiform needle should meet benchmarks for safety before touching the human body with a needle for therapeutic purposes. Acupuncturists go through extensive training to perform safely, specifically at LEAST 660 outpatient clinical training hours under supervision after hundreds of hours of practice and exposure to needling. PT's are trying to perform dry needling/trigger point(basically, a technique and subset of acupuncture) with only 54 hours and ZERO supervised outpatient clinical training hours. Not only is this an insult to us, our profession, and the history of Chinese medicine, but it is a disservice and unsafe to patients.

This is a urgent matter to protect and preserve the high quality of education and training that is required to ensure the safety and efficacy of acupuncture, an important branch of Chinese Medicine. "Dry needling/trigger point" therapy is a documented subset of acupuncture and a technique practiced by acupuncturists. The practice of performing any form of acupuncture without the state regulated standards of safety is a disservice to patients.

Thank you very much for taking the time to read through this email and I hope you take this into serious consideration.

Sincerely,
Alexander Hyun Kim

I highly encourage you to support physical therapist's being allowed to perform dry needling in Washington State. I have been a patient for muscle pain and received this treatment from many different physical therapists in other states and countries, and have had amazing, life changing results. I've also had many, many acupuncture treatments (performed by acupuncturists), and had less effects on my pain and some sessions that didn't even help my symptoms.

There has been a lot of debate about whether what acupuncturists and PTs do with the needles is the same or different, and from my years of experiencing these treatments from both providers, I have to say the treatments are COMPLETELY different. The needles may appear the same, but how they use them, when they use them, and why they're using them varies greatly.

I have also seen an osteopath medical doctor in Seattle for dry needling, and felt the treatment helped, but not as well as when used in conjunction with the simultaneous treatments that physical therapists have provided me.

Many other states allow physical therapists to perform dry needling, and I believe Washington needs to stay up to date with our healthcare and provide the most current, innovative treatments that have evidence to support their effectiveness. Dry needling is inexpensive for patients compared to other treatments, and most importantly allows people like myself other options than taking prescription drugs (which don't really help anyways) to treat chronic pain.

There is plenty of room for multiple providers to use similar tools, as patients and clients tend to seek out what treatments benefit them the most. I think physical therapists and acupuncturists using needle based treatments will not detour anyone from seeing one or the other, and both professions will continue to thrive no matter what decision you make.

Please support physical therapists adding dry needling to their scope of practice, so people in Washington can also benefit from the amazing results others all over the country and world are receiving from physical therapists.

Sincerely,
Jacqui Berg

My name is Allison Pringle and I am a second year student of physical therapy at the University of Washington. I am writing to you in regards to the recent sunrise review of SB 6374 which would allow physical therapists to practice dry needling. I want you to know how important I believe it is for physical therapists to be allowed to incorporate dry needling into their practice in order to best treat their patients.

Throughout our three year education within the doctor of physical therapy program, we participate in rigorous study of human anatomy, physiology, exercise science, patient examination and evaluation, and treatment interventions and strategies (among other coursework). Treatment of patients is complex, and critical thinking and clinical decision making is crucial for each patient interaction. When designing an intervention for patients, we are taught to consider those options that will be most successful for patients in order to both address their primary complaint in an evidence based way as well as working within the constraints of resources available to us as clinicians (number of appointments available, time with each patient, etc). Consideration of effective and efficient treatment is important so that our patients are able to receive the most quality care possible at each appointment. A component of our education focuses on manual therapy techniques that we can utilize to improve overall range of motion of a joint, reduce muscle tightness, increase muscle length, and release muscular trigger points. Dry needling is one way that, if within our scope of practice, we can help to treat these muscular trigger points.

Allowing dry needling to be practiced by physical therapists, would empower clinicians to choose an intervention strategy that they believe would help their patient effectively, and in a timely manner, in order to move their patients forward in their overall treatment progression. Instead of spending a large portion of my future patients' appointments employing other manual techniques to release trigger points, I might be able to utilize dry needling to quickly address trigger points that may be having implications on muscular activation, strength, and range of motion. I would then be able to move forward with the majority of my appointment focusing on the functional impairments that directly affect my patients' daily lives, participation, and independence. My education has taught me the extensive detail of human anatomy and critical thinking regarding patient treatment necessary to begin learning this new manual therapy technique. Having the opportunity to continue my education to learn new techniques that will benefit current and future patients is extremely important to me and is important to the physical therapy field as a whole

Allison Pringle, SPT, University of Washington Doctor of Physical Therapy Program | 2017
Department of Rehabilitation Medicine | University of Washington School of Medicine

I am writing regarding the recent Sunrise Review concerning Dry Needling within the Physical Therapy scope of practice. I am currently a second year student at the University of Washington and I feel compelled to share my personal story. I have received both acupuncture and physical therapy, and I firmly believe there is a huge place for both to effectively exist simultaneously.

For the past four years, I have been experiencing neurological symptoms that remain undiagnosed. In the course of seeking relief for these symptoms I have tried both acupuncture and physical therapy. Acupuncture has served an incredible purpose during this time. I experience significant fatigue and the treatment was centered completely around balance of my immune system, fatigue, and nervous system. The treatments I received were calming and helped to restore energy.

Prior to acupuncture, I sought physical therapy for my neck. Because of fatigable weakness that made it hard to hold up my head, I developed shortened muscles, overactive trapezius muscles, and pain. Much of my treatment centered around stretching and trigger point release. My upper trapezius muscles were so active that the therapist could not get them to shut off, no matter how long he worked at it. I firmly

believe that had he been able to use dry needling, the treatment would have been more effective and save time for additional therapeutic modalities.

Dry needling will not replace acupuncture. Acupuncture has a distinct place in this field. The goal of dry needling is to be used as a modality, not as a stand-alone treatment. At their core, the acupuncturists and physical therapists want the same thing: to provide effective care to help their patients. Dry needling will help achieve that goal as a safe treatment to enhance patient care and it should be within the scope of practice of physical therapy. Thank you for your time.

Kind regards,
Madeline Weismann

I am a licensed acupuncturist in WA (1879) and OR (153822). I am also an academic and clinical researcher. My education began with my completion of the first professional master's degree followed by a post graduate doctorate, and extensive continuing education in clinical practice and clinical research. I have performed thousands of hours of clinical practice beginning as an intern at Bastyr University in the fall of 2000 and professionally in early 2002. I am writing to comment on the upcoming Sunrise Review of PT Dry Needling.

I strenuously oppose state approval of a change of scope for Physical Therapists to allow for Dry Needling for several reasons, but primarily due to insufficient didactic training and complete absence of any supervised clinical training. Acupuncture is dry needling/trigger point therapy and dry needling/trigger point therapy is acupuncture. Please do not adopt the proposed change in scope for the following reasons:

1. Acupuncture and dry needling are indistinguishable from each other from a regulatory and legislative standpoint. Changing the name of a procedure does not change the procedure, nor the risk associated with its use. "Dry needling" is a form of acupuncture.
2. Early promoters of "dry needling" considered them the same and even went so far as to suggest renaming acupuncture points in modern terms so acupuncture would be more accepted by medical doctors. Hence, dry needling should be governed by the same statutes that apply to acupuncture.
3. Anyone using a dry/acupuncture/filiform needle should meet benchmarks for safety before touching the human body with a needle for therapeutic purposes, which requires extensive training to perform safely, far more than 54 hours with no supervised outpatient clinical training hours.
4. Washington state already has benchmarks for didactic education, supervised clinical hours, and a third-party national psychometrically created exam to test for minimum competency that involves the insertion of filiform acupuncture needles.
5. What physical therapists call trigger points are one of the two broad categories of acupuncture points: channel-related points and pain-related points, also known as "ashi" points. Trigger points are ashi points, and have been recognized as acupuncture points since the 7th century CE at the latest.
6. The American Medical Association (AMA) recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.
7. The American Physical Therapy Association (APTA) said that "there is no CPT code that describes dry needling nor do any of the existing CPT codes include dry needling techniques in clinical vignettes utilized by AMA in their process to establish relative value units." In order to establish is new CPT code, you must go through the AMA.

8. The language of the Sunrise Application relies on the language from SB 6374, which is problematic for two primary reasons. First, the language of the bill could prevent licensed acupuncturists from performing dry needling, a technique that is inherently within their scope. Secondly, the RC18.74.010, if adopted, will be unenforceable as written.

9. “Dry needling” is also commonly called “trigger point needling.” This is a technique commonly performed by acupuncturists treating myofascial pain. Dry needling/trigger point needling is a technique that is documented as a subset of acupuncture and is practiced readily in modern treatment.

10. The technique of needling taut bands of tissue is described in the earliest acupuncture text. It is now taught more specifically with greater emphasis on musculoskeletal and neuroanatomy by acupuncturists to acupuncturists.

Lee Hullender Rubin, DAOM, LAc, FABORM, Visiting Research Faculty, Women's Health Research Unit
Oregon Health & Science University

The same 10 points were provided by Vishal Verma, who added:

I am a licensed EAMP in Washington State for the last 14 years. I have practiced with physicians and in private practice over that time and have become very familiar with Eastern Medicine. It is clear that the application of needles to specific areas of the body clearly falls under the scope of acupuncture and should only be allowed by practitioners who have adequate training. After 14 years of successfully treating hundreds of patients (see my testimonials at the end of this page) I am appalled that a completely different field of medicine is attempting to practice without adequate training and safety.

TESTIMONIALS FROM MY PATIENTS:

<http://www.omshen.com/what-my-patients-say/>

<https://www.yelp.com/biz/omshen-holistic-clinic-seattle-3>

Thank you for considering these important points and protecting the profession as well as patients from undertrained practitioners who may want to use needles.

I believe that dry needling is an important part of physical therapy practice. As a previous recipient of dry needling and a future physical therapist, I think this modality is within the PT scope of practice and is a great tool to help improve the quality of life for many people.

As competitive gymnast, I have received dry needling on multiple occasions. One such occasion was following an ankle sprain in order to help release trigger points in the muscles of my lower leg. This helped get me to get back on the competition floor quickly and without pain. Without dry needling, my return to competition may have been delayed due to the time it would have taken my PT to release those trigger points manually. Dry needling was crucial to my timely recovery from this injury and my return to competition.

As a future PT, I hope to be able to use dry needling to help my patients recover and regain function faster. If I am able to release trigger points more quickly, I can spend more time in my PT sessions working on strength and functional tasks. This will help to make me a more efficient PT and improve patient satisfaction and quality of life.

In conclusion, dry needling is an important part of PT treatment following an injury and can help patients return to function more quickly. I believe dry needling should be included in the scope of PT practice in the state of Washington.

Below please find my comment regarding Dry Needling sunrise.

1. Legal or not?

In US medical practices, after going through a comprehensive and systematic training, one should know every treatment method and drug should be approved the Department of Health and FDA. After receiving approval, one can then use the methods to treat patients. For instance, any drug or medicine goes through a series of trials in the labs before being sent to the FDA for approval.

However, during the hearing, some patients talked about their experience receiving the Dry Needling treatment. There was one physical therapist, who talked about giving treatment to soldiers in the military. We would like to know whether or not this is legal? Has the Department of Health given its consent? Does insurance companies cover these treatment? What kind of billing codes do they use? They never showed any medical records, nor did they say who paid for such treatment.

If I were you, I would tell those doctors that what they were doing is illegal, and that they should stop such practice until the DoH gave its approval. If they continue to practice, their license would be suspended. Am I right?

2. Safe or not?

In the medical field, every practitioner should know that one can only start treating patients after a long term systematic training and approval from the appropriate authorities. One should know that their first priority should be their patients' safety and wellbeing. Nowadays, some PTs only receive limited and often times inadequate training (with such methods like Dry Needling). Are they sure that their method is safe, and will not cause medical accidents (or in worse cases, cause the patients' death)?

Say someone in the Department of Health needs acupuncture treatment, would he/she ask for a PT to use Dry Needling, or would they ask for an acupuncturist? Would they trust the PT? Would they be afraid?

Say then that your family and friends need acupuncture treatment, what kind of choice would they make? I think the answer is pretty clear, and that is 100% **NO** Dry Needles.

For safety reasons, we suggest the DoH to suspend the license of anybody who uses Dry Needle to treat patients in the state of Washington.

3. Dry needle is only the beginning

Right now the PTs are asking to be allowed to give Dry Needling treatment. In the future, they will ask for more (dry cupping, dry drugs.....). Before long they will be asking for the ability to give more treatment methods without having the necessary training and qualification for it. Under these circumstances, would the DoH have to approve them all? The PTs will be asking for more, once they get approval for Dry Needling. And then, what if some **nurses** say they want to be able to give Dry Needle treatment as well? After all, you only need 50 hours (or somewhat hours) of training before being able to use dry needles.

If the PTs get their approval, then what if one day our acupuncturists ask if they can do "Dry PT" (after 50 hours of training or more)? There will be no end to this, once the floodgate is opened. What will the DoH do in this situation?

4. Codes and charges

During the hearing, the PT giving treatment to the soldiers didn't answer a lot of questions. For example, what was their diagnosis code? Who paid their bills for the treatment? What was their billing code? They provided no explanation and answer.

So is what they're saying true? They didn't give us any definitive answer to the questions. We hope that the DoH can investigate more into their claims about matters such as insurance companies, billing codes, diagnosis codes, and payment for treatment. We hope that they're not simply using regular PT codes for dry needling treatment. If they're doing this and the insurance companies find out, they will be in a lot of trouble!!!! The PT will lose his PT license, and all his insurance coverage, right?

Li-Juan Chen L.Ac, Acu-Herbs Oriental Medicine Clinic, LLC

I am writing as an acupuncturist and naturopathic physician to document my opposition to the potential legislative change to allow Physical Therapists to perform dry needling within their scope of practice. I oppose this for the following reasons:

- "Dry Needling" into trigger points is simply a thinly veiled attempt for Physical Therapists (PTs) to perform acupuncture, without adequate training in acupuncture.
- Needling trigger points is the same thing as the acupuncture practice of treating "Ashi" points, not a new technique.
- Acupuncturists have extensive training in needle insertion and safety, whereas the PT sunrise bill does not apply the same requirements (only 54 hours, with no clinical supervision) to be able to perform the same practice. This seems to show both that the PTs are having inadequate training as well as a double standard with regards to the requirements of being able to insert needles.
- The language of the sunrise bill could be interpreted to mean that Acupuncturists cannot perform dry needling, despite extensive historical and educational precedent for doing so.

I urge the Washington state Department of health to see this sunrise bill inclusion for what it is - a thinly veiled attempt to allow physical therapists to perform acupuncture, without adequate training. Please do not allow this legislation to pass.

Alex Kraft ND Lac, **Trillium Natural Medicine**

This my recommendation that we do not authorize dry needling to be performed by health-care practitioners other than acupuncturists. I feel that the training other practitioners receive is not enough to perform needling in the body safely. By other practitioners I mean physical therapists, massage therapists, chiropractors, occupational therapists, etc. Please keep any type of acupuncture needling within the scope of acupuncturists only.

Doris E. Reed, L.Ac.

I wanted to share my story in hope that it might illuminate the role dry needling has played in my physical therapy and my perspective on receiving this treatment from my physical therapist. My journey has been difficult psychologically and physically. I have never experienced pain levels that make it hard to sit, work, think, garden, get through a movie, drive in a car. I have never been disabled and struggled so much to regain the quality of life I once had.

At the beginning of this year I was diagnosed with Femoroacetabular hip impingement and have since found out that I have severe tearing around my hip socket, and arthritis. I have always been active and athletic. My sports medicine doctor recommended physical therapy and NSAIDS to manage pain. I

cannot take NSAIDS as they are the likely cause of a GI bleed and anemia, and all other treatments have failed.

After my diagnosis I began working with an experienced physical therapist who helped me learn targeted strengthening exercises, stretches, and provided hands on manipulation of muscle groups. In addition, dry needling was offered as a possible technique to help reduce severe pain muscle/tendon pain. I tried it and it provided relief nearly immediately.

As a medical provider myself, I felt comfortable having a skilled practitioner trained in neuromuscular conditions, and a deep understanding of anatomy administer this procedure. She was assessing my body and pain level on a weekly basis and it seemed a natural fit to have dry needling done when I was at my appointment. I was extremely disappointed to find out that I no longer had this option.

I'm surprised at the fervor incited by the acupuncture community regarding dry needling -it makes good sense that anyone doing this procedure be well trained and have expertise in neuromuscular anatomy. But why this should fall exclusively outside the scope of physical therapy and almost entirely in the scope of acupuncture is unclear. It also makes sense that allowing handfuls of filiform needles in untrained and uneducated hands and give a carte blanche is dangerous. But that isn't what is happening. You have trained skilled professionals that have degrees in extensive knowledge of anatomy, etc. getting more training and then adding this technique. I'm not sure what is driving all the outrage, some of it may be for concern of patients, but having read over many of the letters, what stands out most is a sense of proprietorship.

Some of what I've read assumes physical therapists have no knowledge of the human body before learning this technique. Which is ridiculous. I've had good experiences with acupuncture in the past and found it helpful, I would just rather have the option of getting dry needling when needed at my pt appointment.

After reading the many entries on this subject, I wonder why so many good individuals who have gone into a helping profession have taken such a hard line on dry needling. There seems to be a great deal of fear underlying much of the argument about the SCOPE OF PRACTICE. There seems to be much to lose and gain over the line in the sand, but really what are those things? And while this battle is fought, the people caught in the middle are **patients who are suffering from acute or chronic pain and disability**. Patients that can't afford to take more time off of work for additional appointments, patients who are already stretched thin financially. Patients who don't or can't use oral pain relievers. So if this is being construed to protect the patient why not let a patient decide for themselves who to get a particular service from-it's already done when we sign medical disclaimers that acknowledge risks of particular procedures. If it's being fought to protect a profession, then I hope that the highly regarded field of acupuncture is not seen as diminished if PT's are allowed to perform this one procedure that uses the same needle. I would never see it that way.

Why can't a physical therapist if trained well perform dry needling? I think that is a question I would ask.

I wonder why I as a patient cannot receive a procedure that helped me reduce terrible pain while at my physical therapy appointment?

I have included part of a letter I sent to my internal medicine doctor that may shed more light on the struggles my and many other patients struggle I would imagine.

I hope that the Washington State Legislature and Board of Licensing can find a way, to figure this out. I trust that there is a solution.

Thank you for taking the time to read my letter.

Sincerely-

Donna Flynn

Letter to My Doctor- UW Internal medicine 5/30/2016

I need to find some way to reduce the constant pain in my hips and lower back. I haven't taken any NSAIDs since my hospitalization in April at NW hospital. As I mentioned I was diagnosed with bilateral femoral hip impingement in January. The pain is quite severe and is impossible to ignore radiating from my hip joints through my back it effects me every day in most all areas. I see my sports medicine doctor, at the Polyclinic sports medicine clinic. He has tried steroid shots, and referred me to a physical therapist, who is great. My pain level is between a 6-8. I still am hopeful that physical therapy will ultimately help but it will be a long haul.

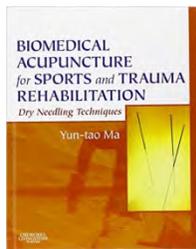
The thing that I was getting some relief was from dry needling (somewhat similar to trigger point injection) however that's out, because my physical therapist is no longer able to provide this, because of new laws. It is a mess. I don't want and can't pursue pain relief in pill form. I am at a loss. This condition is exacerbated by sitting-which is all I do, to make a living as a psychotherapist. I can't stop working, and I can't focus at work, because of the discomfort. I'm now wondering if a pain management clinic could help as I try to gain a foothold on making some progress. I wonder what your thoughts are. Regardless of which way I go, its a long circuitous road.

I am an EAMP license of WA I had been practicing Chinese Medicine that including acupuncture , Chinese herbs for 40years and taught Acupuncture , Chinese medicine for 20year both in China and USA.

Dry needling is part of acupuncture , Chines acupuncturist has been use that method in China for more than 2,0000 years. I TAUGHT THAT METHOD IN ACPUNCTURE CLASS OF MEDICAL SCHOOL IN CHINA , ALSO IT CAN BE FOUND IN ACPUNCTURE TEXT BOOK.. If PT want to use that method need to get fulltime training of acupuncture program comprehensive. It is very importance that medical training seriously for medical provider. which respect life. attached one of dry needling book which "Acupuncture" clearly appear in front of page

Thanks for your attention.

Xue zhong Wang EAMP
Acupuncture & Oriental Medical Center PS



Dry Needling by Physical Therapists

The Washington Osteopathic Medical Association(WOMA) recognizes dry needling as an invasive procedure using acupuncture needles that has associated medical risks. Therefore, the WOMA maintains that this procedure should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed acupuncturists or licensed allopathic or osteopathic physicians.

Dry needling (DN) involves inserting monofilament needles, up to four inches, into the skin or muscle at specific trigger points for therapeutic purposes, including pain relief. The patient can develop painful bruises after the procedure and adverse sequelae may include hematoma, pneumothorax, nerve injury, vascular injury and infection.

Because of a lack of a standardized curriculum for DN, defining what constitutes adequate training is concerning. Very few DPT degree programs offer DN as part of their curriculum. There are independent organizations that train individuals to perform DN, allowing an individual to practice DN after completing as little as 27 hours of training. Appropriate training in dry needling needs to be established for physical therapists. Number of hours, course content, hands-on training, passing theory and practicum exams, completing a certain number of treatment sessions, or passing a certifying exam should be considered. For example: acupuncturists are required to have 1900 hours of training prior to practicing, and the American Academy of Medical Acupuncture (physicians who also practice acupuncture), requires 300 hours of training in addition to four (4) years of medical school (MD or DO). In most states, a non-physician must have in excess of 2,000 hours of clinical and didactic education and training before they can become certified to treat patients.

Language should be incorporated into the PT practice act that allows only dry needling with appropriate training without opening the door to PTs being able to practice other invasive techniques unless acceptable training standards are established and met. The Legislature should carefully consider the wording used to identify Trigger Point Dry Needling as a distinct therapy, and also specify the training requirements, continuing education, limitations on practice, referral specifics, and other details that would be needed to protect both the public and referring physicians. Until there is an established dry needling curriculum that is approved by a recognized authority, no changes in the law should be made.

Because a prescription for physical therapy is required by several health plans, the law should require that physicians either specify dry needling as part of the prescription or give explicit permission for its use as part of a treatment plan. This will provide greater protection for the public.

Kathie Itter

Executive Director, Washington Osteopathic Medical Association

Sunrise Review-

Re: Allowing physical therapists to perform dry needling SB6374.

- Dry needling is already accepted by statute or regulatory board opinion in many states.
- Dry needling is successfully performed by physical therapists in all branches of the U. S. military.
- Please include dry needling in the scope of practice for physical therapists in Washington state.

Thank you. Cheryl French Nevin, MS, PT

Cheryl French Nevin, MS, PT, Patient Care Coordinator, Olympic Sports & Spine Rehabilitation

Good morning, I am writing regarding dry needling. As a graduate of the Army-Baylor class of 2011 I had an opportunity to be introduced to dry needling during graduate physical therapy school. About 2 years after becoming a licensed physical therapist I attended an Army sponsored dry needling course where I was instructed in treatment of muscles consistent with Kinetacore's level 1 instruction. Dry needling was a large part of my physical therapy practice for the two years that followed while on active duty stationed in Texas. I left active duty last September and moved to Washington where I am now practicing 27 hours per week at an outpatient physical therapy clinic. I frequently treat patients that are great candidates for dry needling as it is such a powerful tool for addressing palpable taut bands of tissue contributing to myofascial pain.

One of the arguments against physical therapists dry needling is that training over a weekend to do so is not extensive enough training to practice safely. The training that makes physical therapists great clinicians to dry needle starts long before a three day continuing education course. The knowledge of anatomy, physiology, and pain science begins during our undergraduate schooling with the pre-requisites required for admittance to a physical therapy program. This knowledge is expanded and deepened by our

graduate level training. To argue that a three day continuing education course is inadequate training is to ignore all the foundational knowledge a clinician has prior to attending such a course.

I treated multiple patients with dry needling most days. Over the two years I dry needled I never had a patient experience an adverse event. To my knowledge none of the therapists I trained with have had a patient have an adverse reaction to treatment. Patient's respond very well to dry needling and when performed by a skilled clinician with a strong knowledge of anatomy, physiology, and pain science, as physical therapists are, it is a very powerful technique for improving myofascial pain.

I strongly encourage you to allow physical therapists to dry needle in the state of Washington.

Chelsea Lorenson, DPT, Staff Physical Therapist , Olympic Sports & Spine Rehabilitation

As an acupuncturist practicing in WA, I feel some concern about PT's dry needling. I believe it is very important for health care practitioners to do not harm patients by insufficient training and domain knowledge.

I would like to strongly support the statements addressed by Washington East Asian Medicine Association:

1. Anyone using a dry/acupuncture/filiform needle should meet benchmarks for safety before touching the human body with a needle for therapeutic purposes, which requires extensive training to perform safely, far more than 54 hours with no supervised outpatient clinical training hours.
2. The American Medical Association (AMA) recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.
3. The American Physical Therapy Association (APTA) said that “there is no CPT code that describes dry needling nor do any of the existing CPT codes include dry needling techniques in clinical vignettes utilized by AMA in their process to establish relative value units.” In order to establish is new CPT code, you must go through the AMA.

I am looking forward to taking my opinion into consideration during review.
Sincerely,

--

Heung Lee, EAMP
Heung Lee's Acupuncture & Herb Clinic

I am emailing you in regard to the dry needling subject that has been circling the physical therapy world for some time now. I understand that there are many opinions regarding whether dry needling should be practiced by physical therapists or not. In my opinion, I believe that it should for a variety of reasons. Physical therapists already obtain the vast anatomical knowledge that is required to perform proper placement of needles in the clinic. Physical therapists must already have a good understanding of anatomical structures, and are known to be experts at palpation. Physical therapists also have a great background in clinical reasoning and deciding which method of treatment is best for the patient.

With excellent understanding of human anatomy and best regards for patient care, I believe that physical therapists are more than qualified to perform dry needling.

Stephanie Hinkle, SPT, University of Washington Rehabilitation

I am a physical therapy student at the University of Washington and I am writing in support of physical therapists being able to perform dry needling in the state of Washington. In my opinion, there are two issues at stake here: "Is this best for our patients?" and "Is this best for our healthcare system?" The answer to both questions is yes.

Best for our patients: The safety of dry needling by physical therapists has already been extensively studied and has been found to be safe when performed by physical therapists with the correct training. Beyond safety, it is just a better use of a patient's time. A physical therapist can spend several physical therapy sessions trying to relieve painful muscle trigger points ("knots") with their hands but could have the same effect using dry needling in one session.

Best for our healthcare system: Dry needling by physical therapists is a better use of time and money from a healthcare perspective as well. It is faster and more effective than other treatment options, especially for musculoskeletal pain and problems that arise from associated trigger points.

Thank you for your consideration,
Logan Richards, SPT (student of physical therapy)

University of Washington Doctor of Physical Therapy Program | 2017
Department of Rehabilitation Medicine | University of Washington School of Medicine

I am writing in support of legislation that would allow physical therapists to perform dry needling as part of their practice act. I am a current student of physical therapy at the University of Washington, and also have worked as a licensed massage practitioner since 2008. In my time as a massage therapist, I have learned a great deal about the various treatment approaches for musculoskeletal conditions. A highly effective technique involves release of myofascial trigger points. As a massage therapist, I am able to release these points through providing pressure directly over the affected tissue. However, this technique is laborious and can require multiple sessions for progress to occur. That is one reason why I have chosen to pursue physical therapy as a career. Physical therapists, unlike massage therapists, can perform specific treatment of myofascial trigger points with dry needling. This technique has been demonstrated to be far superior to the traditional method

of triggerpoint release in that it is effective and fast. The main point of contention surrounding physical therapists performing dry needling is that it is unsafe. However, this is untrue and below I will demonstrate that there is no reason why physical therapists cannot perform this technique.

It has been demonstrated that dry needling can be performed safely by physical therapists. This is contrary to the view voiced by the American Association of Acupuncture and Oriental Medicine (AAAOM). The objection raised by supporters of this view is that physical therapists do not receive equivocal training in acupuncture including dry needling. This is based on information from AAAOM, 2011. I reject this claim because while acupuncturists receive 1,490 hrs of education, this is not all specific to dry needling and physical therapists must receive specific intensive training in dry needling techniques to safely use this modality. This is based on information from Rogel, 2012.

Furthermore, there are three strong reasons to support my view that dry needling can be performed safely by physical therapists. The first reason is that physical therapists receive instruction on the human body, screening, interventions and 10 months of apprenticeship that provide an extensive foundational knowledge of the anatomy that they can impact with dry needling techniques, since physical therapists

learn 86% of the knowledge needed to safely apply dry needling in their basic education and advanced or specialized training is only needed for 16/117 needling specific knowledge requirements. This is based on information from Caramagno, 2015. In addition, this reason is supported by the fact that due to foundational DPT instruction only 64 hours of additional training were needed to safely perform dry needling techniques without significant adverse events. This is based on information from Brady, 2013.

The second reason is the obvious view that needles are used safely by physical therapists for other modalities/studies including EMG, NCSs and electrical stimulation. In Washington State, physical therapists are permitted to perform needle EMGs upon referral from a health care practitioner and “upon demonstration of further education and training in electroneuromyographic examinations...” This is based on information from R.C.W. 18.74.010 and 18.74.160(4).

Finally, it is clear that dry needling can be performed safely by physical therapists given significant adverse effects of dry needling by physical therapists are rare. This is based on information from Sarah, 2013. This reason is supported by the contention that with 64 hrs of training, physical therapists had an estimated upper risk rate for significant adverse effects of less than or equal to 0.04% whereas higher rates of reactions to acupuncture found in literature include 11.4% in a prospective acupuncture study by Ernst et al. which were not classified into mild or significant. This is based on information from Brady, 2013.

I restate my contention that dry needling can be performed safely by physical therapists. I urge you to also adopt this view. Please consider supporting legislation for the use of dry needling by physical therapists.

Yours sincerely,

Tess DePalma, SPT, LMP
University of Washington |
Doctor of Physical Therapy Candidate 2017 | Licensed Massage Practitioner 2008

I am a licensed EAMP (acupuncturist) in the state of Washington.

As a professional who is fully trained by accredited institutions and licensed by the State of Washington, I do believe it is unfair to us as a profession and VERY DANGEROUS to the public, if PTs were granted legal to practice " Dry Needle".

The proposal by the Physical Therapy Association of Washington to perform “dry needling” is woefully inadequate. It does not adequately address harm, assurance of professional ability, nor cost-effectiveness. By their own descriptions what they describe is acupuncture.

There are many dual licensed practitioners in the state of Washington, who hold multiple licenses to practice multiple disciplines. This is important to protect the public health and safety of the health care consumers in Washington State.

The Department of Health should require the physical therapists to complete the training and licensure to become EAMPs as is required under RCW 18.06.

Please deny the Physical Therapy Association of Washington’s application in its entirety.

Yiwen Su, EAMP,
Su & Jin Acupuncture and Natural Healthcare

I have worked in the healthcare profession for nearly forty years, in both hospitals and medical offices, for medical doctors and CAM providers (including acupuncture). Over decades, I have seen the

development of both the physical therapy profession and acupuncture profession. I have also been a patient of both physical therapy and acupuncture.

“Dry needling” is acupuncture.

We all rely on health care professionals being fully trained by accredited institutions and licensed by the State of Washington.

The Department of Health should require the physical therapists to complete the training and licensure to become EAMPs as is required under RCW 18.06.

There are many dual licensed practitioners in the state of Washington, who hold multiple licenses to practice multiple disciplines. This is important to protect the public health and safety of the health care consumers in Washington State.

Please deny the Physical Therapy Association of Washington’s application in its entirety.

Thank you for your consideration.

Suzanne Griffin

Hello, my name is Becca Cox, I am a second year physical therapy student at the University of Washington. I am contacting you today to explain the reasons why physical therapists should be able to practice dry needling.

It has been stressed throughout our program that dry needling is a modality that can be incorporated to increase effectiveness of treatment of trigger points. What is important to understand is that dry needling is a modality like ultrasound is a modality. We use ultrasound for therapeutic reasons, which is different than the use for diagnostic imaging done by ultrasound techs or doctors. Acupuncturists like physical therapists can use needles during treatment sessions. It is important to understand that like in the ultrasound example our purpose in using this modality is different than that of Acupuncturists. We are using needles to decrease the time needed to treat trigger points. This enables us to move on to other treatments within a treatment session, rather than spending one whole session on manual treatment of trigger points. This improves two parts of the triple aim, by decreasing treatment sessions spent on this impairment and by increasing the quality of care provided.

As a current physical therapy student I can assure you that our training in human anatomy is thorough. We are trained thoroughly in musculoskeletal, neuromuscular, cardiopulmonary, and organ function. Differential diagnosis is stressed throughout our program, which enables us to provide care as a primary provider and understand when to refer out. I believe our educational training is a foundation that prepares us well for further training in this specific modality. The requirements proposed also verify that therapists with proper training are the ones using this modality.

I believe this is an important modality for my future patients.

Thank you for considering my comments in the review of this topic.

Becca Cox, DPT Student, Division of Physical Therapy, University of Washington School of Medicine

I’ve been an acupuncturist in Wa state for 22 years. I’m writing asking you to oppose the Physical therapist application to do dry needling.

Dry needling is a form of acupuncture, and changing the name of a procedure does not change the actual procedure or the risks associated with it. Dry needling should be governed by the same statutes that apply to acupuncture, and those who do dry needling need to meet a standard of safety that goes well beyond the 54 hrs that PT's need to currently do. As an acupuncturist with a clinical focus on treating myofascial pain, trigger point needling is commonly used in my practice. It is clearly documented as a subset of acupuncture and unreasonable of physical therapists to try and claim this is part of their scope, and not part of an acupuncturists.

Please pass along my comments.

David Lerner, L.Ac., EAMP, MTCM

My name is Sylvia Tam, and I am a student physical therapist writing to you in support of the motion to allow physical therapists to practice dry needling in the state of Washington.

One of the arguments from the East Asian Medicine practitioners is that dry needling is identical to acupuncture. This is not true; dry needling and acupuncture are fundamentally different practices, both in theory and intervention effect. Dry needling was developed approximately 40 years ago and is based on study of the neuro-musculoskeletal system including anatomy, physiology, biomechanics, neuroscience, kinesiology, pathology and pharmacology.

Physical therapists are uniquely qualified to perform dry needling because we have the education, training, and expertise in the biomedical sciences. We physical therapists are especially skilled in treating neuromuscular injuries and pain conditions. Dry needling allows us to have a highly efficient modality to treat patient's musculoskeletal dysfunction. In this way, being able to practice dry needling is a part of best-care practices for physical therapists.

Please support dry needling in physical therapy practice in Washington state. Thank you.

Sylvia Tam, SPT

University of Washington Doctor of Physical Therapy Program | 2017 Department of Rehabilitation Medicine | University of Washington School of Medicine

I'm a second year physical therapy student at the University of Washington. I would like to express my support and opinion for the Sunrise review on dry needling as it will affect my future practice. Dry needling is a safe, effective form of manual therapy that has the potential to relieve pain and increase the efficiency of treatment for physical therapists. If we are able to treat pain, muscle dysfunction, and relieve trigger points more quickly we can improve patient outcomes. In an era of increasing healthcare costs and an opioid addiction epidemic, I think that techniques to improve conservative treatment for issues like chronic pain will be especially important.

I believe that our curriculum provides a base of anatomy, physiology, and kinesiology knowledge that will prepare us for post-doctoral education to perform dry needling safely and it will be a true benefit to the future physical therapy practice as well as improve patient outcomes.

Thanks for your time,

Tasha Chang, SPT

University of Washington Department of Rehabilitation Medicine

I am writing to OPPOSE Physical Therapist application for Dry Needling to be added to their current scope of practice.

My name is Cassie Lowe, East Asian Medicine Practitioner. I have been practicing Acupuncture for 15 years at 3 locations in Seattle, Tacoma, and Issaquah.

Dry needling is indistinguishable from acupuncture because it is the use of filiform needles placing it on human body. Therefore, the physical therapist should meet the same safety benchmark that is currently set for East Asian Medicine Practitioners or Medical doctors to practice acupuncture safely. The current proposal is only requiring physical therapist who wants to practice Dry Needling to have just 54 hours without clinical supervised training.

Washington state already has benchmarks for didactic education, supervised clinical hours, and a third-party national psychometrically created exam to test for minimum competency that involves the insertion of filiform acupuncture needles. Physical Therapists who wish to practice Dry Needling should meet this same standard of safety.

The American Medical Association (AMA) recognize dry needling as an invasive procedure and maintain that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists. Physical therapists currently do not routinely use needles in their scope.

Cassie Lowe, EAMP

I recently found out about the PTWA's sunrise review application. Although I live outside of Washington State, when in Washington State I get my health care from multiple provider types. I may retire here to Washington and have an interest in the healthcare laws here. I have received both physical therapy and acupuncture.

The idea of allowing physical therapists to do needling without the same training that an acupuncturist receives is very scary. I consider physical therapists to be experts in physical therapy: exercises and stretching, and other manual therapies as currently allowed by their statute.

Acupuncturists/EAMPs are experts in needling. There is no way I would go to a PT for needling unless they are trained with the SAME training as an acupuncturist/EAMP in Washington State.

The medical doctor I have received acupuncture from has an acupuncture license in addition to his medical license. PTs just don't receive the education or training that either a medical doctor or an EAMP does to needle.

Neither 300 hours nor 54 hours of training is enough for a PT to do needling.

Because "dry needling" is not a covered service by Medicare nor by my insurance, it is not covered by insurance and requires only out of pocket payment, so there is no and would not be any advantage to allow a PT to do needling.

The Department of Health should **require the physical therapists to complete the training and licensure to become dual licensed PTs and EAMPs, as is required under RCW 18.06.**

Please deny the Physical Therapy Association of Washington's application in its entirety.

Wendy H.
NY State and Bellevue, WA.

My name is Steve N. Harada, PT, EAMP and I am concerned about physical therapists performing what they call dry needling. I have never used a "wet" needle to do acupuncture. Acupuncture needles are dry and I believe acupuncture and the physical therapist's dry needling are one in the same.

I have been a physical therapist for 48 years and never heard about dry needling until about 10 years ago. I do know of trigger point stimulation by Janet Travell, MD. She inserted hypodermic needles, with and without anesthetic, often into the trigger points but she was a physician. She also stimulated them in various superficial ways and physical therapists have been using this superficial stimulation for years.

As an acupuncturist for 38 years, I use acupuncture needles and insert them into acupuncture point as well as “ashi” points. The physical therapists also use acupuncture needles and insert them into trigger points and those are the same as acupuncture and ashi points. A German company is selling “dry needles” but they are same as acupuncture needles, just made in Germany. Trying to say dry needling does not work on the meridian theory cannot be substantiated. As you know, the body is an integrated whole and if one part is stimulated, the rest of the body knows about it. If you step on a tack, your whole body responds to it. If you insert a needle anywhere in the body, it responds. It is acupuncture and I feel it is the same as dry needling.

When I decided to do acupuncture, I had to move to Japan to study it since there were no acupuncture schools in the United States. I then got my license in Japan and then in Washington State. I feel if physical therapists want to do acupuncture, they should go to acupuncture school. There are several schools in Washington State and across the United States so they do not have to leave the country.

The required schooling for an acupuncturist, just in the Eastern Medicine section alone (1,365 hours), is much more rigorous than the amount of hours (about 54 hours spread over 1 year) the physical therapists say they need for treatments and the safety of the patients.

How can Dr. Goodman, MD, who teaches courses in dry needling and makes money from it by teaching physical therapists, justify that physical therapists are the ideal practitioners to provide dry needling? Physical therapists, in the United States, became interested in dry needling around 10 years ago and acupuncture has been around for thousands of years.

As the saying goes, “a rose by any other name is still a rose” and the term dry needling is the same as acupuncture.

Inserting needles into the patient’s skin is not and never has been in the scope of practice for physical therapists and I hope you do not allow it to be part of the physical therapist’s scope of practice in Washington State. If a physical therapist wants to perform acupuncture, they should become dual licensed as other providers have done.

Thank you for your concern,

Sincerely,
Steve N. Harada, PT, EAMP

Hello - my name is Natalie Willits, and I am a fourth year acupuncture student at Bastyr University. I am writing this email today to implore the rejection of the Sunrise request to allow physical therapists to perform dry needling. This is an important decision, and the request must be **"REJECTED"**.

Physical therapists simply do not have the adequate amount of training to be performing needling of any kind on patients. **Fifty-four hours of training is a far cry from being sufficient**, yet these PTs are not even getting a solid **54** hours of directly needling, as this time also includes lecture and trading turns with partners. How does it makes sense that a student of acupuncture must complete a standard level of didactic and clinical schooling to perform needling on patients, while a student of physical therapy can achieve the same thing in a fraction of the time?

Just like any medical profession, there are standards that must be met, and board exams that are absolutely required to be passed, in order to obtain licensure. How could this standard not be applied to PTs "dry" needling, deemed an **invasive procedure by the The American Medical Association (AMA)**? How is it that **a practitioner with 2.5 days worth of experience can insert a needle into a patient?** This is an issue of not only establishing a competent workforce, but of ensuring patient **SAFETY**.

If the training hours for PTs are increased, should they be allowed to perform "dry" needling on willing patients? The answer is still NO. What physical therapists are calling "dry" needling on "trigger points" fall under the category of pain relieving, or "ashi" points in acupuncture. Dating back to the 7th century these exact points have been employed to effectively treat musculoskeletal dysfunction. Today, when a patient comes into an acupuncture clinic complaining of neck pain, **the acupuncturist would utilize the EXACT same points as a PT.** Additionally, not only are the same points used, but the **same filiform NEEDLES** are used as well. If the same technique and tools are used, what is the distinction between these two practices? **To say what PTs are doing is unique to physical therapy is an out-right lie.** If a physical therapist wants to perform dry-needling, on patients, they must be required to complete the standardized acupuncture training program as their acupuncturist peers.

This concludes why I think the Sunrise request to allow physical therapists to perform dry needling should be **REJECTED**.

Thank you for your time,

Natalie Willits

My name is Thi H. Nguyen-Phuoc, and I was one of two Physical Therapists who testified against the inclusion of dry needling in the scope of Physical Therapy on August 2, 2016. There were a few points that were brought up during this hearing that I would like to comment.

“Dry Needling is a technique, and acupuncture is a discipline.”

This statement was made to separate the practice of dry needling from acupuncture, yet testimony from Andrew McIntyre delineates how dry needling uses the same needles, the same point locations, the same techniques, and with the same intentions, all of which make dry needling a subset of acupuncture, paralleling the analogy of the nickname “Bill” for the birth name of “William” as Dr Yang had commented.

Dry needling may be a technique, but it is a technique from a system of medicine called acupuncture, much like grade V mobilization is a technique from a system of medicine called chiropractic. To ignore the system of medicine that informs when the technique is appropriate is not only arrogant and adolescent, but it also sets the stage for when the technique becomes unsafe.

Just because a joint is stuck does not necessarily mean it needs to be adjusted, for the originating restriction may lie elsewhere in the system of joints connected to the restricted joint. Similarly, just because a muscle is tight does not mean it needs to be manipulated strongly with a needle. In acupuncture, there is a concept of *deficiency vs. excess*, and it's only in the latter condition that strong stimulation is indicated. For someone with deficiency pain, strong stimulation will further cause Qi-loss, or devitalization of the body's inherent healing ability. Even if a practitioner doesn't know what deficiency or excess is, it is still a physiologic phenomenon that's happening in the body, and a Physical Therapist would not know how to differentiate which patient has deficiency symptoms versus patients with excess symptoms, the former is the patient for whom dry needling would be contraindicated.

The Physical Therapists minimized the case where there was infection in the calf muscle, stating that it was the water that had been contaminated and dry needling only provided the pathway for the infection to occur. This is a perfect example where the stimulation was too strong as to leave a tract in the tissue where infection can still affect a patient after treatment, and the tract remains is only because the tissue is too deficient to close after needle withdrawal. Such strong stimulation is needed only because there is no other method available when a PT employs needles as a treatment modality; an acupuncturist will have more tools available to address pain, muscle spasms, and trigger points that this kind of injury would not have happened.

Sadly, deficiency and excess is only one of 4 axes of diagnosis to determine which treatment is appropriate.

“Physical Therapists want dry needling in their scope of practice in order to treat the patient as a whole.”

If Physical Therapists truly want dry needling in their scope of practice simply because they want to treat the patient as a whole, why not simply refer the patient to a qualified acupuncturist? Several testifiers hesitated when questions were asked about referral to acupuncture. Why not advertise dry needling techniques to acupuncturists if Physical Therapists think dry needling is so different from acupuncture? Beyond the mere division of deficiency vs. excess symptoms mentioned above, acupuncturists understand that pain and muscular/fascial restrictions may have roots in imbalances of energetic flow or emotional disturbances, and they treat in order to bring the whole person into balance. Why does the lower back flare when there are issues around finances, or why does the sacroiliac joint destabilize around the time of menstruation? The mind is not separate from the body, and this philosophy is inherent in acupuncture, which informs the acupuncturist on which point to select, not merely focus all of the treatment on the strained muscle. If the Physical Therapists want dry needling to treat the root cause, and not merely the symptom, and to treat the whole person, and not simply the disease, then I recommend for more PT referral to acupuncturists.

“There are only 14% education lacking in PT-entry level training for dry needling, which involves the actual handling of the needle itself.”

The HumRRo report “acknowledges the psychomotor skills to handle needles and palpation tissues specifically regard to dry needling appropriately require specialized training.” For any skill to be developed the psychomotor skills need to be supervised and feedback must be given in order for refinement to be made. So even if there were only 14% education/skills lacking, would 8 hours of actual needling practice make someone proficient in mastering a new psychomotor skill? Even in the 104-hour CEU program only provides approximately 30 hours of actual practice. How many different patient populations can a therapist encounter with only 8 or 30 hours of needling practice? Patients differ in their sizes, weight, age, muscle mass, adipose tissue, skin texture, presence of tattoos, varying levels of needle tolerance. Does the CEU training account for these variables when it deems a Physical Therapist to be “safe” in needling patients?

“Physical Therapy students are likely to be exposed to penetrating modalities during internship, most likely in the hospital setting.”

This is not a guarantee, and even if it were, it would not make a difference in helping the Physical Therapy student be prepared for needling insertion. It is like observing chiropractic adjustment versus actual mechanics of setting up the body of the patient, taking the body to its end elastic range, and applying the high velocity low amplitude force in the correct plane of movement to release the restricted joint. Simply being exposed to chiropractic adjustments will do nothing to prepare a person to do the actual adjustments! Simply being exposed to a needle, however it is being used in a hospital setting, will not prepare a Physical Therapy student to be more proficient toward needle insertion.

Furthermore, the 1-year-requirement for Physical Therapist to work in the profession prior to enrolling into dry needling CEU classes are not sufficient. This 1-year must be in an outpatient setting with adult population, for Physical Therapists working with children and those working in inpatient care, rehabilitation units, or assisted living facilities, etc., do not have many opportunities to work with musculoskeletal palpation.

“A Physical Therapist is qualified to examine which patient is a good candidate for dry needling.”

I've made several points in the paragraphs above to outline why a PT is not qualified to examine which patients is a good candidate for dry needling. I would love to see our two professions refer patients to each other more frequently, to allow each of us to do what we do best for the patients, and not to do something we are minimally-trained to do. A Physical Therapist is qualified to assess when needling a muscle would be helpful, and a conscientious Physical Therapist would refer the patient to a qualified acupuncturist.

Thank you for your time and consideration on this important topic, and to allow acupuncture to remain in the scope of practice of acupuncturist.

Thi H. Nguyen-Phuoc

I am a physical therapist and clinic manager at Capstone Physical Therapy in Ferndale, WA.

I am writing to support allowing physical therapists to perform dry needling in WA state. It will help us increase patient access to effective, evidence-based treatments in WA state.

Alyssa Franzen, DPT, Clinic Manager, Capstone Physical Therapy

Thank you for taking the time to listen to the voices of acupuncturists across the state during the sunrise review for dry-needling by physical therapists. We are a much smaller group than physical therapists, but this is an issue of vital importance to us and our patients, and for the wider public.

I'm sure many other acupuncturists have spoken of the fact that "dry-needling" IS acupuncture, and has been for thousands of years now. It can be an extremely effective therapy that should be widely available to and used by the public. However, acupuncture is a therapy that takes years if not decades to master. No medical practice can be learned in a weekend without significant risks to patients.

When a poorly-trained physical therapist causes a pneumothorax (collapsed lung) from inappropriate needling, the public will logically conclude that is a risk of "acupuncture", not "physical therapy".

Finally, the American Medical Association just recently made the following recommendation at their annual meeting:

Regulating Dry Needling

The AMA adopted a policy that said physical therapists and other non-physicians practicing dry needling should – at a minimum – have standards that are similar to the ones for training, certification and continuing education that exist for acupuncture.

"Lax regulation and nonexistent standards surround this invasive practice. For patients' safety, practitioners should meet standards required for licensed acupuncturists and physicians," AMA Board Member Russell W. H. Kridel, M.D.

Thank you again for you time and consideration.

--

Chris Landoll, EAMP
Aspire Acupuncture LLC

As a licensed physical therapist and acupuncturist in Illinois, I would like to express my strong disapproval of the attempt by Washington State physical therapists to add dry needling to their scope of practice with only 54 hours of training and zero supervised clinical training hours. I have practiced physical therapy for 22 years and acupuncture for 15 years. I do not support PT's (or anyone else) doing dry needling with such limited theoretical education, manual training, clinical supervision, and examination that such a short course provides. In 1993 I took an acupuncture course in my final year of PT school, in which I "learned" 'acupuncture' over 4 days (split over 2 weekends) and I know that it did a huge disservice to acupuncture. Dry needling is a kind of acupuncture. The best that a short course like that can offer is an introduction to such a complex practice. It definitely speaks to the Western reductionist model of healthcare, which typically leads to poorer clinical outcomes and dissatisfied patients not to mention the increased risk of injury to the patient.

As someone fully-trained in both forms of therapy, I feel I have the perspective to comment on this matter, as I appreciate it from each. The procedure of inserting an acupuncture needle into the body may seem simple, but mastery takes extensive training, much more than 54 hours could possibly provide. Would you want to be treated by someone who had only had 54 hours of training in this procedure versus someone who had had thousands, including extensive supervised clinical training? Would you want a family member to? These considerations are not abstractions, as should this proposal be allowed, real people will be on the receiving end of deeply inadequate training. Yet they will have no way of knowing how few hours were required to be able to perform dry needling (acupuncture) unless they ask.

The public relies on the judgment of state departments of health to ensure that providers who receive their endorsement have earned it. 54 hours is insufficient to earn this endorsement. I strongly recommend that the Sunrise Committee refuse this request.

Patricia Miller, PhD, L.Ac., PT

I am a physical therapist, practicing in Bellingham, WA. Personally, I do not practice dry needling in my practice. I have not obtained the training to do so and I am focusing my energies in other regions of physical therapy intervention. That said, I think dry needling is an effective tool, well within the scope of physical therapists. Those who have training in dry needling should be able to use it in their practice to better serve their patients.

There is a lot of attention in the news to finding non opiate and cost effective ways to manage pain. Physical therapy often ranks high in the available interventions to help people rehabilitate and learn coping mechanisms to manage chronic pain. Please do not hinder a physical therapist who has the knowledge of an effective tool of treatment from practicing and helping the public. Please allow physical therapists to practice dry needling, as it is a different treatment from acupuncture and both interventions can coexist without harming the public or acupuncturist's revenue.

Katy Smith, DPT, OCS

I have had chronic back/neck issues for almost 15 years. I have tried many therapies including Pilates, various providers/types of physical therapy, personal training, orthopedists, Feldenkrais, massage, Rolwing, acupuncture, and more. They are all different. They can all be helpful. Personally for me, a varying regimen of dry needling, physical therapy, Feldenkrais, and massage have much improved my situation. I see value in all the therapies depending on personal needs and the capabilities of the provider. There are many talented providers bringing relief to different people with different needs.

In this context, the “debate” on dry needling seems strange and artificial. It is clearly not acupuncture. It has brought me (and others) enormous benefit. Saying that it is equivalent to acupuncture is like saying a composer using a pencil to write a symphony is the same as an architect using a pencil to draft a house. Yes, they both use pencils. But no, they are doing very different things. I do not view my employment of dry needling therapy as mutually exclusive or substitutable for acupuncture.

It should of course be regulated and performed safely by well-trained and certified providers, but denying the people of Washington access to this therapy doesn't serve anyone's interest.

Sincerely,

Brian Schultz
Seattle, WA

I have had dry needling performed from a physical therapist and it was extremely beneficial. After surgery on my thoracic outlet syndrome I exhausted other types of therapy and was still in pain. When I found out about dry needling I was ready to try! It actually helped and improved my condition. Please allow the PT to be able to do this.

Sarah Mork
Snohomish county resident

I believe physical therapists in Washington should be allowed to perform dry needling with the proposed 54 hour additional needle-specific training and 1+ full time year of clinical practice after graduation.

I have received extensive benefit from dry needling performed by physical therapists both here and in Georgia. As someone who suffers from chronic pain stemming from congenital conditions, I have tried numerous ways to treat and reduce my pain. These include multiple surgeries, pain medications, physical therapy, chiropractors, acupuncture, and innumerable Eastern medicine practices. The ONLY successful strategy that has been able to significantly reduce my pain and future flare ups has been dry needling paired with physical therapy. This combination has had a uniquely and overwhelmingly positive impact on my health and overall wellbeing. It has prevented me from needing additional surgeries or filling the prescriptions for pain meds that other doctors see as the only solution to my health issues.

I ask that you please allow physical therapists in Washington to continue providing this important procedure that has enormous health impacts for people like me.

Thank you for your time, and please do not hesitate to reach out if you have any questions or would like additional information.

Caroline Lippy

I believe PTs should be allowed to perform dry needling, with the proposed 54 hour additional needle-specific training and 1+ full time year of clinical practice after graduation.

Dry needling performed by PTs was a large component in curing my of bilateral plantar fasciitis pain. A podiatrist had tried two rounds of cortisone injections, followed by bilateral nerve blocks with no improvement before recommending surgery. I refused surgery and sought PT. My PTs recommended dry needling after a very thorough assessment, and after exhausting other treatment methods without much improvement. After dry needling was incorporated in my treatment plan, I began to make significant progress in a short amount of time. I had been limited by the fasciitis pain for 18 months, no running whatsoever for 14 months and I credit the dry needling with giving me back the ability to stand, walk, run, and dance. Without dry needling, I would not have been able to walk down the aisle in my wedding, much less dance with my husband at our reception. Dry needling gave me back the ability to perform my job duties to their fullest along with the joy of daily living and hobbies. I would be very disappointed to see this highly beneficial treatment option prohibited.

Jennifer Sizelove, Raleigh, NC, Exercise Physiologist

I am writing to you regarding the Sunrise Review on Dry Needling for Physical Therapists. I am a Student of Physical Therapy at the University of Washington, studying to earn my Doctorate in Physical Therapy come June of 2017. It is very important to me that dry needling be differentiated from acupuncture practice and be allowed within the current physical therapy (PT) scope of practice within the existing realm of manual therapy that has been a cornerstone of PT practice since the profession began.

Dry needling is a highly effective and efficient way to release trigger points in hyperactive muscles, which helps return the individual to their daily work and recreational activities and lives. Throughout the country we are aiming for the “Triple Aim” in Healthcare: high patient satisfaction, improved outcomes, and decreased cost of delivering services. Without the use of dry needling, releasing trigger points requires more hands-on time between the patient and PT (it can take weeks to release a trigger point through massage, whereas releasing through a needle can be instantaneous). Requiring PTs that have practiced dry needling for years to now become less efficient is a disservice to the patients and the practitioners alike.

The opposition believes that we are performing acupuncture when we do dry needling. Having released trigger points in class just last week, I am very interested in learning more about dry needling techniques, however I know nothing about acupuncture, chi, meridians, or anything else about their scope of practice. I do not wish to encroach upon the acupuncture profession, nor do I feel I would be treating the same ailments as acupuncturists treat. I want to learn dry needling to incorporate into my musculoskeletal and Western medicine physical therapy framework to maximize outcomes and minimize the cost of delivering care in my future practice. Thank you for your time and consideration.

Mary Breckel, Student of Physical Therapy

I believe PTs should be allowed to perform dry needling, with the proposed 54 hour additional needle-specific training and 1+ full time year of clinical practice after graduation.

I DON'T believe that acupuncture encompasses ALL treatments where a thin, filiform needle is used as a tool. Therefore, I believe other areas of medicine should have the freedom/option to also use this tool, as it assists them in their particular treatments.

Pupp Patterson

I personally have had this procedure used on by a trained and licensed PT. It was a success and really helped me and my situation.

“I believe PTs should be allowed to perform dry needling, with the proposed 54 hour additional needle-specific training and 1+ full time year of clinical practice after graduation”

Scott Busby, Cary, NC

I appreciate the fact that you may be inundated with emails from both the “for” and “against” camps regarding the PT application to have acupuncture, aka “dry needling”, added to their scope of practice, so I’ll be brief.

I work with several physical therapists and have a very high respect for what they know and how they apply that knowledge to help our mutual patients recover and regain mobility, function, and return to a state of being pain-free. Acupuncture (what they are calling “dry needling”) is not currently something they have been trained to use in this recovery/treatment process. It is confusing to me as a licensed EAMP why and how they intend to add acupuncture to their scope, when there is already a process in place for folks (like me) to complete training and enter the professional world of acupuncture as an EAMP. Adding acupuncture to their scope and, in doing so, circumnavigate the existing Washington requirements for someone to perform acupuncture, is illogical. If they were able to add this to their scope without having to go through the training I did, I don’t think our mutual patients would as quickly regain their full health as for concerns about their safety I would not refer patients to a non-EAMP doing acupuncture.

Please let logic and status quo guide the DOH’s decision-making around this request. Washington residents are currently safe and healthy with the existing parameters around both physical therapy and acupuncture (as dictated as the scope of EAMPs). Changes to this status quo will only harm, not help, our mutual patients.

Thank you for your attention,

Greg Lewerenz, EAMP, LMP, RYT
Foster Wellness

It has come to my attention that as part of the Sunrise Process in Washington questions arose regarding the selection of subject matter experts for the dry needling competencies study completed by HumRRO for the Federation of State Boards of Physical Therapy (FSBPT). There were three areas of knowledge required to participate in this panel as identified by HUMRRO and FSBPT: (1) PT education and entry level competence standards, (2) dry needling therapies (as practiced by a PT), and (3) the risks associated with performing dry needling therapies. The Federation identified individuals that had knowledge in all these areas and when possible, regulatory experience with regard to physical therapy. It is very unlikely that HumRRO could find experts from other professions knowledgeable in all 3 areas. Each member of our study had at least some knowledge in all three areas, and expertise in at least two. All were PTs who were successfully performing dry needling as a PT intervention and were in good standing with their licensing boards.

Although it is possible FSBPT and HumRRO might have been able to find another health professional who was knowledgeable of PT education and licensing standards (e.g., a faculty member with an MD teaching within a PT school), it was unlikely that this expert would also know very much about dry needling as a PT intervention. Additionally, members of a health profession tend to view the appropriate

scope of other professions more narrowly than their education and training would confer, as evidenced by several recent court cases. The question to be answered was not whether or not dry needling was in the scope of practice of physical therapists but instead to identify the competencies required to safely perform dry needling, identify the knowledge and skills to perform dry needling, and then evaluating to what extent entry-level knowledge is needed for safely and effectively using dry needling. As an independent contractor, HumRRO was tasked to carry out an objective, unbiased analysis.

Thank you for your time,

Leslie Adrian

Leslie Adrian, PT, DPT, MPA, Director of Professional Standards
Federation of State Boards of Physical Therapy

I participated in the recent hearing regarding Dry Needling for Physical Therapists - Possible Expansion of Scope of Practice in Washington State. I am a dually licensed Physical Therapist for 24 plus years in Washington State, with licenses in three other states before moving here, and a Licensed Acupuncturist and East Asian Medicine Practitioner for 11 years in Washington State. I appreciate that licensing keeps the consumer safe with the knowledge that they are in well trained and qualified hands with a Medical Practitioner who is trained adequately to treat them safely and effectively within a specific medical practice. I spoke against this expansion of scope of practice for the following reasons:

- 1) Training PTs in a two weekend course to do “Dry Needling” which is Acupuncture without the proper license, is hazardous to the consumer, and eventually will lead to higher liability insurance for Physical Therapists and a lack of trust by the consumer of Physical Therapists as qualified to treat them effectively with any modality. Those who argue that dry needling is different than Acupuncture are stating this based on the idea that to understand anatomy so extensively gives one the ability to probe into the skin and make changes to the underlying tissue, with no regard for a system of medicine that has been doing just this for over 1500 years successfully and with minimal harm to patients. Acupuncture has ALWAYS been based on anatomy, pathology, physiology, etc., from the start of it. Anatomy, pathology, physiology, etc., are not recent “Western” innovations! As a Licensed Acupuncturist, I have to say that as soon as the needle goes through the skin and into living tissue, everything changes. No amount of cadaver work in a laboratory is going to prepare you for this.
- 2) There is an argument that there is a study in Ireland which shows that “Dry Needling” by Physical Therapists has been shown to be safe. This study asked over 170 Physiotherapists to reply about whether or not they had injured a patient with “Needling”, and less than 40 Physiotherapists replied to the study, and only 35 participated. Since it was voluntary, you can imagine that if a Physiotherapist had injured a patient, she/he might be less likely to respond to the survey. This is not sufficient to constitute proof of safely performing Dry Needling without proper Acupuncture training. Also, Physiotherapists have Needling in their Scope of Practice in Ireland, and therefore have taken educational coursework and training in Acupuncture, so it is like comparing apples to oranges.
- 3) Similarly in the UK, which was also used as a place where Physiotherapists do Dry Needling, the Physiotherapists are under the supervision of Medical Doctors, so that any Acupuncture they are doing has been approved and is being directed by a Medical Doctor. This is not the scenario we are talking about in Washington State.

When issues were addressed around the Classes that are being taught to Physical Therapists by other Physical Therapists in Arizona specifically, it was said by J. Dommerholt, a PT from Maryland, that the PT who was teaching the classes unsafely in Arizona was no longer teaching these classes. This Physical Therapist was providing very minimal supervision, was not

using safe clean needling technique, and was encouraging PTs to begin working on their patients back at their clinics after just 18 hours of lecture and 9 hours of very minimally supervised Acupuncture needling. This Physical Therapist, Susan Falsone, PHD, PT is now teaching Athletic Trainers in Arizona how to do “Dry Needling”. Now this is very scary! Athletic Trainers are minimally trained in Anatomy and Physiology, and are not considered Medical Professionals in any way, shape, or form. This is an example of “you give an inch, and they take a mile.”

According to an Acupuncturist who attended one of these courses, Susan Falsone, PT, is teaching acupuncture points and calling them auriculo-stimulation points (anything not to mention the word acupuncture) , and she is teaching electro-acupuncture, cupping, and very definite acupuncture point usage for patients with musculoskeletal injuries. These are all within the scope of Acupuncture practice specifically, and not Physical Therapy. In this course there are 30 participants, and the modeling for needling would not be considered medically safe. She reinserts needles that are only supposed to be inserted once, a violation of OSHA standards. This is the “quality” of training that Physical Therapists are receiving on a daily basis in “dry needling” workshops and classes.

4) The needles that we use in this country as Acupuncturists, which are the same needles that the Physical Therapists are calling filiform needles, have a warning label on them, and I quote: “Caution: Federal law restricts this device to sale by or on the order of qualified practitioners of acupuncture as determined by the States.”

Since the Physical Therapists are adamant about the point that they are not doing acupuncture, they really should not be using acupuncture needles that are only for the use of Acupuncturists and Medical Doctors who are certified to do Medical Acupuncture. The AMA has put out a statement that Dry Needling is Acupuncture, and therefore should be governed by the laws of each State for Acupuncture.

NO “DRY NEEDLES” HAVE BEEN APPROVED BY THE FDA, new brands have been approved but ONLY as Acupuncture needles.

5) As far as Training to do Acupuncture as a Physical Therapist, as a dually licensed Practitioner of Acupuncture and Physical Therapy here is what I believe to be reasonable: Acupuncture practice does require a foundation in Bio Medicine, 450 hours of Basic Western Sciences, which could be waived for a Physical Therapist as allowed by the school Acupuncture/East Asian Medicine program. Clinical hours involve more than 600 supervised hours in an Acupuncture Clinic as well as 150 plus hours of observation of a Licensed Acupuncturist. Coursework includes at least 750 hours of Chinese Medicine Theory and Application. A clean Needling weekend course is also necessary to fulfill all requirements to practice Needling safely.

I don't think there is much more to be said about this except that the studies are flawed touting the efficacy of Dry Needling. We should not compare Physiotherapists trained in other countries to what the training is in our country to determine whether they should perform acupuncture or not without a license, and we need to really look at what is safe and effective for patients to protect not only the patient but both of our professions.

Dual licensure is the only way to ensure health and safety in Washington State.

Bridget Boylan, PT, EAMP/Lac

I am a patient of an acupuncturist who treated my pain. Before his treating, I experienced a very hard time for the pain. After his treatment, my disease disappeared and I can move as normal person. So I thank him very much! My acupuncturist told me before he needed to study four years for treating patient recently I heard that physical therapy also want to use dry needles to treat patient and they only be trained 54 hours. I think it is too terrible for anyone who be treated. For I know using needle treating patient is very

difficult skill which can't be handled in so short time. So I oppose physical therapy apply dry needle to treat patient.

Yanmin Sun

Two of the main reasons acupuncturist are regulated by the state are:

1. To make sure acupuncture is practiced safely
2. To uphold a standard of care and quality of treatment

If someone wants to become an acupuncturist, they have to go through the system that has been carefully set up. They have to go to a school that is regulated, get a certain amount of supervised practice and then pass a national exam. This helps to secure the quality and safety of acupuncture treatment in the State of Washington.

At the most fundamental level, this system described above ensures that an acupuncturist has studied and practiced the skills of how to deliver an effective medical treatment safely. It is not enough to observe this skill being practiced by someone else in a 54 hour weekend course. A skill needs to be studied, practiced and integrated over a long period of time, with feedback from an experienced instructor, in order for the skill to be refined to a point that it has reached the standard of safety and care that is required of a Washington State Licensed Acupuncturist. For the same reason I support what it means to be an acupuncturist in the State of Washington, I oppose the practice of dry needling by physical therapist, or any other professional who has not gone through the regulations set up by our state regulatory board to ensure the safe practice of acupuncture.

Jon Pontrello, EAMP

I am an EAMP who practiced acupuncture for 4 years. I think the PT association's proposal of including Dry Needling into their practice scope is not adequate for public health safety and convenient for patient. The unsafe part is that needling is a medical procedure that involve proper selection of points, hand techniques, right amount of stimulation that are based on the fundamental of the Chinese medicine theories. Dry needling techniques is based on and identical to TCM's pain points treatment or Ashi points treatment, but it rarely used alone without addressing the imbalance of the channels and organs. By separate the dry needling as a stand alone procedure that only treating trigger points (pain points or ashi points) can potentially do more harm than healing without the basic understanding. This basic understanding takes me or any acupuncturist 3 years graduate level of studies and 600 hours supervised clinic training.

PTs suggestion that they can use dry needling as part of their practice for the convenience of patients. However it is inconvenient for proper treating patients conditions that really need an acupuncturist to come up a needling prescription. Improper needling not only may cause what is increasing problem of medical malpractice and accidents, which is the 3rd leading cause of deaths after heart diseases and cancers, but over-treatment in one treatment section is highly unavoidable. I have see my patients who suffer from delayed recovery due to PT's over-treatment.

I think responsible health care providers will go through multiple licenses or board certification to expand their practice scope rather than short cut the training. I am highly confident your committee will put the public health safety and sustainable care to the top than a single group who is looking for own privilege.

Bing Su, LEAMP

I am an East Asian Medicine Practitioner in both California and Washington as well as in China.

Through all these years of practices in China, California and Washington, I feel the proposal by Physical Therapy Association of WA to perform "dry needling" is woefully inadequate. It does not adequately address harm, assurance of professional ability, nor cost-effectiveness. By their own descriptions what they describe is acupuncture.

There are many dual licensed practitioners in the state of WA, who hold multiple licenses to practice multiple disciplines. This is important to protect the public health and safety of the health care consumers in WA state.

The Department of Health should require the physical therapists to complete the training and licensure to become EAMPs as is required under RCW18.06.

Please deny the Physical Therapy Association of WA's application in its entirety. (Attached is the patients' voice, too)

Xia Che Practitioner, NCCAOM Dipl. & PDA Provider

Dry needling has been brought to my attention and frankly I'm horrified. My Acupuncture specialist is one of 2 people one is a MD + he has a degree in acupuncture as well, the other is a state certified acupuncturist.

Why would you want anyone without the years of classroom and practical experience to work on the bodies of your loved ones or mine?

The pain management I've been blessed with because of their knowledge is beyond awesome, sometimes due to physical booboos, sometime physical or emotional trauma, either way they have been trained to understand how and why needling is a good thing and when it is not, and how to tell which way my treatment should go to best help me recover.

I find it appalling that someone would betray the trust given them by a patient and dry needle in the name of "dry needling" or for a profit of personal gain. Even the name "dry needling" is deceptive. What does that even mean? No water or lotion added? I doubt they would admit to not being fully trained.

Please help to protect the public and the integrity of this truly specialized field that takes more than 54 hours of training.

Kacy Ritter

My body has gone through lots of trauma. As such, I have had various treatments – allopathic, homeopathic, and holistic. I've had at least a dozen surgeries in various parts of my body – from my head down to my ankle as a result of various conditions, including a vehicle accident. As time went by, I was diagnosed with a number of degenerative and painful conditions.

Some of the treatments I've gone through include Physical Therapy and Acupuncture. In going through both, I see PT as a means to bring back elasticity and mobility to certain parts of the body. Whereas Acupuncture seems to work best in pain management. As a result, I do see them as complimentary, but as very separate treatments.

If needling were to be added to PT, I could see how it may benefit by minimizing the number of visits or the number of practitioners a patient would see, but I would still see needling as a separate treatment. The last treatment center that I visited included PTs and Acupuncturists, whom I could set separate appointments with. I had very different conversations with each practitioner and found them to be experts in their respective fields.

Personally, I would consider Acupuncture a specialty and would not like to see it combined as a simple treatment that a Physical Therapist performs. When we look at the way the medical practices are

“partitioned”, it makes it that much more obvious. For instance, would we like an Allergist (no disrespect meant here) performing an Orthopedic surgery? – most likely not. Or how about a Dentist treating a cataract? Or a heart surgeon treating hair loss?

There’s a reason why these practices are very separate from each other. They all require specialized training. Now, could a Dentist help in an emergency situation – like dealing with first aid? Sure, as part of his/her years of study, I’m sure anatomy and lots of other body-specific areas were covered, but would that make him an expert in dealing with emergency traumas? Most likely not.

Last year while in Mexico, I visited a “Natural Clinic” that had been recently established. In talking to the people in charge, I asked what sort of specialists worked there. One of them happened to be an acupuncturist. Out of curiosity, I asked what sort of training she had gone through. He told me that, in Mexico, they offer these “*diplomados*” (courses where you take a short class and get an attendance certificate or “diploma”). As it turned out, she had gone through one of these “diplomados” for a couple of weekends and that made her a “certified” acupuncturist.

Is this what our country is coming to? Where you could go, listen to someone speak for a few hours and, by default, that makes you an expert and allows you to treat patients? I REALLY HOPE NOT.

At best, I would see having 54 hours of needling training as a Continuing Education course where a PT would become more aware of other treatments to recommend to his/her patients.

Frank from Redmond

As a patient who has worked with 6 different acupuncturists, have taken classes on how it is done and the effects of acupuncture, I DO NOT agree with physical therapists taking only 54 hours of training on a weekend. It would be irresponsible give them a licence to do dry needling. I really doubt they can know all the points in each meridian, how they can combine them for the best effect for the patient and I would not let a PT do it on me. They couldn't have the knowledge to know the best size of needle to use or how deep or the angle to use for the different points in each meridian and how to combine them. They would not have had the supervision to know if they were doing it correctly. Even though to the average person it looks simple it is not and it would be unprofessional to let them use needles. If they want to have the ability to give acupuncture, have them enroll in an acupuncture program and go through the whole program with supervision, pass the state tests, get a state licence and then become acupuncturists and only then they can add it to their practice. Protect the best interest of the patients.

Patricia Owen

I would like to introduce myself - my name is Rachel Weissman and I am a NCCAOM (national) board certified acupuncturist, as well as a Washington State licensed acupuncturist. My undergraduate degree is in engineering, and I studied at both Bastyr University here in Washington, as well as Tri State College of Acupuncture [TSCA] in New York City. I have taught at schools in Denver and now am on faculty for Bastyr. I also owned and operated my own private practice in Iowa City for 7 years, then Denver and now in Bellevue.

I understand that there is an attempt by Physical Therapists include acupuncture ("dry needling" "trigger point therapy") into their scope of practice. I believe my understanding of the situation is unique and would like to share a bit of my experience with you.

I began my training in an integrative medical center at Thomas Jefferson University Hospital (Philadelphia). There, the staff acupuncturist introduced me to several techniques used by acupuncturists for years - this includes specializing what PT's are calling dry needling and trigger point therapy. At TSCA we were formally trained in what the school's founder has called Acupuncture Physical Medicine

(APM). This style of acupuncture combines classics-based French-meridian acupuncture and physical medicine, most notably what we have now termed "trigger point" needling. We studied Chinese and Japanese acupuncture while undertaking a detailed study of myofascial trigger points. Of course, all of these are simply specializations or styles of acupuncture.

This concerns me.

First, and most importantly, I believe that if PTs are going to be allowed to practice acupuncture/dry needling/trigger point therapy WITHOUT EXTENSIVE CLINICAL TRAINING, then they are putting their patients in harm's way. As acupuncturists we are required to complete graduate level training of at "least three academic years in length; it must be a resident program; it must demonstrate attainment of professional competence; it must have a adequate clinical component." It is my understanding that if given permission, PT's will begin to practice our medicine with only 54 hours of training, and without supervised clinical training. This potentially puts patients at risk! Licensed acupuncturists have the advanced training necessary to deal with the occasional difficult problem or complication. We had many more years of training and are better prepared to offer patients the safest care possible.

Another issue is strictly one of terminology. Trigger point therapy is a style of acupuncture. Dry needling is also a style of acupuncture. Similarly, Traditional Chinese Medicine (TCM) and Japanese are all styles of acupuncture. Each of these approaches are equally unique in their approach and require the appropriate training. But they all have one thing in common. They utilize single use, disposable, stainless steel filiform needles. I do not believe that a new name (like "dry needling") to describe an old procedure (acupuncture) should permit its usage for another profession (physical therapy).

Physical therapists receive training in their field, but again, their clinical training does not, and should not include needling. In my cohort at TSCA, at least 10% of my fellow students were PTs. They were completing the full 3 year post graduate education for an acupuncture degree in order to best serve their patients. Some of my students at Bastyr are also massage therapists, NDs, RNs and even MDs. Again, they recognize the importance of a thorough clinical training in order to safely and effectively treat patients with acupuncture needles.

A study(1) examines the correlation between trigger points and acupuncture points for pain. It notes "A remarkably high degree (71%) of correspondence was found. This close correlation suggests that trigger points and acupuncture points for pain... represent the same phenomenon and can be explained in terms of the same underlying neural mechanisms." There is a class of acupuncture points 'ashi' (dating back to at least the 7th century CE) that, had the investigators taken this into account, would have explained the remaining 29% of correlation.

Finally I believe the AMA clearly recognizes that dry needling is an invasive procedure, one that should only be performed by practitioners with standard training and familiarity with the routine use of needles in their practice such as licensed medical physicians and licensed acupuncturists.

Thank you for your time and consideration. Please do not hesitate to call or email me with any questions or concerns.

Rachel Weissman BAS, MS, LAc

(1) Trigger points and acupuncture points for pain: correlations and implications. [Melzack R, Stillwell DM, Fox EJ. Pain.](#) 1977 Feb;3(1):3-23.

As a long time sufferer of chronic low back pain and spending thousands of dollars on various treatments, I finally found something that helped in 2007. I was in physical therapy school and did an internship at a clinic in Denver, CO. I was seeing just how amazing this tool (dry needling) was in the hands of a skilled

physical therapist. After seeing great results as a student, I ended up getting treatment on my own back. It has been the only thing that has helped my back pain. Because of this, I stayed on top of the research and dry needling and knew I wanted to be able to utilize it when I became a physical therapist. After receiving my Doctorate of Physical Therapy in 2010 and utilizing it in Colorado and for a short time in Washington, it is heartbreaking I am unable to receive treatment as a patient but also provide the treatment as a practitioner. I am seriously considering moving to another state to practice if I am unable to perform dry needling here. Please look at all the FACTS and not the scare tactics from the opposition. It is an extremely safe and effective technique.

Austin

As an Acupuncturist I am deeply bothered by PT's practicing "dry needling". This is not because I see them as competition but rather I am concerned for the safety of their patients. "Dry needling" is a form of acupuncture, there is no difference between a filiform needle used to perform "dry needling" and a filiform needle used to perform acupuncture. The trigger points used by PTs are what acupuncturists call "ashi" points, and they have been used since the 7th century CE. There has been no new discovery by PTs and the PT scope of practice should not be expanded to include placement of needles in bodies. The invasive nature of placing a needle into the skin and musculature requires more than 54 hours of training. There are far too many delicate structures in the body for someone without the proper training to be inserting needles. The American Medical Association even states dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists. As a licensed acupuncturist I had over 660 hours of supervised clinical training after years of exposure to theory, anatomy, and plenty of practice. Washington state already has benchmarks for the education, supervision and testing required to insert filiform needles and what PTs are proposing does not meet those standards. I can only hope Washington State DOH will decided to stand by their requirements and maintain their high expectations to protect the people who wouldn't know any better.

Nancy Palmer L.Ac. EAMP

I was writing to protest the recent adoption of East Asian acupuncture techniques by physical therapists. This was quite alarming to me as a regular acupuncture patient. I know that the argument given by PT practitioners is that it is not acupuncture. However, they are using acupuncture needles, and inserting the needles into the area of the patient where they are experiencing symptoms (which is definitely an acupuncture technique).

I have a torn left rotator cuff in my left arm. I had a right one torn as well, but had it surgically repaired by a surgeon (not a physical therapist) and it took close to 3 years of therapy to get it back to normal. I decided not to have the other shoulder operated on and instead chose acupuncture and it has really saved me or at least enabled me to put off the surgery, maybe indefinitely because all the pain is gone.

It doesn't seem fair to make people go to school for years and learn Traditional Chinese Medical theory in order to get a license while other's are not held to the same refined standards who are basically by comparison "not trained." Imagine if acupuncturists started doing minor surgery in their offices and said "oh, it's not really surgery because we don't use scalpels." We also don't stitch we use scotch tape.

I believe that it is a danger to patients having untrained people administer acupuncture needles.

Sincerely,
James V. Waugaman

I am writing in support of the proposal to add dry needling to the physical therapy scope of practice. Dry needling has been more effective in treating my migraines and chronic neck pain then any alternative

treatment I have tried over the years. This technique, along with a physical therapy home exercise program, helped to significantly reduce my pain almost immediately. I rely on dry needling for pain management and urge you to add language which allows physical therapists to dry needle in Washington, so that myself and others can continue to benefit.

Jennifer Hass

I believe PT's should be allowed to perform dry needling with the proposed 54 hour additional needle-specific training and 1+ full time year of clinical practice after graduation.

Debbi Patterson

Without a doubt, dry needling should be included in the scope of practice for physical therapists.

On top of their hands-on dry needling training, PTs have completed physical therapy school. They have an exquisite understanding of human anatomy and what conditions would benefit most from dry needling.

Acupuncturists are claiming that PTs are only required to take a weekend course before being certified to use needles for patient treatment. That claim is being used as a scare tactic that is NOT factual. Physical therapists have years of anatomy training before the dry needling course.

As a patient who has been treated with both acupuncture and dry needling, I can confidently say that they are not the same. The methods and applications are considerably different. I experienced significant benefit from both dry needling and acupuncture, but not for the same conditions. They both have a place in our health care system.

As I wrote in a previous testimony about my personal health issues, I will reiterate here: Excluding dry needling from the PT scope of practice takes away a lifeline many of us with chronic and/or acute medical issues absolutely rely on. Acupuncturists are calling on you to protect people by limiting the medical professionals that can perform dry needling, but in reality you would be putting many patients at greater risk.

I can't speak to what that greater risk may look like for others, but I can detail what it would be for me. Without dry needling, my overall quality of life could decrease greatly. I am able to manage a chronic pain condition without the use of habit-forming narcotic pain medications. Additionally, I am able avoid another risky, costly and incredibly painful knee operation because of my access to dry needling.

Over the course my 3-4 year dry needling treatment, I have never been in a position where I questioned my PT's knowledge nor have I felt that I was in danger.

Please consider the facts when making this decision that will affect so many people suffering from health issues.

Jessica Winkler,
Seattle, Wa

Dry needling is an exciting new approach to acupuncture--exciting in the same way that riding on the freeway with a brand new teenage driver is exciting: seemingly limitless new horizons excite the driver; fear of catastrophe "excites" the passenger. Medicine should not be exciting in either fashion. The practice of medicine should be consistent, effective, and rational, with the risk of harm to patients carefully controlled.

Acupuncture can be all of those things, as licensed acupuncturists in this state have amply demonstrated for several decades. The fact that our state has established a clear set of training requirements for anyone seeking to use acupuncture needles on patients within its boundaries has played an important role in our success.

Dry needlers use acupuncture needles to pierce surface structures and deliver a therapeutic stimulus to deeper tissues, typically intending to effect change in the contractile properties of muscle fibers. Dry needlers seem to feel that their innovation is so potentially beneficial to patients in our state that the established training requirements for acupuncture practice should be set aside.

As a licensed acupuncturist with three years of specialized post-graduate education, and thirteen years of practice, and even more so after having instructed acupuncture interns and active medical professionals from many specialties over several years, I understand how exciting acupuncture needles can be. It turns out that acupuncturists too use acupuncture needles to pierce surface structures and deliver a therapeutic stimulus to deeper tissues, often intending to effect change in the contractile properties of muscle fibers. I have worked in an integrative rehab setting for most of my career. I agree that filiform acupuncture needles can markedly improve outcomes for patients recovering from musculoskeletal injury, (often complex) motor dysfunction, and surgery.

I, however, also understand that acupuncture is a physical skill. As such, good technique is critical to positive outcomes. Good technique, in turn, develops only with practice. Acupuncture interns either develop such skill over three or more years of supervised practice, or else they are not allowed even to sit for the national board examination which they must pass in order even to apply for a license which they must have in hand even to begin to practice in Washington State. These are stringent requirements. And they are appropriate. Acupuncture enjoys a reputation in our state for being safe and effective. That reputation is a result of the stringent system we have in place here.

If dry needling were to successfully circumvent our state's quality checks, as its advocates request, then in Washington State good conscience would require us to add a disclaimer every time acupuncture, in any form, including dry needling, was discussed: "acupuncture is safe and effective *only when practiced by a licensed acupuncturist.*" Any rational conversant at this point should scratch their head and question why their state would even allow anyone other than a licensed acupuncturist to practice acupuncture in the first place. No amount of non-invasive medical training, of any sort, equates to even a single episode of invasive experience, and the bar has already been set for how much experience is adequate for one to practice acupuncture.

Dry needling is exciting. Medicine should not be exciting. On sober analysis, I must insist (and anyone who survived PT school, certainly anyone with professional medical experience, and I hope anyone working on this legislation should realize) that mere enthusiasm is a poor substitute for technical skill. And in the medical world, it is a dangerous substitute.

Thank you for considering these thoughts. Lets keep medicine in Washington State consistent, effective, rational, and safe.

Trevor Sevigny, Lac

¹ Dry needlers use a form of needle called "filiform" by acupuncturists and although it is but one of several forms of acupuncture needle, it is by far the one most frequently used. A licensed acupuncturist in the State of Washington will have used several thousand such needles, always under the careful supervision of an acupuncturist with several years of experience, before even having applied for licensure. The use of the term "filiform needle" by dry needling advocates, in lieu of "acupuncture needle", is likely as specious and intentionally obfuscating as it appears to be.

I am strongly in favor of dry needling in the scope of Physical Therapists in the State of Washington. As a runner, I have frequent overuse injuries and have found the use of Dry Needling to not only be therapeutic but a significant help in my healing process with my personal Physical Therapist.

In my years seeking professional therapy for my injuries I have utilized both acupuncture and dry needling and have found the former ineffective as a treatment for my muscular injuries. Dry Needling has proven to be safe effective and at some times provided a miraculous relief to nagging muscular tightness and pain.

I put my faith and confidence in the hands of my Physical Therapist, who is a trusted professional, who is always searching for opportunities to help me heal and strengthen myself physically and emotionally. This is the type of relationship that I search for in a health professional – someone who can heal the whole body through a variety of processes. It poses a strong financial hardship for me to find it necessary to search for Dry Needling outside of the comfort of my own health professional, and therefore state, and perhaps even my country.

I am an active member of the sports road running and track and field community and feel strongly that dry needling should be within the scope of physical therapist practice based on safety and efficacy.

Patricia Crookshank

My name is Ray Stephanson, Mayor of the City of Everett and a patient of Benjamin Boyle, Clinic Director of Everett Physical Therapy.

In the past, I have received and support the Physical Therapy Association of Washington's (PTWA) request to include dry needling in the physical therapy scope of practice, as outlined in SB 6371. After right shoulder surgery a few years ago, Dr. Boyle successfully performed dry needling treatment that accelerated my recovery. I believe SB 6374 will ensure the safe practice of dry needling treatment of musculoskeletal impairments by defining the education requirements for physical therapists to perform this technique.

I am currently recovering from a lower leg injury that has been slowed because dry needling treatment is not available.

Thank you for the opportunity to express my views as a patient.

Ray Stephanson

Physical therapists are trained and educated to be manual therapists; hands on without invasive treatment procedures. Acupuncture, also known as needling, dry needling, trigger point therapy, intramuscular therapy, etc., should be allowed only by medical doctors, osteopathic doctors, and licensed East Asian Medicine Practitioners.

Physical therapists are not trained to the level of a Medical Doctor or Doctor of Osteopathic Medicine so even 300 hours of training in acupuncture, let alone 54 hours as proposed, is insufficient for physical therapists to be allowed to do acupuncture or any therapeutic needling except by MDs and DOs.

The financial and health-risk costs to the public are too great under the PTWA's application. Increased costs to the PT profession due to likely increased costs such as increased professional liability insurance would be passed on to patients raising physical therapy fees, with no coverage allowed for needling under insurance nor Medicare.

Please uphold the current precedent of requiring non-MD/DO health care practitioners who want to do acupuncture or any therapeutic needling, to the same standard and require them to be dual licensed as an EAMP under RCW 18.06.

Washington State has a long history of protecting the public from harm by requiring dual licensure for practitioners to practice different modalities beyond their scope of practice.

Please continue to protect the health and safety of people in Washington State by denying the PTWA's application in its entirety.

Sally Doran

Physical therapists are trained and educated to be manual therapists; hands on without invasive treatment procedures. Acupuncture, also known as needling, dry needling, trigger point therapy, intramuscular therapy, etc., should be allowed only by medical doctors, osteopathic doctors, and licensed East Asian Medicine Practitioners.

Physical therapists are not trained to the level of a Medical Doctor or Doctor of Osteopathic Medicine so even 300 hours of training in acupuncture, let alone 54 hours as proposed, is insufficient for physical therapists to be allowed to do acupuncture or any therapeutic needling except by MDs and DOs.

The financial and health-risk costs to the public are too great under the PTWA's application. Increased costs to the PT profession due to likely increased costs such as increased professional liability insurance would be passed on to patients raising physical therapy fees, with no coverage allowed for needling under insurance nor Medicare.

Please uphold the current precedent of requiring non-MD/DO health care practitioners who want to do acupuncture or any therapeutic needling, to the same standard and require them to be dual licensed as an EAMP under RCW 18.06.

Washington State has a long history of protecting the public from harm by requiring dual licensure for practitioners to practice different modalities beyond their scope of practice.

Please continue to protect the health and safety of people in Washington State by denying the PTWA's application in its entirety.

Becky Bankart

I believe PTs should be allowed to perform dry needling, with the proposed 54 hour additional needle-specific training and 1+ full time year of clinical practice after graduation. While living in Virginia, I received dry needling as treatment for back mobility issues, and I am very pleased with the results. It *perfectly* complemented the physical therapy treatment plan I received and completed. Please keep/expand dry needling within the physical therapy scope of practice for PTs nationwide.

Diana Lindsay
Tampa, FL 33647

I believe licensed PTs throughout the United States should be allowed to perform dry needling in their treatment of patients' pain, with the proposed 54 hour additional needle-specific training and 1+ full time year of clinical practice after graduation. Their education, knowledge of human anatomy and sources of pain in the musculoskeletal system provide a sound basis for performing this technique to bring relief to their patients, possibly avoiding the need for surgery and/or opioid pain killers. All of this contributes to a better quality of life for their patients.

Patients should be able to receive this treatment from PT's no matter where they live in the United States.

–Marcie Smith
Indian Shores, FL 33785

As an acupuncture patient and someone familiar with dry needling as used by PTs, I DON'T believe that "acupuncture" encompasses ALL treatments where a thin, filiform needle is used as a tool. Therefore, I believe other areas of medicine should have the freedom/option to also use this tool, as it assists them in their particular treatments.

Restricting use off this tool to only a certain group of practitioners limits possible health benefits for so many people.

Thank you for your time and consideration.

Meagan Casselberry
Indian Shores, FL 33785

My name is Raymond Chan, LEAMP with 48+ years of experience in Traditional Chinese Medicine! I am writing to oppose PT's application to include dry needling as part of their scope of practice.

What PT's recommendation about the dry needling is reminiscent of "barefoot doctors" in 60s and 70s. The barefoot doctors had 6 months of training in both Western and Chinese medicine. The amount of hours of needling training was similar to what PT is recommending now. I have witnessed some injuries such as paralysis and pneumothorax caused by short period of needling training during that time! Barefoot doctor system was finally abolished in 1981. Regardless what name of needling PT use, needling is an invasive procedure which demands more than 54 hours of unsupervised clinical training can do!

Since a MD is required to take 300 hours of vigorous training to do medical acupuncture, and an acupuncturist to take 600+ hours alone of supervised clinical needling training in addition to hundreds of hours of theories, I would recommend PT take no less than 500 hours of clinical needling training in order to keep the public safe from needling injuries!

Thank you for your attention to this matter! We depend on the Health Department to safeguard the public health safety in Washington State!

Sincerely,
Raymond Chan, LEAMP

I am writing this email in regards to a very important matter...Dry Needling has been brought to my attention, and frankly I am shocked. I am a 25 year old female who is living with ankylosing spondylitis, A.S. for short. It is a form of arthritis that lives in the base of my spine and SI joints and affects me on a daily basis. Living with the pain has been nothing short of a challenge. I have been to several different specialists who have all just written me a prescription for pain medicine, cortisone injections, and physical therapy....not a routine I wanted to get into long term.

I was recommended to Bastyr by a dear friend who had wonderful success doing acupuncture for her neck and back pain from a past car accident. I now have a wonderful acupuncturist/herbalist who has given me so much relief of the daily pain and struggle from my arthritis. The in depth and intensive training that she received from her schooling is what has made her the acupuncturist she is today.

Dry needling should not be allowed...period. Why on earth would I trust anyone who has not had the proper training? Someone who does not receive their certification in acupuncture has no business what so

ever needling someone. Acupuncture is an art form...reading an individuals body and their needs is crucial with needle placement. The delicate touch mixed with some tricky placement can go really well or bad...and Im not willing to go to someone who was taught dry needling over someone who has had intensive, in-depth, proper training and certification. I truly and sincearly hope that this potential new law for dry needling does not pass. It would be a disservice to the Chinese medicine, licensed acupuncturists, and patients. Thank you.

Best Wishes- Christina Hansen

I am a practicing physical therapist in New York State and have practiced for 30 years. I am also a licensed acupuncturist with a degree in Oriental Medicine and graduated from a fully accredited, credentialed school. I have practiced since 2006. I have also been trained extensively in the understanding of trigger points and perform ashi needling myself, so I feel qualified to have an opinion about whether physical therapists should be allowed to include this type of acupuncture into their scope of practice. Under the current proposal, they should not be.

I am extremely disappointed with the behavior of some of my physical therapist colleagues. In my opinion, some have allowed themselves to be swayed by a movement that does not come from the real training requirements that are needed for the subject matter being taught, established, independently certified training needs, but by for-profit programs that need to sell seminars and courses. The hours in these seminars appear to have been driven by recognizing that PT's will sign up for continuing education courses and seminars if they are only a few weekends. The current resistance to the proper training that would come from dual licensing looks like evidence of this and suggests that PT's won't sign up if more time is required, as the dual licensing I have requires. This is why 54 hours looks less coincidental than it might appear. The 54 hrs would not make sense, otherwise, even according to the PT HumRRO report, which does not agree with this. This report does not suggest or even support this. The 54 hour number looks like it comes from seminar hours from these programs and not from the real training needs. This creates an unsafe situation for patients.

As an experienced acupuncturist and physical therapist, I find this alarming. In my opinion, the current weekend courses offered by for-profit companies are at best an introduction to therapeutic needling. I am deeply concerned that PT's who take these courses will believe unrealistically that they are fully qualified to needle, which creates a risk to their patients. In my opinion, these PT's are not adequately prepared to needle people safely, comfortably, or effectively after 54 hrs of training, with no further oversight or most importantly, supervised clinical hours.

The Sunrise Committee should deny the physical therapy attempt to expand their scope of practice in Washington State.

Sincerely,
Mona Lee-Yuan L.Ac., Dipl. In OM (NCCAOM), PT

I've been writing comments ever since before the last Senate session early this year per **SB 6374** to our State senators and Governor Jay Inslee that led to the Sunrise Review that we're addressing now. I was also at the Olympia Review Session on August 2, 2016 with a group from WEAMA. In summary, way too much time has been spent on this topic and my honest opinion is that the Acupuncture community has commented all it could without changing its mind. Ultimately, it's up to the DOH, and the lawmakers in Olympia, WA to pass/fail this bill. A good bill passed will enrich patient's well being, avoid unnecessary litigations, and leverage the best in the healthcare of PT's and Acupuncturists. I can't imagine what the alternative might be and only choose to be positive.

At the Review Session, I heard for the first time that we're dealing with the same needles. PT's feel they could just use them (DN) within their "new scope" of practice with a ceremonious 54 hours such as taking

a weekend workshop, etc., without even satisfying a Clean Needle class or a Clinical Apprenticeship when asked by the panelist from the DOH. PT's reasoned that they just care to do their own thing without getting into this "Disciplined Acupuncture" trap. Dr. Jan Donahoe's "Stethoscope" analogy that this instrument should not only be used by a cardiologist is fine with me as long as the user has proof of medical competency in the care of a heart patient. I was also troubled in hearing about a report on PT's deliberately subjected some pregnant women to the so-called forbidden Acupuncture points just to want to prove that their DN didn't result in any adverse effects. A forbidden point is NOT a made-up point, but rather based on repeated clinical evidence in the ancient Chinese Medical text. I hope I only heard about this by mistake, but when I thought I did, it did send a jolt to my heart. Seriously, why would anyone try such risky experiment?

The bottom line is that our patient's safety and trust is entirely at stake, no matter how many countries, towns, and agencies (FDA, VA, AMA, etc.) have already approved DN for PT. Therefore, I don't believe the issue is about the endless battles between two professional organizations that started out with quite clearly defined missions and objectives without crossing each other's paths.

I personally have gone to several PT's for my own health and have received outstanding results so much that I would refer my own patients, relatives and others to PT's. This year, I have had an ongoing cross-referral with a group of PT's near my town. The first patient I got from them had severe shoulder injury and inflammation that recovery went slowly. After my first treatment this patient reported immediate pain reduction to the relief of both the patient and the PT. Another referral to me was a Tech worker with bursitis and tendonitis in the shoulder who's been visiting the PT for over a month and still hurt like hell. The PT's been happy that these two patient's healing rate has upgraded, while they continued to visit the PT. I reciprocated a referral to this PT when a new patient of mine didn't feel her pain had gone down substantially on her very first visit. Looking back, I believe this kind of honest referral could continue to work well. However, at the August hearing PT's felt they don't want to refer patients to us as DN has proven to work a lot faster and better via a very subjective assessment when asked by the panelist from the DOH Likewise, when two patients from the PT side were asked if they would seek Acupuncture treatment sometimes instead of DN, and they replied with a resounding NO, only because they were already there to support the PT's. One patient simply said that he didn't care for a whole-body Acupuncture treatment because he just wanted his specific pain areas taken care of – an answer that demonstrated NO understanding of what whole-body treatment is all about. In conclusion, I highly respect PT's professional trainings with their original scope of practice and often express my empathy that some of them don't get the Dr. Title they well deserve with their elaborate amount of training, the equivalent of a Chiropractor's or MD's. I'm making my comments to demonstrate that if we continue to label this Sunrise Review effort as the battle between two perfectly respectable professions, we all have more to lose and honesty is thrown out the door. In the 21st Century as the Healthcare Industry is moving more rapidly towards Integrated Medicine, inclusion for universal healthcare and much lowered costs as in many other countries, the current division arising from such heated Sunrise Review may create more bad than good.

Mayme Fu, LAc/EAMP, Dipl., O.M.

My name is Angie Yin. I'm a licensed acupuncturist and oriental medicine practitioner located in Bellevue, WA. I'm writing to VETO the attempt of PT practicing acupuncture aka. dry needle, with only 54 hours of training and unsupervised outpatient clinical hours. It is unfair to those who spend at least three years of formal acupuncture training at an accredited university, not to mention the safety issues it would bring to patients of dry needle done by PT.

We, all the licensed acupuncturists, friends and families in WA State, DISAGREE with PT Sunrise proposal UNLESS interested PT(s) are willing to go through the rigorous training program as we've been through, that is, a three-year formal training at an accredited acupuncture school. The practice of dry needle should never be treated like a joke. We all are very serious on this matter and we will continue to dedicate and defend safe acupuncture practice to the public in our state.

Best regards,

Angie Yin, EAMP

I was alarmed when I found out about this! Please continue to protect the health and safety of people in Washington State by denying the PTWA's application in its entirety.

Acupuncture, also known as needling, dry needling, trigger point therapy, intramuscular therapy, etc., should be allowed only by medical doctors, osteopathic doctors, and licensed East Asian Medicine Practitioners.

Physical therapists are not trained to the level of a Medical Doctor or Doctor of Osteopathic Medicine so even 300 hours of training in acupuncture, let alone 54 hours as proposed, is insufficient for physical therapists to be allowed to do acupuncture or any therapeutic needling except by MDs and DOs.

Physical therapists are trained and educated to be manual therapists; hands on without invasive treatment procedures.

The financial and health-risk costs to the public are too great under the PTWA's application. Increased costs to the PT profession due to likely increased costs such as increased professional liability insurance would be passed on to patients raising physical therapy fees, with no coverage allowed for needling under insurance nor Medicare.

Please uphold the current precedent of requiring non-MD/DO health care practitioners who want to do acupuncture or any therapeutic needling, to the same standard and require them to be dual licensed as an EAMP under RCW 18.06.

Washington State has a long history of protecting the public from harm by requiring dual licensure for practitioners to practice different modalities beyond their scope of practice.

Again, Please continue to protect the health and safety of people in Washington State by denying the PTWA's application in its entirety.

Sincerely,
MARY HAMILTON
La Conner, Washington

My name is Sik Chi Stanley Chan, LEAMP. I am a licensed acupuncturist in Washington State with 14 years of experience in this field. I am writing against PT's proposal to include dry needling as part of their scope of practice.

In the meeting dated 8/1/2016, PT representative seemed to acknowledge that dry needling is part of acupuncture. They said they just wanted to use "a small part" of acupuncture to treat pain including headache! They were not interested in treating other ailments such as pregnancy, etc. My concern is once they are allowed to do dry needling in Washington, who can check whether they secretly treat other ailments! As we researched online, we have found that PTs had used acupuncture needles to treat other ailments such as sinus issues! Some other photos online showed that they drew meridians on the body to locate acupuncture points! In fact, it is difficult to tell whether they are doing acupuncture or dry needling with the same needles and procedures!

My major concern of PT's dry needling is their insufficient training -- 54 hours of classes without supervised outpatient clinical training hours while military PTs have three months of clinical training with around 25 patient contacts! I have seen photos posted by PT that they punctured a patient through the

clothes on! They don't seem to have clean needle technique training! It is so scarring! The public health safety is endangered!

The MDs has extensive medical training and they still need to take additional 300 hours of training to do medical acupuncture. I don't think personally PT's training is as extensive and vigorous as that of MDs. Besides, the PT needs a referral from MD to do physical therapy on patients! Even the PTs have extensive training of anatomy and physiology, needling a living person is a totally different thing! Therefore, PT should not have less needling training hours than the MD even though they claim they were not doing acupuncture! Needling per se is an invasive procedure regardless what name you use and what terminology you use to describe the mechanism of the procedure! The best option, however, is to ask the PT to do the dual programs (physical therapy and acupuncture) so that they can master well the two different therapies! That would be the best benefits for the patients!

PTs also said that in the meeting they would refer patients to acupuncturist to do acupuncture. I have a friend who was treated by a military PT told me otherwise! How could you check they would do what they said?

Sik Chi Stanley Chan, LEAMP

Physical therapists are trained and educated to be manual therapists; hands on without invasive treatment procedures. Acupuncture, also known as needling, dry needling, trigger point therapy, intramuscular therapy, etc., should be allowed only by medical doctors, osteopathic doctors, and licensed East Asian Medicine Practitioners.

Physical therapists are not trained to the level of a Medical Doctor or Doctor of Osteopathic Medicine so even 300 hours of training in acupuncture, let alone 54 hours as proposed, is insufficient for physical therapists to be allowed to do acupuncture or any therapeutic needling except by MDs and DOs.

The financial and health-risk costs to the public are too great under the PTWA's application. Increased costs to the PT profession due to likely increased costs such as increased professional liability insurance would be passed on to patients raising physical therapy fees, with no coverage allowed for needling under insurance nor Medicare.

Please uphold the current precedent of requiring non-MD/DO health care practitioners who want to do acupuncture or any therapeutic needling, to the same standard and require them to be dual licensed as an EAMP under RCW 18.06.

Washington State has a long history of protecting the public from harm by requiring dual licensure for practitioners to practice different modalities beyond their scope of practice.

Please continue to protect the health and safety of people in Washington State by denying the PTWA's application in its entirety.

Gary Jacobson

Please do not pass the The dry needling for PTs. I'm concerned about this because I am an acupuncture student and it takes me at least 3 years to finish the program. We receive alot of hours to learn the needling technique and we are also under the supervisor when we practice acupuncture at the clinic. We also learn about the therapeutic action of the points that we use. they should go back to school and study acupuncture. Dry needling is a part of acupuncture. The value of acupuncture should be respected. Thank you for your consideration.

Vanessa Duong, Bastyr student- class of 2018

I'm a EAMP and opposite to add dry needling acupuncture to physical therapy scope of practice. Acupuncture and dry needling are indistinguishable from each other from a regulatory and legislative standpoint. Changing the name of a procedure does not change the procedure, nor the risk associated with its use. "Dry needling" is a form of acupuncture.

1. Early promoters of "dry needling" considered them the same and even went so far as to suggest renaming acupuncture points in modern terms so acupuncture would be more accepted by medical doctors. Hence, dry needling should be governed by the same statutes that apply to acupuncture.
2. Anyone using a dry/acupuncture/filiform needle should meet benchmarks for safety before touching the human body with a needle for therapeutic purposes, which requires extensive training to perform safely, far more than 54 hours with no supervised outpatient clinical training hours.
3. Washington state already has benchmarks for didactic education, supervised clinical hours, and a third-party national psychometrically created exam to test for minimum competency that involves the insertion of filiform acupuncture needles.

Gary Wu

From an economical perspective it is illogical to me that we would even consider limiting our ability to provide the best health alternatives for patients in need. As a young but active professional (34 years old), I have endured chronic back problems for nearly two decades now. After a recent flare up, a friend recommend I try dry needling at a local sports medicine physical therapy firm. In only a few sessions, I was able to get back on my feet leading our team. At the time, I was the Store Manager of Nordstrom at the Alderwood Mall with a team of 400. Had it not been for dry needling, I likely would have had to miss work (economic opportunity cost for our local economy) or unresolved longer term pursue an LNI claim (state expense incurred). In a time of escalating medical expenses that are ever difficult to understand and parse through, we have an obligation to be pushing to make cost effective alternatives as readily available to our Washington state residents as possible.

Troy Nelson, Vice President, Nordstrom Inc, Kirkland, WA

Thank you for taking my letter. I have attached a narrative from one of my patients who suffered needlessly when she was "dry needled".

Dry needling is an advanced acupuncture technique taught in the last year of school, and practiced under direct clinical supervision. The 54 hours proposed here and in earlier legislative attempts is severely inadequate. The physical therapists' own studies show that over 300 hours is necessary to be competent in these skills.

September, 2015 Statement from Suzanne Frewin-Nankervis, Quilcene

My husband and I have had 40 years experience with traditional acupuncture and have been patients of Heather Spencer EAMP since 2007. She has treated me for hip and back pain and, most importantly, for chronic migraine syndrome (CMS). I am now 68 yrs old and have suffered with CMS since I was in my mid-twenties. The syndrome has finally mediated over the past five years.

Pursuing relief from CMS, I was referred to the University of Washington Pain Center in the early 1990s where many different medications and treatments were tried with no success.

One of those treatments was an experimental technique performed by a visiting Japanese specialist termed dry needling. We were counseled that it was intended to damage the muscles in my neck, shoulders and back so that they would not be able to spasm, and constrict the nerves and blood vessels to my head with little pain and no ill effects. Having had previous experience with acupuncture, I was open to trying the dry needling.

The two experiences could not have been more different. The needles used were obviously much larger - guess how I knew! As many as 40 needles were inserted during the treatment.

The aftereffects were excruciating. I could hardly move; the pain was incapacitating. I could not manage the long journey home from Seattle to Quilcene. We stayed on with friends in Seattle and I used heat and ice alternately to alleviate the pain.

Now, many years later, I am appalled that I was willing to subject myself to three such treatments, testifying to the agony of CMS. With hindsight, I realize I was simply a human guinea pig, sadly tortured by a cynical system.

This technique has no relationship whatsoever to the delicacy and effectiveness of traditional acupuncture. The proponents of dry needling have neither the extensive training nor experience of the time-tested depth of traditional Chinese medicine and acupuncture.



August 16, 2016

American Academy of Manipulative Therapy
James Dunning, DPT, MS, FAAOMPT, MAACP (UK)
Director, AAMT Fellowship in Orthopaedic Manual Physical Therapy
President, Dry Needling Institute & Spinal Manipulation Institute
1036 Old Breckenridge Ln
Montgomery, AL 36117

Dear Mrs. Sherry Thomas and Washington State Department of Health:

It has come to our attention that one or more ‘East Asian Medicine Practitioners’ in Washington State have expressed concern over a picture that was posted by Dr. Thomas Perreault, a licensed Physical Therapist in New Hampshire and a Senior Instructor for Dry Needling Institute, on Twitter that depicted written abbreviations of acupoints for a dry needling protocol for knee osteoarthritis. Please allow this letter to serve as the formal response to this inquiry.

1. Dry Needling Institute teaches to many licensed healthcare providers: medical physicians, osteopathic physicians, naturopathic doctors, nurse practitioners, physical therapists, and oriental medicine practitioners

The dry needling courses offered through Dry Needling Institute of the American Academy of Manipulative Therapy have been approved by the Federation of State Boards of Physical Therapy (FSBPT) to use as continuing education units for license renewal requirements in multiple states; however, licensed practitioners from many different healthcare disciplines attend our courses including: medical physicians, osteopathic physicians, naturopathic doctors, nurse practitioners, chiropractors, physical therapists, and oriental medicine practitioners. Notably, some of the licensed healthcare providers on our dry needling courses are permitted by law to practice ‘acupuncture’ in their respective state and scope of practice, while others legally cannot. Therefore, the academic illustration of acupoints, Ahshi points and/or trigger points associated with the management of

neuromusculoskeletal conditions is necessary to facilitate a working understanding across healthcare professions of the acupoint nomenclature that has been, and is being, used by medical physicians and physical therapists, in the main, in the methodology of randomized controlled trials that have investigated the effectiveness or neurophysiologic mechanisms of using solid monofilament needles (i.e. acupuncture needles!) in the treatment of a variety of Western (not East Asian or Oriental medicine diagnoses that involve tongue and pulse diagnosis and the theoretical movement of ‘*qi*’ or ‘energy’ along traditional Chinese meridians or channels) medical diagnoses including, but not limited to: knee osteoarthritis, plantar fasciitis, cervicogenic headaches, tension type headache, migraine, low back pain with or without radiculopathy, neck pain, internal shoulder impingement syndrome, temporomandibular disorder, lateral epicondylalgia, or carpal tunnel syndrome.

In addition, physical therapists, chiropractors, naturopathic physicians, nurse practitioners, oriental medicine practitioners, and medical doctors alike need to be able to critically appraise and interpret the Western or biomedical acupuncture and dry needling literature, that by enlarge has chosen to use the acupoint nomenclature system in order to communicate across professions where exactly the needles were placed in clinical trials—performed in the main by medical doctors and physical therapists—in order to investigate efficacy on pain and disability and the underlying neurophysiologic mechanisms in patients with Western medical or musculoskeletal diagnoses (e.g. knee osteoarthritis, not ‘*bi*’ syndrome as Oriental medicine practitioners would term it). Notably, use of the nomenclature alone for point location and interpretation of existing randomized controlled trials that were conducted by medical doctors and physical therapists (our own profession!) has nothing to do with “regulating the flow and balance of energy to restore and maintain health”¹—which is how traditional Chinese acupuncture or Oriental medicine is most commonly described in the United States. Nevertheless, and of significance, all of the course manuals published by Dry Needling Institute clearly state “the use of acupoints is only for those licensed to practice acupuncture in their respective state.”

2. Vastly different theoretical paradigms distinguish dry needling from traditional Chinese acupuncture, East Asian or Oriental medicine

There is a clear distinction between the Western scientific principles that underpin the use of dry needling by physical therapists for the diagnosis and treatment of neuromusculoskeletal conditions and the traditional Chinese, Oriental or East Asian medicine framework that governs the use of needles without injectate by ‘acupuncturists’ for the diagnosis and treatment of all 10 organ systems. According to the Federation of State Boards of Physical Therapy² dry needling is a “skilled technique performed by a physical therapist using filiform needles to penetrate the skin and/or underlying tissues to affect change in body structures and functions for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disability”. Importantly, dry needling neither attempts to move energy or “*qi*” along meridians, nor does it rely on diagnoses from traditional Chinese acupuncture or Oriental medicine.^{3,4} Dry needling also relies on Western medical diagnoses such as chronic neck pain^{5,6-13}, plantar fasciitis^{14,15,16}, knee osteoarthritis¹⁷⁻³⁰, and carpal tunnel syndrome,³¹⁻³⁵ instead of traditional Chinese, Oriental or East Asian medicine^{36,37} diagnoses such as *bi* syndrome, *qi*, blood stagnation, and kidney *yang* deficiency.^{38, 39}

3. Acupoints and trigger points are anatomically at very similar, if not identical, locations much of the time clinically in the management of neuromusculoskeletal disorders

The Chinese originally established a set of 349 acupoints between 259 and 282 AD, while trigger points were first described as “nodular tumors or thickenings” by Balfour⁴⁰ in 1816 and “fibrosis” by Gowers⁴¹ in 1904. While Steindler is widely recognized as coining the term “trigger point” in 1940, Dr. Lewit, a medical physician and physiatrist from Czechoslovakia, published the first article on dry needling in 1979, noting that the needle insertion itself rather than the injectate appeared to be the cause of the analgesic response.⁴² Despite the unique developmental lineage of acupoints and trigger points, a number of journal articles have noted significant anatomical and clinical similarities between the phenomena. In 1977, Melzack et al⁴³ compared 48 known trigger points to acupoints for pain, giving a 100% anatomic correspondence and a 71% clinical correlation to pain patterns. While 48 trigger points is certainly less than the 255 myofascial trigger points documented by Travell and Simons,⁴⁴ Dorsher et al^{45,46} provided a more comprehensive comparison of trigger points and acupoints, reporting 92% agreement for location and 79.5% agreement for pain referral patterns. Moreover, another recent study reported a 70% correlation between trigger points and classical acupoints.⁴⁷

Following a 3-part analysis for the anatomical location, pain location and referred pain patterns of acupoints and trigger points, and using graphic software, Dorsher^{44,45} superimposed 255 of the most common myofascial trigger points from the Travell and Simons Trigger Point Manual⁴³ with 361 classical acupoints. Dorsher concluded that 238 of the classical acupoints matched with the 255 myofascial trigger points, with 89, 107 and 32 acupoints falling within 1, 2 and 3 cm of myofascial trigger points, respectively.^{44,45} Dorsher then took the 238 corresponding anatomical points and cross-referenced their indications for pain with the Travell and Simons Trigger Point Manual⁴³ and classical acupuncture texts. Dorsher found 221 of 238 points (93%) had myofascial trigger point pain indicators, 208 of 221 points (94%) had similar regional pain indicators, and 180 of 238 points (81%) had complete or near complete pain referral patterns.^{44,45}

Notably, recent investigations by Western-based medical practitioners report a lack of robust evidence validating the clinical diagnostic criteria for trigger point identification and/or diagnosis. In a recent systematic review on the reliability of physical examination for the diagnosis of myofascial trigger points, Lucas et al⁴⁸ concluded, “There is no accepted reference standard for the diagnosis of trigger points, and data on the reliability of physical examination for trigger points is conflicting.” Lew et al⁴⁹ further reported that the inter-examiner agreement was only 21%, and Sciotti et al⁵⁰ reported error rates of 3.3–6.6 cm among examiners attempting to identify the specific location of trigger points in the upper trapezius muscle. In another recent literature review, Myburgh et al⁵¹ found poor inter-examiner reliability of manual palpation of trigger points in various muscle groups. Only ‘tenderness’ of the upper trapezius, not the actual location of the trigger point, was found to be moderately reliable. Therefore, high-quality evidence suggests that manual examination for the identification of the specific location of the ‘trigger point’ is not a valid⁵¹⁻⁵³ or reliable⁴⁸⁻⁵¹ process between-examiners—this is perhaps one reason why medical physicians and physical therapist researchers have chosen to use the acupoint nomenclature to more reliably identify the exact insertion location, angulation and depth of the needle placement, which is of course

required when using standardized interventions or needling protocols in the confines of randomized controlled trials.

In a recent review paper on the similarities and differences between dry needling and acupuncture, Zhu et al⁵⁴, a medical physician and licensed acupuncturist, recommended “collaboration and integration should be strengthened between dry needling practitioners who are not physicians and acupuncturists so that the patients can receive safe and high quality acupuncture treatment”. Consistent with the remarks of Zhu et al⁵³, healthcare providers—i.e. physical therapists, chiropractors, nurse practitioners, naturopaths, osteopathic physicians and medical physicians—should possess a fundamental and working knowledge of the acupoint nomenclature so as to more reliably treat myofascial pain located throughout the body. That is, without using the principles or theories of traditional Chinese acupuncture or Oriental medicine (i.e. movement of *qi* or energy along Chinese meridians to alter function of all 10 organ systems, use of tongue and pulse diagnosis, use of Oriental medicine diagnoses such as *bi* syndrome, kidney *yang* deficiency, blood stagnation etc.), physical therapists can achieve greater accuracy in needle placement (due to the poor inter-examiner reliability associated with localizing myofascial trigger points) by becoming familiar with the location of acupoints that correspond, in the main, to the very same ‘trigger point’ locations.⁴¹⁻⁴⁷ For this reason, Dry Needling Institute of the American Academy of Manipulative Therapy educates licensed healthcare providers from a variety of disciplines in a combined approach that includes manual palpation, knowledge of surface and underlying anatomy, and the location of acupoints to help determine where exactly to insert needles for the most evidence-based treatment of neuromusculoskeletal conditions.

4. Acupuncture and acupoints are universal terms referenced by multiple professions (medical physicians, osteopathic physicians, physical therapists, chiropractors, naturopathic physicians, and oriental medical practitioners) throughout the literature; that is, these generic terms should not be considered synonymous with, or exclusively owned by, traditional Chinese acupuncture or Oriental medicine practitioners

Despite the difference in terminology, theoretical constructs, and philosophies, the actual procedure of inserting thin monofilament needles, as used in the practice of acupuncture, without the use of injectate is similar across professions.⁵⁵ In fact, the most common term used to describe dry needling is ‘acupuncture’. Physiotherapists and/or medical physicians^{56-60,61} within both government administered national health services and mainstream university health systems,^{30, 56, 62-66} in the UK,^{18, 19, 23, 67, 68} Canada,⁵⁶ USA and Germany^{30,62-66, 69} use the term ‘acupuncture’ to describe dry needling methodologies. The same is true of articles published in mainstream, highly respected journals, including the British Medical Journal,^{23, 29, 67, 68, 70} European Journal of Pain,^{6, 71} Archives of Physical Medicine & Rehabilitation,^{51, 72-75} Pain,^{27, 42, 76-78} Annals of Internal Medicine,^{20, 26, 79-81} Headache,^{82, 83} Rheumatology,^{8, 18, 24} Spine,^{56, 84-86} and Cochrane Database of Systematic Reviews^{85, 87}. Even the Physical Therapy Journal⁸⁸ sponsored by the APTA and the Journal of Orthopaedic and Sports Physical Therapy⁸⁹ have used acupuncture and dry needling interchangeably in recent publications.

Likewise, a number of Western-based medical professions reference acupoints without claiming to alter energy flow or move “*qi*” along meridians. It is perhaps noteworthy that the dry needling protocol for knee osteoarthritis taught by the Dry Needling Institute and

referenced by a Washington State East Asian Medicine provides a perfect example of the interdisciplinary use of acupoints. The protocol is a compilation of common sites of pain and discomfort in patients with knee osteoarthritis—i.e. muscles, musculotendinous junctions, teno-osseous insertions and connective tissue structures—that also have common acupoint names or labels that have been described in scholarly medical journal articles published predominantly by PhDs^{23, 26, 90-92} and MDs^{17, 18, 20, 21, 27-30, 62}. Reference to acupoints can also be found throughout journal articles published by chiropractors⁹³⁻⁹⁶, osteopathic physicians^{97,98,99} and physical therapists.^{88,100}

Importantly and of significance in this discussion, the use and labeling of acupoints have been a formal component of entry-level and post-graduate training of physical therapists for more than 40 years, as they help facilitate the identification of painful tissue¹⁰¹ and direct the placement of interferential current stimulation pads for electrotherapy in a variety of neuromusculoskeletal conditions.¹⁰² Consistent with this training, EMPI, one of the most well known and respected medical device and supply companies in the United States, has provided physical therapists with products related to electrotherapy, and notably, they continue to publish booklets and operating manuals containing clinical guidelines on the placement of stimulation pads according to acupoints.¹⁰³

According to the Revised Standards for Reporting Interventions in Clinical Trials of Acupuncture (STRICTA) by McPherson and colleagues^{104, 105}, “acupuncture point descriptions based on anatomical locations and proportional ‘*cun*’ measurement systems have served as a blueprint for many Western translations.” In order to maximize methodological reproducibility, the authors further recommend, “specific point locations used in treatments where standardization should be described in terms of an accepted nomenclature (e.g. GB21) or in terms of anatomical location where there is no accepted name”.¹⁰⁵ That is, studies that investigate acupuncture and/or dry needling interventions (i.e. insertion of needles without injectate for therapeutic purposes) should use acupoints or an “accepted nomenclature” so as to facilitate reproducibility by Western practitioners. Given the limited number of studies presently available that has used the word or title ‘dry needling’, physical therapists should consider high-quality studies that have used needling without injectate to treat neuromusculoskeletal conditions, regardless of profession. Clearly, STRICTA standards require that healthcare researchers and clinicians alike are familiar with acupoint locations. The physical therapy profession must also be able to publish studies on dry needling treatments for neuromusculoskeletal conditions in accordance with STRICTA guidelines (i.e. with a methodology that is reproducible and in a language that consistent with that used by other professions). Given the exponential growth in the number of research articles that have been published on dry needling since 2000,⁵³ familiarization of acupoints by the physical therapist has never been more important.

5. The biomedical scientific evidence supporting the peripheral and spinal mechanisms of dry needling mediated analgesia and tissue remodeling at acupoint locations was developed, in the main, by PhDs, medical physicians and physical therapists in Germany, England and the USA, not by Oriental medicine practitioners

Through a series of high-quality and elegant studies, Langevin et al, an American medical physician, found that a greater pullout force is required to remove a needle from

tissue when the needle is wound in one direction compared to when it is wound in both directions.^{106, 107} Moreover, there was a greater pullout force following uni- and bidirectional winding compared to needle insertion without manipulation.^{106, 107} By using Trichrome staining, Langevin further demonstrated that pullout force is due to the mechanical coupling of collagen fibers to the needle.¹⁰⁶ The mechanical coupling directly pulls on collagen fibers, resulting in better alignment of collagen bundles, and stimulates cells via mechanotransduction.¹⁰⁸

According to Wu et al,¹⁰⁹ the mechanotransduction of connective tissue stimulates TRPV1 receptors on both neural and non-neural cells, resulting in intracellular calcium wave propagation (CWP). The intercellular CWP leads to alteration of C-fiber afferents and, subsequently, the release of glutamate from first order sensory afferents. According to Zhou et al the altered C-fiber excitation stimulates glycinergic interneurons in laminae-2 of the spinal cord to release glycine.¹¹⁰ When glycine receptors on postsynaptic dorsal horn neurons receive glycine, they attenuate pain transmission.¹¹⁰ The noxious stimulus-induced analgesia (NSIA) from dry needling also likely stimulates the nucleus accumbens, resulting in opioid release. The subsequent stimulation of μ and κ opioid receptors on interneurons in the dorsal horn results in the release of GABA and glycine, further inhibiting the transmission of pain information from sensory afferents to second order dorsal horn neurons.^{109, 111}

Goldman et al¹¹² also found that CWP causes the release of ATP via pannexin-1 hemichannels, which catabolizes to adenosine. After needling ST36 for 30-minutes with needle rotation every 5 minutes to establish mechanotransduction, Takano et al reported a significant increase in interstitial adenosine¹¹³, which activates A1 adenosine receptors located on nerve endings¹¹⁴, afferent nerves¹¹⁵ and pre-synaptic DRG terminals¹¹⁶, resulting in anti-nociception. As G-protein coupled receptors, A1 receptor activation is thought to work by inhibiting adenylyl cyclase, attenuating Camp and phospholipase C.¹¹³ Since an increase in Camp is associated with chronic pain, the inhibition of adenylyl cyclase is noteworthy.¹¹³

Mechanotransduction mediated CWP further leads to rho-kinase-dependent, transient disassembly of polymerized actin and the subsequent decrease in fibroblast stress fibers¹¹⁷. Simply put, a reduction of fibroblast stress fibers changes the viscoelastic properties of the cells, allowing them to be more easily remodeled. Dry needling mediated mechanotransduction may therefore be able to help remodel painful tissue by dampening tissue tension via actin polymerization.¹¹⁷ A number of studies—by PhDs, MDs and/or PTs—have demonstrated the use of dry needling to reduce pain associated with scar^{42, 118} and fibrotic tissue¹¹⁹ further supporting this possibility.

Thus, the stimulation of TRPV1 receptors via tissue mechanotransduction may help explain the physiologic mechanism responsible for dry needling-mediated peripheral and spinal analgesia and tissue remodeling. Interestingly, Langevin et al¹²⁰ used diagnostic imaging to determine that there was a higher concentration of connective tissue (i.e. collagen fibers) at acupoint versus non-acupoint locations. Given that mechanotransduction requires the physical attachment of connective tissue to the needle, it may be more therapeutic (i.e. lead to better clinical outcomes for reduced pain and disability) for clinicians to consider inserting needles at both acupoint and nonacupoint locations. Therefore, the neurophysiology underpinning Western-based pain science strongly suggests that it may be advantageous for physical therapists to become familiar with acupoint terminology and location.

6. Attorney General opinions and conclusions

Dry needling and acupuncture dramatically differ in their origins, theoretical and scientific underpinnings; however, “dry needling and acupuncture overlap in terms of needling technique with solid filiform needles.”¹²¹ Notably, in response to an Attorney General Opinion request made by the Texas State Board of Acupuncture Examiners in 2016, the Attorney General of Texas opined, “it should not be assumed that the scope of practice of physical therapy and the scope of practice of acupuncture are mutually exclusive; that is, overlap between the scopes of practice of acupuncture and physical therapy may exist (recognizing that the scopes of practice of medicine and physical therapy overlap with regard to a procedure called needle electromyography).” [Texas Att’y Gen. Op. KP-0082 (2016)] Moreover, at the request of the Chiropractic Examining Board, the Attorney General of Wisconsin concluded that “chiropractors do not have a monopoly on the application of therapeutic touch to the neck, back and joints”; furthermore, “even if nearly identical physical motions were performed by a chiropractor”, the “terms such as adjustment and manipulation have a variety of appropriate meanings to various healing disciplines”—that is, it is “the principles of physical therapy science” versus “chiropractic science” that separates the two disciplines, not the actual performance of the manipulation technique itself. [Wisconsin Att’y Gen. Op. OAG 1-01 (2001)].

In the words of Zhou and colleagues (2015), “Because of the close relationship between dry needling and acupuncture, collaboration rather than dispute between acupuncturists and other healthcare professionals should be encouraged with respect to education, research, and practice for the benefit of patients with musculoskeletal conditions who require needling therapy.”¹²¹

In short, and contrary to the claims made by one or more ‘East Asian Medicine Practitioners’ in Washington State, Dr. Thomas Perreault, PT, DPT, does not teach or practice traditional Chinese acupuncture or Oriental Medicine at continuing education courses offered through Dry Needling Institute or at his physical therapy clinic in New Hampshire. We thank the ‘East Asian Medicine Practitioners’ from Washington State and the Washington State Department of Health for their time and attention on this matter.

With kind regards,

James Dunning, PT, DPT, MS, FAAOMPT, MAACP (UK)

Director, AAMT Fellowship in Orthopaedic Manual Physical Therapy
President, Dry Needling Institute & Spinal Manipulation Institute

Raymond Butts, PT, PhD, DPT, MS, Cert. DN, MAACP (UK)

Senior Faculty, AAMT Fellowship in Orthopaedic Manual Physical Therapy
Senior Instructor, Dry Needling Institute & Spinal Manipulation Institute

Thomas Perreault, PT, DPT, OCS, Cert. DN, MAACP (UK)

Senior Faculty, AAMT Fellowship in Orthopaedic Manual Physical Therapy
Senior Instructor, Dry Needling Institute & Spinal Manipulation Institute

REFERENCES

1. Dunning J, Butts R, Mourad F, Young I, Flannagan S, Perreault T. Dry needling: a literature review with implications for clinical practice guidelines. *Phys Ther Rev.* 2014;19(4):252-65.
2. Association, A.P.T., Physical therapists & the performance of dry needling: an educational resource paper. Alexandria, VA: APTA Department of Practice and APTA State Government Affairs, 2012.
3. Deadman P, Al-Khafaji M, Baker K. A manual of acupuncture, 2nd ed. Hove, East Sussex, UK: Journal of Chinese Medicine Publications; 2011.
4. O'Conner J, Bensky D. *Acupuncture: a comprehensive text.* Seattle, WA, USA: Eastland Press; 1981.
5. Tough EA, White A. Effectiveness of acupuncture/dry needling for myofascial trigger point pain—a systematic review. *Phys Ther Rev.* 2011;16(2):147–54.
6. Tough EA, White AR, Cummings TM, Richards SH, Campbell JL. Acupuncture and dry needling in the management of myofascial trigger point pain: a systematic review and meta-analysis of randomised controlled trials. *Eur J Pain.* 2009;13(1):3-10.
7. Hong CZ. Lidocaine injection versus dry needling to myofascial trigger point. The importance of the local twitch response. *Am J Phys Med Rehabil.* 1994;73(4):256-63.
8. Kamanli A, Kaya A, Ardicoglu O, Ozgocmen S, Zengin FO, Bayik Y. Comparison of lidocaine injection, botulinum toxin injection, and dry needling to trigger points in myofascial pain syndrome. *Rheumatol Int.* 2005;25(8):604-11.
9. Franca DL, Senna-Fernandes V, Cortez CM, Jackson MN, Bernardo-Filho M, Guimaraes MA. Tension neck syndrome treated by acupuncture combined with physiotherapy: a comparative clinical trial (pilot study). *Complement Ther Med.* 2008;16(5):268-77.
10. Ga H, Choi JH, Park CH, Yoon HJ. Acupuncture needling versus lidocaine injection of trigger points in myofascial pain syndrome in elderly patients—a randomised trial. *Acupunct Med.* 2007;25(4):130-6.
11. Ga H, Choi JH, Park CH, Yoon HJ. Dry needling of trigger points with and without paraspinal needling in myofascial pain syndromes in elderly patients. *J Altern Complement Med.* 2007;13(6):617-24.
12. Ga H, Koh HJ, Choi JH, Kim CH. Intramuscular and nerve root stimulation vs lidocaine injection to trigger points in myofascial pain syndrome. *J Rehabil Med.* 2007;39(5):374-8.
13. Itoh K, Katsumi Y, Hirota S, Kitakoji H. Randomised trial of trigger point acupuncture compared with other acupuncture for treatment of chronic neck pain. *Complement Ther Med.* 2007;15(3):172-9.
14. Cotchett MP, Landorf KB, Munteanu SE. Effectiveness of dry needling and injections of myofascial trigger points associated with plantar heel pain: a systematic review. *J Foot Ankle Res.* 2010;3:18.
15. Ebrahim AHM, Ahmed GM, Elsayed E, Sarhan R. Effect of electroacupuncture TENS, stretching exercises, and prefabricated insole in patients with plantar fasciitis. *Sci J Al-Azhar Med Univ.* 2007;28(3):1–10.

16. Perez-Millan R, Foster L. Low-frequency electroacupuncture in the management of refractory plantar fasciitis: a case-series. *Med Acupunct*. 2001;13(1):1-7.
17. Vas J, White A. Evidence from RCTs on optimal acupuncture treatment for knee osteoarthritis--an exploratory review. *Acupunct Med*. 2007;25(1-2):29-35.
18. White A, Foster NE, Cummings M, Barlas P. Acupuncture treatment for chronic knee pain: a systematic review. *Rheumatology (Oxford)*. 2007;46(3):384-90.
19. Whitehurst DG, Bryan S, Hay EM, Thomas E, Young J, Foster NE. Cost-effectiveness of acupuncture care as an adjunct to exercise-based physical therapy for osteoarthritis of the knee. *Phys Ther*. 2011;91(5):630-41.
20. Berman BM, Lao L, Langenberg P, Lee WL, Gilpin AM, Hochberg MC. Effectiveness of acupuncture as adjunctive therapy in osteoarthritis of the knee: a randomized, controlled trial. *Ann Intern Med*. 2004;141(12):901-10.
21. Berman BM, Singh BB, Lao L, Langenberg P, Li H, Hadhazy V, et al. A randomized trial of acupuncture as an adjunctive therapy in osteoarthritis of the knee. *Rheumatology (Oxford)*. 1999;38(4):346-54.
22. Ezzo J, Hadhazy V, Birch S, Lao L, Kaplan G, Hochberg M, et al. Acupuncture for osteoarthritis of the knee: a systematic review. *Arthritis Rheum*. 2001;44(4):819-25.
23. Foster NE, Thomas E, Barlas P, Hill JC, Young J, Mason E, et al. Acupuncture as an adjunct to exercise based physiotherapy for osteoarthritis of the knee: randomised controlled trial. *BMJ*. 2007;335(7617):436.
24. Kwon YD, Pittler MH, Ernst E. Acupuncture for peripheral joint osteoarthritis: a systematic review and meta-analysis. *Rheumatology (Oxford)*. 2006;45(11):1331-7.
25. Manheimer E, Cheng K, Linde K, Lao L, Yoo J, Wieland S, et al. Acupuncture for peripheral joint osteoarthritis. *Cochrane Database Syst Rev*. 2010(1):CD001977.
26. Manheimer E, Linde K, Lao L, Bouter LM, Berman BM. Meta-analysis: acupuncture for osteoarthritis of the knee. *Ann Intern Med*. 2007;146(12):868-77.
27. Mavrommatis CI, Argyra E, Vadalouka A, Vasilakos DG. Acupuncture as an adjunctive therapy to pharmacological treatment in patients with chronic pain due to osteoarthritis of the knee: a 3-armed, randomized, placebo-controlled trial. *Pain*. 2012;153(8):1720-6.
28. Scharf HP, Mansmann U, Streitberger K, Witte S, Kramer J, Maier C, et al. Acupuncture and knee osteoarthritis: a three-armed randomized trial. *Ann Intern Med*. 2006;145(1):12-20.
29. Vas J, Mendez C, Perea-Milla E, Vega E, Panadero MD, Leon JM, et al. Acupuncture as a complementary therapy to the pharmacological treatment of osteoarthritis of the knee: randomised controlled trial. *BMJ*. 2004;329(7476):1216.
30. Witt C, Brinkhaus B, Jena S, Linde K, Streng A, Wagenpfeil S, et al. Acupuncture in patients with osteoarthritis of the knee: a randomised trial. *Lancet*. 2005;366(9480):136-43.
31. Khosrawi S, Moghtaderi A, Haghghat S. Acupuncture in treatment of carpal tunnel syndrome: A randomized controlled trial study. *J Res Med Sci*. 2012;17(1):1-7.
32. Kumnerdee W, Kaewtong A. Efficacy of acupuncture versus night splinting for carpal tunnel syndrome: a randomized clinical trial. *J Med Assoc Thai*. 2010;93(12):1463-9.
33. Yang CP, Hsieh CL, Wang NH, Li TC, Hwang KL, Yu SC, et al. Acupuncture in patients with carpal tunnel syndrome: A randomized controlled trial. *Clin J Pain*. 2009;25(4):327-33.
34. Yang CP, Wang NH, Li TC, Hsieh CL, Chang HH, Hwang KL, et al. A randomized clinical trial of acupuncture versus oral steroids for carpal tunnel syndrome: a long-term follow-up. *J Pain*. 2011;12(2):272-9.

35. Napadow V, Liu J, Li M, Kettner N, Ryan A, Kwong KK, et al. Somatosensory cortical plasticity in carpal tunnel syndrome treated by acupuncture. *Hum Brain M.* 2007;28(3):159-71.
36. Deadman P, Al-Khafaji M, Baker K. *A manual of acupuncture*, 2nd ed. Hove, East Sussex, UK: Journal of Chinese Medicine Publications; 2011.
37. O'Conner J, Bensky D. *Acupuncture: a comprehensive text*. Seattle, WA, USA: Eastland Press; 1981.
38. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Irnich D, et al. Interventions and physician characteristics in a randomized multicenter trial of acupuncture in patients with low-back pain. *J Altern Complement Med.* 2006;12(7):649-57.
39. Moffet HH. Traditional acupuncture theories yield null outcomes: a systematic review of clinical trials. *J Clin Epidemiol.* 2008;61(8):741-7.
40. Stockman R. The Causes and Treatment of Chronic Rheumatism. *Br Med J.* 1904;1(2252):477-9.
41. Steindler A. The interpretation of sciatic radiation and the syndrome of low-back pain. *J Bone Joint Surg Am.* 1940;22:28-34.
42. Lewit K. The needle effect in the relief of myofascial pain. *Pain.* 1979;6(1):83-90.
43. Melzack R, Stillwell DM, Fox EJ. Trigger points and acupuncture points for pain: correlations and implications. *Pain.* 1977;3(1):3-23.
44. Travell JG, Simons DG. *Myofascial Pain and Dysfunction: The Trigger Point Manual*. Vol 1. Baltimore, MD: Williams & Wilkins; 1983.
45. Dorsher, P. and J. Fleckenstein, *Trigger Points and Classical Acupuncture Points*. *Deutsche Zeitschrift fuer Akupunktur*, 2009. 1(52): p. 9-14.
46. Dorsher, P.T., *Myofascial referred-pain data provide physiologic evidence of acupuncture meridians*. *J Pain*, 2009. 10(7): p. 723-31.
47. Peter T. Dorsher. *The Journal of Alternative and Complementary Medicine*. May 2008, 14(4): 353-359.
48. Lucas N, Macaskill P, Irwig L, Moran R, Bogduk N. Reliability of physical examination for diagnosis of myofascial trigger points: a systematic review of the literature. *Clin J Pain.* 2009;25(1):80-9.
49. Lew PC, Lewis J, Story I. Inter-therapist reliability in locating latent myofascial trigger points using palpation. *Man Ther.* 1997;2(2):87-90.
50. Sciotti VM, Mittak VL, DiMarco L, Ford LM, Plezbert J, Santipadri E, et al. Clinical precision of myofascial trigger point location in the trapezius muscle. *Pain.* 2001;93(3):259-66.
51. Myburgh C, Larsen AH, Hartvigsen J. A systematic, critical review of manual palpation for identifying myofascial trigger points: evidence and clinical significance. *Arch Phys Med Rehabil.* 2008;89(6):1169-76.
52. Tough EA, White AR, Richards S, Campbell J. Variability of criteria used to diagnose myofascial trigger point pain syndrome--evidence from a review of the literature. *Clin J Pain.* 2007;23(3):278-86.
53. Myburgh C, Lauridsen HH, Larsen AH, Hartvigsen J. Standardized manual palpation of myofascial trigger points in relation to neck/shoulder pain; the influence of clinical experience on inter-examiner reproducibility. *Man Ther.* 2011;16(2):136-40.
54. Zhu H, Most H. Dry Needling in One Type of Acupuncture. *Medical Acupuncture*. Volume 28, Number 4, 2016.

55. Casanueva B, Rivas P, Rodero B, Quintial C, Llorca J, Gonzalez-Gay MA. Short-term improvement following dry needle stimulation of tender points in fibromyalgia. *Rheumatol Int.* 2014;34(6):861-6.
56. Trinh K, Graham N, Gross A, Goldsmith C, Wang E, Cameron I, et al. Acupuncture for neck disorders. *Spine (Phila Pa 1976).* 2007;32(2):236-43.
57. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, et al. Acupuncture in patients with chronic low back pain: a randomized controlled trial. *Arch Intern Med.* 2006;166(4):450-7.
58. Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, et al. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. *Arch Intern Med.* 2009;169(9):858-66.
59. Cook JL, Purdam CR. Is tendon pathology a continuum? A pathology model to explain the clinical presentation of load-induced tendinopathy. *Br J Sports Med.* 2009;43(6):409-16.
60. Kietrys DM, Palombaro KM, Azzaretto E, Hubler R, Schaller B, Schluskel JM, et al. Effectiveness of dry needling for upper-quarter myofascial pain: a systematic review and meta-analysis. *J Orthop Sports Phys Ther.* 2013;43(9):620-34.
61. Ceccherelli F, Gioioso L, Casale R, Gagliardi G, Ori C. Neck pain treatment with acupuncture: does the number of needles matter? *Clin J Pain.* 2010;26(9):807-12.
62. Witt CM, Jena S, Brinkhaus B, Liecker B, Wegscheider K, Willich SN. Acupuncture in patients with osteoarthritis of the knee or hip: a randomized, controlled trial with an additional nonrandomized arm. *Arthritis Rheum.* 2006;54(11):3485-93.
63. Melchart D, Thormaehlen J, Hager S, Liao J, Linde K, Weidenhammer W. Acupuncture versus placebo versus sumatriptan for early treatment of migraine attacks: a randomized controlled trial. *J Intern Med.* 2003;253(2):181-8.
64. Melchart D, Linde K, Fischer P, White A, Allais G, Vickers A, et al. Acupuncture for recurrent headaches: a systematic review of randomized controlled trials. *Cephalalgia.* 1999;19(9):779-86; discussion 65.
65. Molsberger AF, Mau J, Pawelec DB, Winkler J. Does acupuncture improve the orthopedic management of chronic low back pain--a randomized, blinded, controlled trial with 3 months follow up. *Pain.* 2002;99(3):579-87.
66. Witt CM, Jena S, Brinkhaus B, Liecker B, Wegscheider K, Willich SN. Acupuncture for patients with chronic neck pain. *Pain.* 2006;125(1-2):98-106.
67. Vickers AJ, Rees RW, Zollman CE, McCarney R, Smith CM, Ellis N, et al. Acupuncture of chronic headache disorders in primary care: randomised controlled trial and economic analysis. *Health Technol Assess.* 2004;8(48):iii, 1-35.
68. Wonderling D, Vickers AJ, Grieve R, McCarney R. Cost effectiveness analysis of a randomised trial of acupuncture for chronic headache in primary care. *BMJ.* 2004;328(7442):747.
69. Melchart D, Linde K, Streng A, Reitmayr S, Hoppe A, Brinkhaus B, et al. Acupuncture Randomized Trials (ART) in patients with migraine or tension-type headache--design and protocols. *Forsch Komplementarmed Klass Naturheilkd.* 2003;10(4):179-84.
70. Irnich D, Behrens N, Molzen H, Konig A, Gleditsch J, Krauss M, et al. Randomised trial of acupuncture compared with conventional massage and "sham" laser acupuncture for treatment of chronic neck pain. *BMJ.* 2001;322(7302):1574-8.
71. Foster NE, Thomas E, Hill JC, Hay EM. The relationship between patient and practitioner expectations and preferences and clinical outcomes in a trial of exercise and acupuncture for knee osteoarthritis. *Eur J Pain.* 2010;14(4):402-9.

72. Cummings TM, White AR. Needling therapies in the management of myofascial trigger point pain: a systematic review. *Arch Phys Med Rehabil.* 2001;82(7):986-92.
73. Fishman LM, Dombi GW, Michaelsen C, Ringel S, Rozbruch J, Rosner B, et al. Piriformis syndrome: diagnosis, treatment, and outcome--a 10-year study. *Arch Phys Med Rehabil.* 2002;83(3):295-301.
74. Ingber RS. Shoulder impingement in tennis/racquetball players treated with subscapularis myofascial treatments. *Arch Phys Med Rehabil.* 2000;81(5):679-82.
75. Shah JP, Danoff JV, Desai MJ, Parikh S, Nakamura LY, Phillips TM, et al. Biochemicals associated with pain and inflammation are elevated in sites near to and remote from active myofascial trigger points. *Arch Phys Med Rehabil.* 2008;89(1):16-23.
76. Napadow V, Kettner N, Liu J, Li M, Kwong KK, Vangel M, et al. Hypothalamus and amygdala response to acupuncture stimuli in Carpal Tunnel Syndrome. *Pain.* 2007;130(3):254-66.
77. Vas J, Aranda JM, Modesto M, Benitez-Parejo N, Herrera A, Martinez-Barquin DM, et al. Acupuncture in patients with acute low back pain: a multicentre randomised controlled clinical trial. *Pain.* 2012;153(9):1883-9.
78. Ahsin S, Saleem S, Bhatti AM, Iles RK, Aslam M. Clinical and endocrinological changes after electro-acupuncture treatment in patients with osteoarthritis of the knee. *Pain.* 2009;147(1-3):60-6.
79. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain. *Ann Intern Med.* 2005;142(8):651-63.
80. Chou R, Qaseem A, Snow V, Casey D, Cross JT, Jr., Shekelle P, et al. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. *Ann Intern Med.* 2007;147(7):478-91.
81. White P, Lewith G, Prescott P, Conway J. Acupuncture versus placebo for the treatment of chronic mechanical neck pain: a randomized, controlled trial. *Ann Intern Med.* 2004;141(12):911-9.
82. Allais G, De Lorenzo C, Quirico PE, Airola G, Tolardo G, Mana O, et al. Acupuncture in the prophylactic treatment of migraine without aura: a comparison with flunarizine. *Headache.* 2002;42(9):855-61.
83. Coeytaux RR, Kaufman JS, Kaptchuk TJ, Chen W, Miller WC, Callahan LF, et al. A randomized, controlled trial of acupuncture for chronic daily headache. *Headache.* 2005;45(9):1113-23.
84. Gunn CC, Milbrandt WE, Little AS, Mason KE. Dry needling of muscle motor points for chronic low-back pain: a randomized clinical trial with long-term follow-up. *Spine (Phila Pa 1976).* 1980;5(3):279-91.
85. Furlan AD, van Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, et al. Acupuncture and dry-needling for low back pain: an updated systematic review within the framework of the cochrane collaboration. *Spine (Phila Pa 1976).* 2005;30(8):944-63.
86. Eisenberg DM, Post DE, Davis RB, Connelly MT, Legedza AT, Hrbek AL, et al. Addition of choice of complementary therapies to usual care for acute low back pain: a randomized controlled trial. *Spine (Phila Pa 1976).* 2007;32(2):151-8.
87. Green S, Buchbinder R, Hetrick S. Acupuncture for shoulder pain. *Cochrane Database Syst Rev.* 2005(2):CD005319.
88. Leo KC. Use of electrical stimulation at acupuncture points for the treatment of reflex sympathetic dystrophy in a child. A case report. *Phys Ther.* 1983;63(6):957-9.

89. Cox J, Varatharajan S, Cote P, Optima C. Effectiveness of Acupuncture Therapies to Manage Musculoskeletal Disorders of the Extremities: A Systematic Review. *J Orthop Sports Phys Ther.* 2016;46(6):409-29.
90. Hinman RS, McCrory P, Pirodda M, Relf I, Forbes A, Crossley KM, et al. Acupuncture for chronic knee pain: a randomized clinical trial. *JAMA.* 2014;312(13):1313-22.
91. Vickers AJ, Cronin AM, Maschino AC, Lewith G, MacPherson H, Foster NE, et al. Acupuncture for chronic pain: individual patient data meta-analysis. *Arch Intern Med.* 2012;172(19):1444-53.
92. Corbett MS, Rice SJ, Madurasinghe V, Slack R, Fayter DA, Harden M, et al. Acupuncture and other physical treatments for the relief of pain due to osteoarthritis of the knee: network meta-analysis. *Osteoarthritis Cartilage.* 2013;21(9):1290-8.
93. Giles LG, Muller R. Chronic spinal pain: a randomized clinical trial comparing medication, acupuncture, and spinal manipulation. *Spine (Phila Pa 1976).* 2003;28(14):1490-502; discussion 502-3.
94. Pfefer MT, Cooper SR, Uhl NL. Chiropractic management of tendinopathy: a literature synthesis. *J Manipulative Physiol Ther.* 2009;32(1):41-52.
95. Olson E, Bodziony M, Ward J, Coats J, Koby B, Goehry D. Effect of lumbar spine manipulation on asymptomatic cyclist sprint performance and hip flexibility. *J Chiropr Med.* 2014;13(4):230-8.
96. Ohlsen BA. Combination of acupuncture and spinal manipulative therapy: management of a 32-year-old patient with chronic tension-type headache and migraine. *J Chiropr Med.* 2012;11(3):192-201.
97. Sandweiss J., and Bensky D.: Integrating Acupuncture and Annual Medicine, Physical Medicine, and Rehabilitation: State of the Art Reviews, Vol. 14, No. 1. In (eds): . Philadelphia, PA: Hanley & Belfus, Inc, 2000. pp. 141-149.
98. Teitelbaum D.E.: Osteopathic vertebral manipulation and acupuncture treatment using front mu and back shu points. *Med Acupunct 2000-2001*; 12: pp. 36-37
99. Stager W. Acupuncture and the Osteopathic Family Physician. *Osteopathic Family Physician*, 2009-11-01, Voume 1, Issue 3, Page 84-87.
100. Butts R, Dunning J, Perreault T, Maurad F, Grubb F. Peripheral and Spinal Mechanisms of Pain and Dry Needling Mediated Analgesia: A Clinical Resource Guide for Health Care Professionals. *Int J Phys Med Rehabil* 2016, 4:2.
101. Castel D. (1987). *Physiotherapist Pain Reference.* Topeka, KS: International Academy of Physio Therapeutics.
102. Castel D. (1989). *Electric Muscle Stimulation Desk Reference.* Topeka, KS: International Academy of Physio Therapeutics.
103. EMPI. *Clinical Guidline Electrotherapy: Compliments of Empi, Your Partner in Rhabilitation Outcomes.*
104. MacPherson H, White A, Cummings M, Jobst K, Rose K, Niemtzow R, et al. Standards for reporting interventions in controlled trials of acupuncture: The STRICTA recommendations. *STANDARDS FOR REPORTING INTERVENTIONS IN CONTROLLED TRIALS OF ACUPUNCTURE.* *Acupunct Med.* 2002;20(1):22-5.
105. MacPherson H, Altman DG, Hammerschlag R, Youping L, Taixiang W, White A, et al. Revised STANDARDS for Reporting Interventions in Clinical Trials of Acupuncture (STRICTA): Extending the CONSORT statement. *J Evid Based Med.* 2010;3(3):140-55.
106. Langevin HM, Churchill DL, Cipolla MJ. Mechanical signaling through connective tissue: a mechanism for the therapeutic effect of acupuncture. *FASEB J.* 2001;15(12):2275-82.

107. Langevin HM, Churchill DL, Fox JR, Badger GJ, Garra BS, Krag MH. Biomechanical response to acupuncture needling in humans. *J Appl Physiol* (1985). 2001;91(6):2471-8.
108. Langevin HM, Bouffard NA, Badger GJ, Iatridis JC, Howe AK. Dynamic fibroblast cytoskeletal response to subcutaneous tissue stretch ex vivo and in vivo. *Am J Physiol Cell Physiol*. 2005;288(3):C747-56.
109. Wu SY, Chen WH, Hsieh CL, Lin YW. Abundant expression and functional participation of TRPV1 at Zusanli acupoint (ST36) in mice: mechanosensitive TRPV1 as an "acupuncture-responding channel". *BMC Complement Altern Med*. 2014;14:96.
110. Zhou HY, Zhang HM, Chen SR, Pan HL. Increased C-fiber nociceptive input potentiates inhibitory glycinergic transmission in the spinal dorsal horn. *J Pharmacol Exp Ther*. 2008;324(3):1000-10.
111. Tambeli CH, Quang P, Levine JD, Gear RW. Contribution of spinal inhibitory receptors in heterosegmental antinociception induced by noxious stimulation. *Eur J Neurosci*. 2003;18(11):2999-3006.
112. Goldman N, Chen M, Fujita T, Xu Q, Peng W, Liu W, et al. Adenosine A1 receptors mediate local anti-nociceptive effects of acupuncture. *Nat Neurosci*. 2010;13(7):883-8.
113. Takano T, Chen X, Luo F, Fujita T, Ren Z, Goldman N, et al. Traditional acupuncture triggers a local increase in adenosine in human subjects. *J Pain*. 2012;13(12):1215-23.
114. Lima FO, Souza GR, Verri WA, Jr., Parada CA, Ferreira SH, Cunha FQ, et al. Direct blockade of inflammatory hypernociception by peripheral A1 adenosine receptors: involvement of the NO/cGMP/PKG/KATP signaling pathway. *Pain*. 2010;151(2):506-15.
115. Zylka MJ. Pain-relieving prospects for adenosine receptors and ectonucleotidases. *Trends Mol Med*. 2011;17(4):188-96.
116. Schulte G, Robertson B, Fredholm BB, DeLander GE, Shortland P, Molander C. Distribution of antinociceptive adenosine A1 receptors in the spinal cord dorsal horn, and relationship to primary afferents and neuronal subpopulations. *Neurosci*. 2003;121(4):907-16.
117. Goldman N, Chandler-Militello D, Langevin HM, Nedergaard M, Takano T. Purine receptor mediated actin cytoskeleton remodeling of human fibroblasts. *Cell Calcium*. 2013;53(4):297-301.
118. Fang S. The successful treatment of pain associated with scar tissue using acupuncture. *J Acupunct Meridian Stud*. 2014;7(5):262-4.
119. Wang R, Luo D, Xiao C, Lin P, Liu S, Xu Q, et al. The time course effects of electroacupuncture on promoting skeletal muscle regeneration and inhibiting excessive fibrosis after contusion in rabbits. *Evid Based Complement Alternat Med*. 2013;2013:869398.
120. Langevin HM, Yandow JA. Relationship of acupuncture points and meridians to connective tissue planes. *Anat Rec*. 2002;269(6):257-65.
121. Zhou K, Ma Y, Brogan MS. Dry needling versus acupuncture: the ongoing debate. *Acupunct Med*. 2015;33(6):485-90.

8 August 2016

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Sunrise Reviews
P.O. Box 47850
Olympia, WA 98504-7850
sunrise@doh.wa.gov

Re: Physical therapy scope of practice sunrise – dry needling

Dear DOH:

This letter provides public comment in reference to the proposal to add dry needling to the physical therapist scope of practice.

I request the WA State Department of Health to recommend adding dry needling to the physical therapy scope of practice. The following is provided in response to the requirements set forth in RCW 18.120.030:

Pain causes people to do harm to themselves and others in the quest to reduce the agony. They take NSAIDs which raises the risk of coronary artery events by ~30%. They take Tylenol which is known to cause kidney damage. They take narcotics which are known to be addictive. These addicts fill our emergency rooms and doctors offices daily in their demands for pain medication. When they can no longer obtain prescriptive narcotics they frequently turn to alcohol, illegal drugs or legalized marijuana. It's obvious that pain has caused a lot of damage to our society and economy.

- I am a patient with a damaged heart and damaged knees. I am not allowed to take NSAIDs because of the increased risk of cardiac events. One knee needs to be replaced but cannot be replaced because of my weakened heart. I am relatively young and have, perhaps, decades of excruciating pain. Dry needling is a technique proven to reduce/remove pain without risking further heart damage. My health insurance plan was chosen to support my in-network health care providers – heart transplant team, cardiologists, orthopedic surgeons and physical therapists. Very few Washington State acupuncturists are in network for my health insurance plan which is aligned to Western Medicine.
- My elderly mother herniated a disc in her spine @ L4 last year then experienced multiple fractures to her pelvis due to osteoporosis early this year. She spent a week in the hospital and was released in the same level of pain that she had when she entered the hospital. She was in terrible pain – long term pain. Back surgery was deemed too risky and the pelvis fractures needed time to repair. The back surgeon recommended acupuncture. I spent weeks calling acupuncturists in Snohomish County – dutifully leaving messages and hoping for a return call. Sadly, few returned the calls which indicate a lack of compassion/caring. Most of the local acupuncturists are out of network for my mothers' Med-advantage plan, resulting in frequent commutes into Seattle which was contra-indicated for her health condition. She could not remain in her apartment if she took narcotic pain medicine, so she chose – at 87 years of age – to utilize only Tylenol and NSAIDs for months of extreme pain during the healing process. She would have had a better quality of life if her physical therapist had been allowed to perform dry needling. Medicare costs would be reduced and the government metrics for re-hospitalization would improve.

It is simply ridiculous that any patient be required to travel out of state or out of country to seek pain relief and healing from physical therapists that are licensed to provide dry needling!

Research, data and comments presented to the Department of Health during the subject Sunrise Review has shown:

- Dry needling by physical therapists has now had over 30 years of experience.
- No known increase in health risk posed by allowing physical therapists to dry needle instead of dry needling performed by acupuncturists. Risks may also be due, in part, to non-compliant patients. One can't fix stupid, no matter how hard you try. Call it selective elimination and move on.
- Physical therapists and acupuncturists have both completed extensive studies and training; both areas fall under the control environment provided by the DOH.
- DOH in every State provides the primary control environment – both licensing requirements and monitoring - to both the acupuncturist and to the physical therapist. From the patient's perspective, whether it's a service provided by an acupuncturist or a physical therapist or physician, the State provides the primary control (the licensing requirement) and the monitoring control is provided by the State and by patient attorneys.
- The arguments put forth by Bastyr leave me wondering if they are more concerned about the potential for falling enrollment and the resulting impact to their financial health. The petty squabbling must stop for the sake of the patients who are in pain and needing relief from dry needling. This need not be a concern for the Department of Health.
- Medical insurance plans are aligned to Western vs. Eastern medicine. Patients preferring Western medicine may choose to be treated by physical therapists while patients preferring Eastern medicine have chosen insurance plans that support Eastern Medicine providers.
- The DOH needs to add dry needling to the physical therapist scope of practice in WA State in order to provide equal access to pain relief.

For these reasons, please add dry needling to the physical therapist scope of practice in WA State. We would appreciate receiving sunrise review updates. Thank you, in advance, for your support

Sincerely,

Anne Coxon

Attached please find three PDF documents concerning the 2014 South Sound Acupuncture Association (SSAA) v Kinetacore lawsuit in King County, WA, case number 13-2-35460-8 SEA

The importance of presenting these documents to the Sunrise Review Board, is to show that every argument regarding dry needling that has come up in the review process has already been addressed in the lawsuit, the court having agreed with the plaintiff. Of special note are the sections discussing EMG and wound debridement, procedures that PTs somehow see as relevant experience in their push to be allowed to do surgically invasive therapeutic needle procedures. Also the illogical argument that invasive needle therapy (acupuncture) is somehow a form of manual therapy is examined. The erroneous legal assessment promulgated by APTA and FSBPT regarding the FDA's clear definition and regulation of acupuncture needles is discussed by the plaintiff and agreed upon by the court.

The attachments consist of:

5 declarations (25 pages total) from expert witnesses on behalf of SSAA, the plaintiff and prevailing party in the lawsuit.

SSAA's response (24 pages) to Defendant (Kinetacore's) Motion for Summary Judgment dated September 29, 2014.

The 4 page Court Order signed by Judge Laura Inveen on October 10, 2014, King County, WA, ruling.

Thank you for including this material for the public record,

Dan Dingle
Olympia, WA

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING

STATE OF WASHINGTON *ex rel.*
SOUTH SOUND ACUPUNCTURE
ASSOCIATION, a State of
Washington non-profit corporation,

Plaintiff,

vs.

KINETACORE, a Colorado LLC doing
business in the State of Washington; **EDO
ZYLSTRA**, CEO and owner of
Kinetacore; **KERI MAYWHORT**, a
Kinetacore instructor; **EMERALD
CITY PHYSICAL THERAPY
SERVICES LLC** doing business as
**SALMON BAY PHYSICAL THERAPY
LLC**, a limited liability company; **JOHN
DOES 1-10**; and **JANE DOES 1-10**.

Defendants.

NO. 13-2-35460-8 SEA

**DECLARATION OF DR. IMAN
MAJD, M.D.**

I, Dr. Iman Majd, declare the following based upon my personal knowledge:

1. I am familiar with the facts below, am over the age of 18, and am otherwise competent to testify on the issues described here.

2. I am a medical doctor practicing in Washington, having first practiced as a Family Practice physician in Iran, from 1996 to 2002. I received my Masters of Science

DECLARATION OF DR. IMAN MAJD, M.D.

- 1

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 in Acupuncture from Basytr University, Seattle, in 2005, followed by a residency in
2 Family Medicine from 2009 through 2012 at the University of Washington, Department
3 of Family Medicine, Seattle.

4 2. Since 2012 I have worked as a Family Medicine Physician at the University of
5 Washington, specializing in Acupuncture and Integrative Medicine. I am Board Certified
6 in Family Medicine, as well as being a Diplomate of the American Academy of Medical
7 Acupuncture; the American Board of Integrative Holistic Medicine; as well as a
8 Diplomate in Acupuncture, NCCAOM.

9 3. My CV is attached at Exhibit A.

10 4. From 2005 through present, I have been on clinical faculty for acupuncture at
11 Bastyr University. From 2012 through present, I have been a clinical instructor at the
12 University of Washington School of Medicine.

13 5. I have authored several medical research projects and published a book on the
14 methodology of medical research that was used as a reference for first year residents in
15 Iran.

16 6. Since 2010, I have served as a Subject Matter Expert for the Biomedical Exam
17 Development Committee for the National Certification Commission of Acupuncture and
18 Oriental Medicine (NCAOM), and I am currently the NCCAOM board liaison of that
19 committee.

20 7. Dry needling is acupuncture, specifically "ashi point" needling that addresses
21 tender "trigger" points. This part of acupuncture's history has been known and
22 documented for thousands of years. The proponents of dry needling promulgate a deeply
23 flawed representation of the history and application of acupuncture that originated in
24 China and has evolved throughout the world using the scientific and societal influences
25 of each culture. Cultural differences notwithstanding, the puncturing of the skin with
acupuncture needles has been universally known and accepted as Acupuncture. Only

DECLARATION OF DR. IMAN MAJD, M.D.

-2

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 recently have western based dry needlers re-written the true history of "ashi point"
2 acupuncture, calling it by various other names, but the fact remains that it is still
3 acupuncture, regardless of the name or theory used to describe it. The dry needling
4 stance promulgated by dry needlers in general negates the true history of acupuncture.

5 8. As a physician, I am able to refer patients to physical therapists for EMG testing,
6 but EMG is a diagnostic test only and not an invasive therapeutic procedure.
7 Additionally, I am able to refer patients to physical therapists for sharps debridement but
8 this consists of the removal of dead tissue only and does not include the invasive surgical
9 procedure of removing living tissue. The training and skills needed to perform EMG and
10 sharps debridement are not remotely equivalent to the supervised training and skills set
11 needed to insert acupuncture needles for therapeutic purposes.

12 9. As a Family Practice provider, I have referred patients to physical therapist for
13 movement based therapy and have found that a collaborative effort between all providers
14 yields the best outcomes, and gives patients confidence in their providers and the healing
15 process. Under-trained practitioners increases the likelihood of dissatisfaction and injury
16 to the patient, as is the case with physical therapists who are performing dry needling
17 after taking only a weekend workshop.

18 10. I am aware of the claims by physical therapists and others that dry needling is
19 substantially different from the practice of acupuncture, but I believe this is
20 fundamentally incorrect.

21 11. The claim that acupuncture needles are only placed on the surface of the skin or
22 only on meridians, and therefore different than dry needling, is also untrue.

23 12. Trigger point dry needling (aka. dry needling) and acupuncture both aim to
24 alleviate pain and other dysfunction by inserting acupuncture needles into sensitive or
25 tight points on the body that can be identified through palpation.

13. Trigger point dry needlers use the acupuncture needle in the same way as

1 acupuncturists, albeit in a less skilled manner. In contrast, acupuncture students at
2 Bastyr typically observe a significant number of hours of needle insertion before
3 practicing on a human subject, and after that, they must complete hundreds of hours of
4 supervised training. Furthermore, the American Board of Medical Acupuncture (ABMA)
5 requires a physician satisfactorily complete a minimum of 300 hours of systematic
6 acupuncture education acceptable to the ABMA and that a minimum of 100 hours of
7 clinical acupuncture training be completed before the physician qualifies to sit for board
8 certification. The mere weekend workshops offered by Kinetacore and other dry
9 needling trainers, is simply not enough to “certify” safe and efficacious practitioners,
10 regardless of the title they give themselves.

11 14. As a Family Practice physician, I have treated thousands of patients of various
12 constitutions and backgrounds. It is my opinion that hundreds of hours of supervised
13 training is needed to be able to safely insert acupuncture needles given the multitude of
14 differences in the human body and the plethora of considerations that must be factored in
15 to any given needle insertion.

16 15. The 500 hours of clinical supervised training required for acupuncture
17 practitioners before they are allowed to be licensed is a critical part of ensuring the safe
18 use of acupuncture needles that cannot be substituted in a 27-hour dry needling course.

19 16. Without the ability of students to repeatedly treat patients in a mentored
20 setting, where an extensively trained practitioner can oversee a student treating a
21 significant number of patients with a spectrum of real ailments in a real world clinical
22 setting a student will lack proper training in the safe use of acupuncture needles
23 regardless of whether they refer to this use as acupuncture or dry needling.

24

25 I declare under penalty of perjury under the laws of the state of Washington that the
foregoing is true and correct.

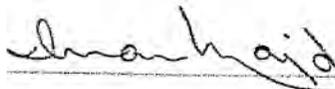
DECLARATION OF DR. IMAN MAJD, M.D.

- 4

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

DATED this 29th day of September, 2014 in Seattle, Washington



Iman Majd MD, MS, EAMP, Dip. ABFM,
Dip. Ac NCCAOM, DABMA, ABIHM
Faculty, Department of Family Medicine, University of
Washington
UW Physicians - Neighborhood clinics
4111 East Madison Street # 325
Seattle, WA 98112

DECLARATION OF DR. IMAN MAJD, M.D.

- 5

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING

SOUTH SOUND ACUPUNCTURE
ASSOCIATION, a State of Washington
non--profit corporation,
Plaintiff/Petitioner,

NO. 13-2-35460-8 SEA

DECLARATION PER GR 17(2) RE:
DECLARATION OF DR. IMAN
MAJD, M.D.

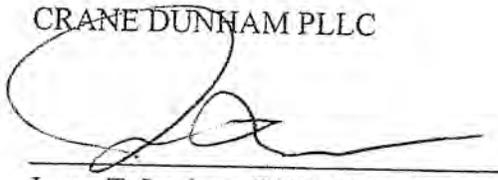
vs.

KINETACORE, a Colorado limited
liability company doing business in the
State of Washington, et.al.

I hereby declare under penalty of perjury pursuant to the laws of the State of Washington,
as follows: I am the attorney for the Plaintiff. I have examined the document to
which this Declaration is attached; have determined that said document consists of
six (6) pages; including this declaration page; and that it is complete and legible.

Dated this 6th day of September, 2014, at Seattle, WA

CRANE DUNHAM PLLC



Jason T. Leehan, WSBA No. 42463

DECLARATION OF JASON T. LEEHAN - 1

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE,
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING

STATE OF WASHINGTON *ex rel.*
SOUTH SOUND ACUPUNCTURE
ASSOCIATION, a State of
Washington non-profit corporation,

Plaintiff,

vs.

KINETACORE, a Colorado LLC doing
business in the State of Washington; **EDO**
ZYLSTRA, CEO and owner of
Kinetacore; **KERI MAYWHORT**, a
Kinetacore instructor; **EMERALD**
CITY PHYSICAL THERAPY
SERVICES LLC doing business as
SALMON BAY PHYSICAL THERAPY
LLC, a limited liability company; **JOHN**
DOES 1-10; and **JANE DOES 1-10**.

Defendants.

NO. 13-2-35460-8 SEA

DECLARATION OF TED PRIEBE,
LAC

I, Ted Priebe, declare the following based upon my personal knowledge:

1. I am familiar with the facts below, am over the age of 18, and am otherwise competent to testify on the issues described here.
2. I have practiced acupuncture for over 32 years including 18 years in an accredited pain management center. My *curriculum vitae* is attached at

DECLARATION OF TED PRIEBE

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 Exhibit A.

- 2 3. I have extensively researched the history, safety and effectiveness of
3 acupuncture and have reviewed more than 1,200 different published medical
4 studies relating to acupuncture.
- 5 4. Since 2008 I have been an accredited Education Provider by the California
6 Workers Medical Division of Continuing Medical Education and since 2010
7 I have been authorized as a Continuing Medical Education Provider for the
8 Medical Board of California and the Board of Podiatric Medicine.
- 9 5. I am very familiar with the claims by physical therapists that "dry needling"
10 is different from the practice of acupuncture and believe such claims are
11 factually incorrect and are based on lack of knowledge regarding
12 acupuncture, its history, and the principles underlying it.
- 13 6. The assertion that acupuncture is solely based "upon the Chinese spiritual
14 concepts of Chi and vital life energy" is wrong. The Chinese concept of
15 physiological function was well understood, highly sophisticated for its time
16 and involved a dynamic view of the function of all body systems.
17 Acupuncture was not based merely on "spiritual concepts." This early
18 documented understanding embraces concepts such as feedback control of
19 "homeostasis" as well as the unstable feed-forward aspects of hormone
20 mediated vitalities and emotions called "allostasis."
- 21 7. Selection of neurovascular nodes within the practice of acupuncture are also
22 correctly based on the longitudinal distribution of nerves, blood vessels and
23 arteries, lymphatic and segmental dominance through muscle distributions
24 specific in relation to pathology and injury. The suggestion that dry needling
25 is unique from acupuncture because of its physiological basis is incorrect.
8. Adopting semantics such as dry needling or percutaneous nerve stimulation

DECLARATION OF TED PRIEBE

- 2 -

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

- 1 (PENS) supposedly rediscovered by dry needling promoters such as Travell
2 & Simmons does not change history or proper application of this modality.
- 3 9. All proponents claim these theories and applications to be an adaptation of
4 Chinese acupuncture, while proclaiming they are derived from vastly
5 different concepts, without qualification of this perceived difference, as we
6 all have the same physiology. This has led to inconsistent data in research
7 design, unreliable methodology and underutilization.
- 8 10. The modality of acupuncture meets the fundamental, scientific requirements
9 for medicine in being explainable via physiological mechanisms, and having
10 a peer reviewed and authenticated clinical practice consistent with its
11 historic, theoretical, physiological, and experimental foundations. (Kendall
12 2008).
- 13 11. Recognition of the authentic roots of Chinese medical history meritoriously
14 provides a scientific explanation on the effect of: needle insertion; by the
15 muscles; vascular and nervous structures notably their regulatory centers in
16 the brain and spine cord (CNS); as well as, provide a repeatable outcome
17 protocol based on the Chinese discovery of blood circulation; recognition of
18 longitudinal distribution and segmental dominance of vessels (blood) and
19 nerves. (Han 2002)(Han 2008).
- 20 12. Dry needling is a name that has been given to the practice of acupuncture by
21 persons who have not satisfied the significant training and licensing
22 requirements for licensing as an acupuncturist.
- 23 13. Dry needling uses the same exact needles used in acupuncture that are even
24 labeled as acupuncture needles. Dry needling targets the same points on the
25 body, including sore or sensitive points that have been targeted for over
2,000 years in acupuncture known as “a shi points.”

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

14. The claim that dry needling is distinct from acupuncture because acupuncture targets only “meridians” is without merit. Some acupuncture points occur along mapped “meridians,” but acupuncture has also since its origin targeted the same sensitive or sore spots that are used in “dry needling.”
15. The actions applied to an acupuncture needle by those claiming to practice “dry needling” are the same as the actions used in acupuncture.
16. Those claiming to practice dry needling claim they are targeting “trigger points” aimed to solicit a “twitch response” and are based on Western, as opposed to Eastern medical concepts. These differences, however, are merely differences in naming and describe well-known aspects of acupuncture.
17. I believe the use of acupuncture needles by physical therapists that have had only a weekend of training in either a Kinetacore course or similar courses presents a significant threat to public safety.
18. The reason why hundreds of hours of clinical training is required for licensed acupuncturists is that those most familiar with the risks of inserting acupuncture needles demand such an intensive level of training and experience.
19. The potential harms that can be caused by the inadequately trained use of acupuncture needles range from pneumothorax and the potential to puncture numerous other organs to nerve damage and infection. A weekend course in dry needling, does not constitute a level of training that would qualify a physical therapist to safely use acupuncture needles over the long-term.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

References

Kendall, DE. Energy-meridian misconception of Chinese medicine. Schweizerische Zeitschrift für Ganzheits Medizin: Swiss Journal of Integrative Medicine, 2008; 20(2):112-117.

Ulett GA, Han SP. The Biology of Acupuncture. Warren H. Green, Inc. St. Louis, Missouri, 2002.

Ulett GA, Han JS, Han SP. Traditional and Evidence-Based Acupuncture: History, Mechanisms, and Present Status. Southern Medical Journal Dec 1998;91(12) 1115-20.

Simons DG, Travell JG, Simons LS. Myofascial pain and dysfunction: the trigger point manual. Volume 1. Upper half of body. 2nd ed. Baltimore: Williams & Wilkins, 1999.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 28th day of September, 2014 in Redondo Beach, California.


Ted Priebe, O.M.D

700 Meyer Ln Unit 1
Redondo Beach, CA 90278

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING

STATE OF WASHINGTON *ex rel.*
SOUTH SOUND ACUPUNCTURE ASSOCIATION, a State of Washington non-profit corporation,

Plaintiff,

vs.

KINETACORE, a Colorado LLC doing business in the State of Washington; **EDO ZYLSTRA**, CEO and owner of Kinetacore; **KERI MAYWHORT**, a Kinetacore instructor; **EMERALD CITY PHYSICAL THERAPY SERVICES LLC** doing business as **SALMON BAY PHYSICAL THERAPY LLC**, a limited liability company; **JOHN DOES 1-10**; and **JANE DOES 1-10**.

Defendants.

NO. 13-2-35460-8 SEA

SECOND DECLARATION OF DANIEL DINGLE

I, Daniel Dingle declare the following based upon my person knowledge:

- 1. I am a licensed practitioner in East Asian Medicine and a board member of the South Sound Acupuncture Association(SSAA) which is a non-profit corporation whose members are primarily licensed acupuncturists from the Puget Sound area.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

2. I received my Master's degree in acupuncture from the Northwest Institute of Acupuncture and Oriental Medicine in 1993. I am certified by the National Certification Commission for Acupuncture and Oriental Medicine and licensed to practice acupuncture in Washington.
3. I hold a Bachelor's degree in Asian Studies from the Jackson School of International Studies at the University of Washington. While at the University of Washington, I was co-founder and chairperson of Organization of Nurses for Integrative Care, and an Executive Committee member of the Complementary and Alternative Medicine Grant program, "Integrating CAM, a Nursing Emphasis," funded by the National Institutes for Health. This grant program facilitated the education of key UW School of Nursing department heads and faculty in issues and modalities of Complimentary and Alternative Medicine (CAM).
4. I have been in private practice for over 21 years. In Seattle, I founded an integrated health clinic offering acupuncture, massage therapy, physical therapy and physician services.
5. In Seattle, I was an onsite acupuncturist for the King County Drug Court program and served as independent consultant to various chemical dependency treatment programs. I currently practice in Olympia, Washington where I collaborate with a variety of health care providers on treating different types of healthcare issues, with a focus on chronic pain management and musculoskeletal disorders.
6. Washington law requires 500 hours of clinical training in acupuncture, but acupuncturists who graduate from schools in this state have at least 660 hours of hands on supervised clinical training which conforms to the National Certification Commission for Acupuncture and Oriental Medicine

1 (NCCAOM) requirements used as a prerequisite for licensure in Washington.²
2 Some states require more experience, for example, California requires 950
3 hours of supervised clinical training before licensure in that state.³

4 7. Additionally, licensing requirements in Washington require passing of the
5 NCCAOM Clean Needle Technique Course administered by the Council of
6 Colleges of Acupuncture and Oriental Medicine (CCAOM). This is typically
7 an 8 hour course.^{4,5}

8 8. According to the CCAOM, the Accreditation Commission for Acupuncture
9 and Oriental Medicine (ACAOM) curriculum requirement for an acupuncture-
10 only training program ranges between 1950-2600 hours for ACAOM
11 accredited and candidate acupuncture-only training programs.⁶

12 9. The Defendants' describe acupuncture as:

13 *acupuncture is based upon the Chinese spiritual concepts of Chi and vital life*
14 *energy. Needles are placed into the skin along meridians through which Chi*
15 *flows. Acupuncturists believe that changing the flow of Chi creates a balance*
16 *of yin and yang.*

17 10. This definition is simplistic and specious. Trigger-point dry needling is not
18 some new twentieth century discovery but was, in fact, first described in detail over
19 2,000 years ago in the Chinese medical treatise the *Huang Di nei jing, Yellow Emperor's*
20 *Inner Classic.*⁷

21 11. These tender points found in muscle and connective tissue were located by
22 palpation, which was acupuncture's earliest form of point selection. This method of point
23 selection was defined as *yǐ tòng wéi shù*, or [the point of] pain or tenderness⁷ and was not
24 based on "meridian" theory nor on some mystical, "spiritual" concept as presumptively
25 and patronizingly stated by the Defendants.

12. *Sun Si Miao*, 581-682 C.E. China's pre-eminent physician referred to these
tender points as *ā shì xué*, meaning "ah yes! points, due to the fact that the patient felt an

1 unexpected local or referred “wince-pain” when the spot was palpated.’

2 13. In a 1977 study published in the journal *Pain*, Melzack et al found that “every
3 trigger point has a corresponding acupuncture point,”* a 100% correspondence.*

4 14. Corroborating the Melzack study was one by Hong in 2000 appearing in the
5 British Medical Journal. The author reiterated the conclusion of the Melzack study and
6 added that it is very likely that *all trigger points are acupuncture points* [emphasis
7 added].*

8 15. The Defendants’ misconception that acupuncture is narrowly defined by
9 needles “placed into skin along meridians through which chi flows” reflects either an
10 ignorance of medical history or an unwillingness to cite at least one study showing that
11 the Western imposed and inadequate definition of *mai* (meridians), actually has physical
12 correlates in the body. Dorsher’s article in the 2009 journal *Pain*, “demonstrates that
13 myofascial referred-pain data provides independent physiologic evidence of acupuncture
14 meridians.”

15 References

- 16 1. RCW 18.06.050 (2) (b)
17 2. 2014 NCCAOM Certification Handbook, p. 22
18 3. Title 16, Article 3.5 Acupuncture Training Programs, 1399.434. Criteria for
19 Approval of Acupuncture and Oriental Medicine Training Programs (effective
20 1/1/05) (i)
21 4. WAC 246-803-240 (d)
22 5. <http://www.ccaom.org/cntprogram.asp>
23 6. Know Your Acupuncturist, www.ccaom.org
24 7. National Center for Acupuncture Safety, www.acupuncturesafety.org
25 8. Trigger points and acupuncture points for pain: Correlations and implications,
Ronald Melzack, Dorothy M. Stillwell and Elisabeth J. Fox, *J Pain*, Volume 3, Issue
1, February 1977
9. Myofascial trigger points: pathophysiology and correlation with acupuncture points,
Chang-Zern Hong, *Acupuncture in Medicine*, June 2000, Vol 18 (1), British Medical
Journal
10. Myofascial referred-pain data provide physiologic evidence of acupuncture
meridians, Dorsher PT, *J Pain*, 2009 Jul;10(7):723-31

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 29th day of September, 2014 in Olympia, Washington.

Daniel Dingle
Daniel Dingle

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING

STATE OF WASHINGTON *ex rel.*
SOUTH SOUND ACUPUNCTURE
ASSOCIATION, a State of
Washington non-profit corporation,

Plaintiff,

vs.

KINETACORE, a Colorado LLC doing
business in the State of Washington; EDO
ZYLSTRA, CEO and owner of
Kinetacore; KERI MAYWHORT, a
Kinetacore instructor; EMERALD
CITY PHYSICAL THERAPY
SERVICES LLC doing business as
SALMON BAY PHYSICAL THERAPY
LLC, a limited liability company; JOHN
DOES 1-10; and JANE DOES 1-10.

Defendants.

NO. 13-2-35460-8 SEA

**DECLARATION OF DR. FUJIO
MCPHERSON**

I, Dr. Fujio McPherson, declare the following based upon my person knowledge:

1. I am familiar with the facts below, am over the age of 18, and am otherwise competent to testify on the issues described here.
2. I have a Doctorate in Acupuncture and Oriental Medicine (DAOM) from Oregon College of Oriental Medicine in Portland Oregon.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

3. I have over 16 years experience as a primary care provider and Family Nurse Practitioner, 30 years experience as a Registered Nurse and 28 years experience as an officer and soldier in the United States Army where I held the rank of Lt. Colonel.
4. I have worked for five years as a clinical preceptor for acupuncture students at Bastyr University in Seattle, WA and this work included training acupuncture students in TCM diagnostics and clinical skills in preparation for their board exams.
5. I worked for over 17 years as a Family Nurse Practitioner and over 10 years as an acupuncturist at the Internal Medicine Clinic at Madigan Army Medical Center at Ft. Lewis, WA and my CV is attached here.
6. I am very familiar with both acupuncture and the practice of acupuncture by physical therapists that is often referred to as "dry needling."
7. There is no genuine distinction between dry needling and acupuncture since both use a closed tapered needle that is inserted into the body at various locations and depths.
8. Dry needling uses the same type of needle that is used by acupuncturists and targets points on the body intended to achieve similar goals, particularly pain relief. There are differences in nomenclature and explanations as to how the same treatment using the same tool produces the same desired effect, but these are not real or substantive distinctions in the underlying treatment.
9. Those claiming dry needling is fundamentally different from acupuncture typically have a limited understanding of Chinese Medicine Theory or the safe practice of acupuncture and appear to lack awareness that without proper training in TCM theory and clinical training, needling points on any portion of the body under whatever alternate name you give it can still result in a

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

bodily response defined by TCM regardless of whether or not the practitioner refers to it as dry needling, trigger points or any other definition.

10. Acupuncture is not defined solely by the treatment of meridian points as some physical therapists have incorrectly asserted in an attempt to distinguish dry needling from acupuncture.

11. The claim that dry needling is distinct from acupuncture because it is based on Western as opposed to Eastern principles is erroneous since it fails to recognize the evidence based research that support the insertion of acupuncture needles as a means of curing or treating pain, muscle soreness, mobility, and numerous bodily functions, all rooted in TCM theory.

12. Based on my extensive practice and use of acupuncture needles and studies of the risks of acupuncture needles I can confidently say that the 27 hours of training typical in a Kinetacore dry needling course is an entirely insufficient level of training to ensure the safety of any patient, especially when practiced without knowledge of theory, sufficient classroom training and clinical training.

13. Important lessons and skills such as clean needle techniques, training in how to remove broken and stuck needles, proper placement and needle angles at specific areas of the body cannot be taught let alone practiced to a high degree of safety in just 27 hours.

14. Washington law requires at least 500 hours of supervised clinical training because this is the level of training that is required to ensure those using acupuncture needles on their patients can safely and effectively practice.

15. There are many inherent risks in placing any form of sharp penetrating instrument in the human body and particularly an acupuncture needle that can be multiple inches in length. These risks are made higher depending on the

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

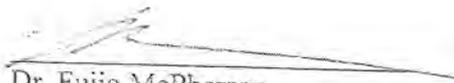
location of the insertion and are well documented to include pneumothorax, infection, bleeding, broken needles which may lodge in the body unable to be immediately removed, and pain.

16. There is a particularly strong basis for safety concerns about physical therapists using acupuncture needles since there is no requirement under Washington's licensing rules that physical therapists be trained in the safe use of acupuncture needles. Washington's physical therapy schools may offer some limited dry needling courses, but these are not mandatory curriculum for graduation.

17. It is entirely possible that a physical therapist graduates from a physical therapy program and obtains a license to practice physical therapy without any training in the safe use of acupuncture needles. Allowing such individuals to start inserting acupuncture needles into their patients would present a significant risk to the public.

I declare under penalty of perjury under the laws of the state of Washington that the foregoing is true and correct.

DATED this 26th day of September, 2014 in Lacey, Washington.


Dr. Fujio McPherson
6501 Candace Court SE
Lacey, WA 98513

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING

STATE OF WASHINGTON *ex rel.*
SOUTH SOUND ACUPUNCTURE
ASSOCIATION, a State of
Washington non-profit corporation,

Plaintiff,

vs.

KINETACORE, a Colorado LLC doing
business in the State of Washington; **EDO**
ZYLSTRA, CEO and owner of
Kinetacore; **KERI MAYWHORT**, a
Kinetacore instructor; **EMERALD**
CITY PHYSICAL THERAPY
SERVICES LLC doing business as
SALMON BAY PHYSICAL THERAPY
LLC, a limited liability company; **JOHN**
DOES 1-10; and **JANE DOES 1-10**.

Defendants.

NO. 13-2-35460-8 SEA

DECLARATION OF DR. DAVID W.
MILLER, M.D., L.A.C

I, Dr. David W. Miller, declare the following based upon my person knowledge:

1. I am familiar with the facts below, am over the age of 18, and am otherwise
competent to testify on the issues described here.

2. I am a medical doctor in Illinois, where I have practiced medicine for 15 years.
I am board certified in Pediatrics. Additionally, in 2005, I obtained my Masters of

1 Science in Traditional Oriental Medicine and became a licensed acupuncturist in Illinois.

2 My CV is attached at Exhibit A.

3 3. I have lectured extensively on Complementary and Alternative Medicine
4 (CAM) and Chinese medicine including acupuncture across the country and in Korea,
5 including a Lecture presented at the National Association of Myofascial Trigger Point
6 Therapists National Conference in 2010.

7 4. I have 45 hours of training in myofascial trigger point therapy (MTPT), the
8 field from which dry needling as a western concept originated.

9 5. Since 2010, I have served as a Subject Matter Expert for the Biomedical Exam
10 Development Committee for the National Certification Commission of Acupuncture and
11 Oriental Medicine (NCAOM), and I am currently Chair of that committee.

12 6. Since 2012 I have served as a member of both the Illinois State Medical
13 Society Council on Education and Health Workforce, and on Congressman Mike
14 Quigley's Committee on Healthcare.

15 7. I have been an associate professor at Pacific College of Oriental Medicine
16 since 2005 and I have been adjunct faculty at National University of Health Sciences,
17 since 2008.

18 8. As a physician, I am licensed to perform invasive procedures. As an
19 acupuncturist, by statute, I am also licensed to insert needles for the purposes of
20 preventing or modifying the perception of pain, normalizing physiological functions, and
21 treating dysfunctions of the body.

22 9. As a medical doctor I have referred patients to physical therapy and find their
23 services invaluable to the recovery of many of my patients. Physical therapists I know
24 and have worked with have been intelligent, well-intentioned individuals with a sincere
25 goal to better the health of their clients. However, certain physical therapists who
engage in dry needling absent proper training in the practice of acupuncture compromise

DECLARATION

-2

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 these otherwise positive attributes and pose a significant health risk to the public.

2 10. I am aware of the claims by physical therapists and others that dry needling
3 is sufficiently different from the practice of acupuncture, but I believe this is not accurate
4 and demonstrates either an incorrect or incomplete knowledge of acupuncture.

5 11. The charge that acupuncture is focused only on meridians or is based solely
6 on spiritual or non-physical philosophies and is therefore different than dry needling is
7 untrue.

8 12. Dry needling or trigger point dry needling is not alone in aiming to alleviate
9 pain and other ailments by inserting acupuncture needles into sensitive or tight points on
10 the body that can be identified through palpation. This has been an important component
11 of acupuncture since its inception and is known as "Ashi" point needling in Chinese
12 medicine.

13 13. Multiple published medical studies have directly correlated virtually every
14 major "trigger point" with a corresponding acupuncture point. These studies include:

15 Dorscher PT, 2007. Can classical acupuncture points and trigger points be
16 compared in the treatment of pain disorders? Birch's analysis revisited. J
17 Altern. Complement Med. 14(4):353-9.

18 Melzack R, 1977. Trigger points and acupuncture points for pain:
19 correlations and implications. Pain, 3(1): 3-23.

20 14. The manner in which an acupuncture needle is used by those claiming to
21 practice dry needling is identical to techniques used in acupuncture for "Ashi" point
22 needling, and the needles used are also the same. Dry Needling originally used
23 hypodermic needles without the injection of saline, lidocaine, or other substances. The
24 change in practice to the use of acupuncture needles moves the current practice of Dry
25 Needling further away from its historic origins and into the realm of acupuncture. Dry
Needling was also meant to be used within the full context of Myofascial Trigger Point
Therapy rather than as a stand-alone technique. It was a method used later in treatment

DECLARATION
-3

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 when more conservative methods were insufficient, and was not meant to be used
2 outside of the context of teaching patients self-care methods, teaching patients to seek
3 the 'perpetuating factors' for pain, and outside of the hands-on techniques for relieving
4 trigger point discomfort. Current practice of Dry Needling is divorced (or 'cherry
5 picked') from the field from which it was drawn.

6 15. The dry needling training that "certifies" physical therapists to insert
7 acupuncture needles after just a 27-hour workshop is woefully inadequate and presents a
8 very real public health risk.

9 16. Hundreds of hours of mentored clinical experience is needed in order to be
10 able to safely and competently insert acupuncture needles into the diversity of patients
11 with the diversity of symptoms that any health care practitioner is expected to face.

12 17. The unskilled and untrained use of an acupuncture needle, as performed by
13 dry needlers, has lead to both minor and significant injuries, including pneumothorax,
14 nerve damage, infection, and damage to internal organs and other tissues. While the
15 number of dry needlers is fairly limited at present, as numbers increase and training
16 standards remain undefined, we can be expected to result in a elevated level of injures to
17 patients, many of whom are not informed of either the practitioner's limited training or
18 the related risks.

19 18. Dry Needling as it is being practice is essentially a form of inadequately
20 trained acupuncture. The act of untrained and unlicensed acupuncture, as performed by
21 dry needlers, damages patients by providing a therapeutic service that is significantly less
22 than the "best practice of acupuncture" that is known to be safe and efficacious when
23 performed by qualified practitioners of acupuncture. It distracts patients from seeking
24 care from a qualified practitioner, and puts them at unnecessary and non-beneficial risk.
25 Patients also fail to receive other physical therapy services from which they might
benefit more, as their treatment now becomes focused on dry needling instead of

DECLARATION

-4

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 physical therapy techniques with known benefits.

2 19. There are no third-party evaluated, objectively determined competencies for
3 dry needling, nor any validated curriculum for this practice. Training is unstandardized,
4 and there are no psychometrically sound methods of evaluation used to determine
5 baseline knowledge and safety. There is no way to monitor, assess, or regulate whether
6 Physical Therapists practicing Dry Needling have adequate training, because no basal
7 standards for minimal competency have been determined.

8
9 I declare under penalty of perjury under the laws of the state of Washington that the
10 foregoing is true and correct.

11
12 DATED this 28th day of September, 2014 in Chicago, Illinois

13
14 
15 Dr. David W. Miller, M.D., FAAP, L.Ac., Dipl. OM
16 East-West Integrated Medicine, LLC
17 4361 N. Lincoln Ave., Office Unit
18 Chicago, IL 60618-1741
19 Phone: 773.969.8901
20 Fax: 866.259.4969

21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
841
842
843
844
845
846
847
848
849
850
851
852
853
854
855
856
857
858
859
860
861
862
863
864
865
866
867
868
869
870
871
872
873
874
875
876
877
878
879
880
881
882
883
884
885
886
887
888
889
890
891
892
893
894
895
896
897
898
899
900
901
902
903
904
905
906
907
908
909
910
911
912
913
914
915
916
917
918
919
920
921
922
923
924
925
926
927
928
929
930
931
932
933
934
935
936
937
938
939
940
941
942
943
944
945
946
947
948
949
950
951
952
953
954
955
956
957
958
959
960
961
962
963
964
965
966
967
968
969
970
971
972
973
974
975
976
977
978
979
980
981
982
983
984
985
986
987
988
989
990
991
992
993
994
995
996
997
998
999
1000

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98112-2810
206.292.9000 FAX 206.295.9706

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING

**STATE OF WASHINGTON *ex rel.*
SOUTH SOUND ACUPUNCTURE
ASSOCIATION**, a State of
Washington non-profit corporation,

Plaintiff,

vs.

KINETACORE, a Colorado LLC doing
business in the State of Washington; **EDO
ZYLSTRA**, CEO and owner of
Kinetacore; **KERI MAYWHORT**, a
Kinetacore instructor; **EMERALD
CITY PHYSICAL THERAPY
SERVICES LLC** doing business as
**SALMON BAY PHYSICAL THERAPY
LLC**, a limited liability company; **JOHN
DOES 1-10**; and **JANE DOES 1-10**,

Defendants.

NO. 13-2-35460-8 SEA
**RESPONSE TO DEFENDANTS’
MOTION FOR SUMMARY
JUDGMENT**

I. INTRODUCTION

Defendants’ cross Motion for Summary Judgment obscures the fact that there is just one real question the court must answer in order to rule on Plaintiff’s and Defendants’ motions for summary judgment: Did the Washington Legislature intend to authorize the insertion of acupuncture needles into humans when it adopted the scope of practice for physical therapy in RCW § 18.74.010(8). There can be no real question that

PLAINTIFF’S RESP. TO DEF’S MOTION
FOR SUMMARY JUDGMENT

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 the insertion of acupuncture needles as deep as 4” into humans falls within the broad
2 definition of the practice of medicine since this act “penetrates the tissues of human
3 beings,” and therefore meets one of the specific criteria for what constitutes the practice
4 of medicine. RCW § 18.71.011(3)1. Pursuant to RCW § 18.71.030(4), which is part of
5 the statute regulating the practice of medicine, a person is only exempt from the
6 requirement for a physician’s license in RCW § 18.71.021 if they are authorized to
7 penetrate human tissue under a statute regulating another “healing art.” RCW §
8 18.71.030(4)² is clear that the exemption from a physician’s license only applies if the
9 person is acting “under the methods or means permitted by such license.”

10 Similarly, the statute regulating East Asian Medicine and the practice of
11 acupuncture, exempts a person from an East Asian Medicine license if the person is
12 licensed under another healing art and if they are, “performing services within such
13 individual's authorized scope of practice.” (emp. added). RCW 18.06.045(1)³; RCW
14 18.06.020(2)(prohibiting practice without a license).

15 Plaintiff’s First Cause of Action, as argued in Plaintiff’s Motion for Partial
16 Summary Judgment, asserts that physical therapists are not exempt from the requirement
17 for a physicians’ license because the insertion of acupuncture needles is not within the
18 physical therapy scope of practice. The plain text of the physical therapy scope of
19 practice at RCW § 18.74.010(8) and (3), the legislative history related to its adoption, and
20 applicable case law all support that the Washington Legislature had no intent to authorize
21 the insertion of acupuncture needles within the practice for physical therapy.

22
23 ¹ RCW § 18.71.011 states: “A person is practicing medicine if he or she does one or more of
the following: (3) Severs or penetrates the tissues of human beings.” (emphasis added).

24 ² RCW § 18.71.030(4) exempts from licensure: “The practice of dentistry, osteopathic medicine and
25 surgery, nursing, chiropractic, podiatric medicine and surgery, optometry, naturopathy, or any other healing
art licensed under the methods or means permitted by such license.”

³ RCW 18.06.045(1) provides: “Nothing in this chapter shall be construed to prohibit or restrict: (1) The
practice by an individual credentialed under the laws of this state and performing services within such
individual's authorized scope of practice.”

1 Plaintiffs Second Cause of Action asserts that Defendants are also practicing
2 “acupuncture” under Washington law and therefore require licensure under the East
3 Asian Medicine statute. RCW § 18.06.010(1)(a); RCW 18.06.020(2). This Second Cause
4 of Action is also based on physical therapists lack of legal authority to insert needles but
5 further requires a showing that “dry needling” constitutes acupuncture.

6 Washington courts have described acupuncture as, "the insertion of needles beneath
7 the skin to alleviate pain, infirmity, or disease" and "the selective stimulation of the
8 body's neurological and defense mechanisms by the insertion of needles in an effort to
9 correct neuromuscular and organic disorders or to induce analgesia." *In re: Stockwell*, 28
10 Wn. App. 295, 302 (1981) quoting *State v. Rich*, 44 Ohio St. 2d 195, 197 (1975) and
11 *State v. Won*, 19 Ore. App. 580, 582 (1974).

12 There is a strong argument that dry needling falls squarely within the definition of
13 acupuncture. But given the robust factual dispute between the parties on this point, it is
14 not appropriate to decide on summary judgment. CR 56. Much of Defendants briefing is
15 spent arguing that dry needling is different than acupuncture, is safe, is allowed in other
16 states, and by the Washington Board of Naturopathy. None of these points are relevant,
17 however, to the key question of whether the *Washington* Legislature intended to authorize
18 the insertion of acupuncture needles within the *physical therapy* scope of practice.

19 Defendants admit that, “Washington's Physical Therapy Practice Act makes no
20 mention of dry needling...” Def’s SJM at 3. But they suggest that the absence of any
21 mention of dry needling or any act that even generally resembles it, supports that the
22 statute neither “authorizes or prohibits” the insertion of acupuncture needles. *Id.* But this
23 ignores the legal reality that under Washington law, the authority of limited medical
24 license holders to engage in a limited field of practice within the broad “practice of
25 medicine” is restricted to the scope of practice the Legislature has expressly granted.

In absence of any explicit authority to insert acupuncture needles, or a needle by
any other name for the purpose of dry needling, Defendants offer an illogical

1 interpretation claiming the text of the physical therapy statute indirectly includes the
2 authority to insert acupuncture needles. Def’s SJM at 14-20. They argue that the
3 reference in RCW § 18.74.010(8) to "physical agents or modalities" and "mechanical
4 modalities" means that physical therapy includes use of “any physical or mechanical
5 technique” and is thus virtually without limit. Def’s SJM at 17 (emp. added). Defendants
6 cannot cite to a single case to support this strained interpretation and they ignore a long
7 history of cases rejecting attempts to inflate vague medical scopes of practice terms into
8 the right to engage in an invasive act. *State v. Lydon*, 170 Wash. 354, 366 (1932).

9 Defendants also fail to explain the fact the relevant legislative history supports
10 that the Legislature had no intent to include the right to invasively insert acupuncture
11 needles as part of the physical therapy scope when they adopted it in 2005. Defendants
12 instead raise the red herring that Plaintiff’s case is really a challenge to administrative
13 regulations adopted by the Department of Health’s Physical Therapy Board (“PT Board”)
14 at WAC 246-915-185(1). But Plaintiff is clearly not challenging WAC 246-915-185(1)
15 or any other administrative action. Plaintiffs bring this action under the explicit authority
16 in RCW § 18.130.190(6) to seek injunctive relief against Defendants who are practicing
17 medicine and acupuncture without a required license.

18 Finally, Defendants re-raise their same motion to stay the case that the court
19 already denied on May 8, 2014. The motion continues to be without merit.

20 II. ARGUMENT

21 **A. The Washington Legislature did not intend the scope of practice for physical** 22 **therapy to include the authority to insert acupuncture needles**

23 1. Washington law must be interpreted to determine the Legislature’s intent

24 The primary task of the court in applying and interpreting Washington statute is
25 “to discern and implement the intent of the legislature.” *City of Olympia v. Drebeck*, 156
Wn.2d 289, 295 (2006) quoting *State v. J.P.*, 149 Wn.2d 444, 450 (2003). “The court’s
fundamental objective is to ascertain and carry out the Legislature’s intent and if the

1 statute's meaning is plain on its face, then the court must give effect to that plain meaning
2 as an expression of legislative intent.” *Dep't of Ecology v. Campbell & Gwinn, L.L.C.*, 146
3 *Wn.2d 1, 9-10 (Wash.2002)*. Similarly, stated, “[w]hen construing a statute the court's
4 purpose is to ascertain and give effect to the intent of the Legislature.” *Addleman v. Bd. of*
5 *Prison Terms & Paroles*, 107 Wn.2d 503, 509(Wash.1986).

6 The plain text of the physical therapy scope of practice as adopted by the
7 Washington Legislature supports that the Legislature did not intend to include the
8 authority to insert acupuncture needles as deep as 4” into human tissue and then attach
9 electrical current to these needles. Ans. ¶ 59, 60; RCW § 18.74.010(8). Washington
10 statute describes the “[p]ractice of physical therapy” as based on “movement science,”
11 “therapeutic exercise,” and “therapeutic massage.” *Id.* The main statutory paragraph⁴
12 describing the physical therapy scope of practice describes physical therapy as:

13 (b) Alleviating impairments and functional limitations in movement by
14 designing, implementing, and modifying therapeutic interventions that
15 include therapeutic exercise; functional training related to balance,
16 posture, and movement to facilitate self-care and reintegration into home,
17 community, or work; manual therapy including soft tissue and joint
18 mobilization and manipulation; therapeutic massage; assistive, adaptive,
19 protective, and devices related to postural control and mobility except as
20 restricted by (c) of this subsection; airway clearance techniques; physical
21 agents or modalities; mechanical and electrotherapeutic modalities; and
22 patient-related instruction. RCW § 18.74.010(8) (emp. added).

23 Consistent with this text, the PT Board explicitly warned the Defendant
24 Kinetacore that, “dry needling is not listed in the scope of practice for Washington
25 physical therapists.” Foster Decl., Ex. 4. The PT Board through its top manager has
similarly explained that, “[n]othing in the physical therapy statutes cited above [RCW §
18.74.010] would authorize a physical therapist to perform trigger point injections or dry
needling.” Foster Decl., Ex. 5. Washington Department of Health (“DOH”) legal counsel

⁴ While RCW 18.74.010(3) also provides some definition of physical therapy the key scope of practice definition is at RCW § 18.74.010(8).

1 has also stated that, “dry needling is essentially acupuncture using different terminology”
2 and explained that, “the Physical Therapy Board has received informal advice from the
3 AGO [Attorney General’s Office] that dry needling is not within the [physical therapy]
4 scope of practice.” *Id.* Foster Decl., Ex. 6, 18. Defendants ignore all of these statements
5 while continuing to hope for some change in position from the PT Board.

6 **2. There is no rational argument that references to “physical agents or
7 modalities; mechanical and electrotherapeutic modalities” reflects a
8 Legislative intent to authorize the insertion of needles for dry needling**

9 There is no rational argument to support Defendant’s claim that references to
10 "physical agents or modalities" and "mechanical and electrotherapeutic modalities" in
11 RCW 18.74.010(8) reflect the Legislature’s intent in 2005, when RCW 18.74.010(8) was
12 adopted, to authorize the insertion of any needle for the purpose of dry needling.

13 Defendants argue that, “[d]ry needling employs solid filiform needles, which are
14 permissible as "physical agents or modalities" and/or "mechanical modalities." Def’s
15 SJM at 17. They further claim that, “a physical or mechanical modality could be any
16 physical or mechanical technique.” Def’s SJM at 17(emp. added).

17 This expansive and interesting interpretation would allow use of “any” physical or
18 mechanical tool. It is flawed, however, because it divorces the terms "physical agents or
19 modalities" and "mechanical modalities" from the statute’s surrounding text and context
20 that defines physical therapy as a “movement science” that depends on:

21 therapeutic exercise; functional training related to balance, posture, and
22 movement...; manual therapy including soft tissue and joint mobilization
and manipulation; therapeutic massage...” RCW § 18.74.010(8)(b).

23 This is at odds with the basic rules that a statutory term should be interpreted
24 consistent with the terms that surround it and the context of the statute. *C.J.C. v.*
25 *Corporation of the Catholic Bishop*, 138 Wn. 2d 699, 708 (Wash. 1999).

The claim that the Legislature intended to include “any physical or mechanical
technique” within the physical therapy scope of practice highlights the fundamental

1 weakness in Defendant’s interpretation. Did the Legislature really intend to authorize
2 physical therapists to use any physical object or any mechanical medical device from a
3 scalpel and hypodermic needle to surgical scissors? Did it mean to authorize physical
4 therapists to stitch wounds or use a surgical knife to remove a tumor? Of course not.
5 Such a reading would lead to exactly the type of illogical result that should be rejected by
6 court. *State v. Stannard*, 109 Wn.2d 29, 36, 742 P.2d 1244 (1987); *State v. Keller*, 98
7 Wn.2d 725, 728, 657 P.2d 1384 (1983). The only plausible interpretation is that the
8 Legislature’s reference to "physical agents" and "mechanical modalities" refers to those
9 mechanical and physical modalities related to “movement science,” as well as,
10 “therapeutic exercise,” “manual therapy” and “therapeutic massage,” but not the invasive
11 insertion of needles or other similar acts. RCW § 18.74.010(8).

12 Relevant case law also undermines the Defendants’ interpretation. The
13 Washington Supreme Court has flatly rejected claims that the statutory authority for
14 “mechanical manipulation” and “mechanotherapy” could be inflated into the right to use
15 invasive procedures such as puncturing the skin. After evaluating the predecessor to the
16 physical therapy statute, the Court rejected the authority of “drugless healers” to penetrate
17 human tissue based on a statute allowing “mechanical manipulation” and
18 “mechanotherapy” explaining:

19 The appellant makes some further contention that his right to practice
20 surgery arises by virtue of his right to practice mechanotherapy and
21 mechanical manipulation. These terms mean simply a remedial treatment
22 consisting of manipulating a part, or the whole, of the body, with the hand
23 or by mechanical means. *In plain English, they mean massage, manually or*
mechanically performed. They certainly do not include the practice of
24 surgery in any form. *State v. Lydon*, 170 Wash. 354, 366 (1932).

25 As explained in Plaintiff’s Summary Judgment Motion, the traditional definition
of surgery includes penetration of the skin with an acupuncture needle. *State v. Wilson*,
11 Wn. App. 916, 917-918 (1974). In that case, the court found chiropractors and
drugless healers lacked authority to practice acupuncture “[s]ince both galvanic

1 acupuncture and the taking of blood samples involve the penetration of human tissue,
2 they likewise constitute surgery,” which was outside the relevant scope of practices. *Id.*

3 Washington courts have consistently required clear and explicit language
4 reflecting a legislative intent to allow a person practicing medicine under a limited
5 license, such as a chiropractor or physical therapist, to invasively penetrate human tissue.
6 *State v. Houck*, 32 Wn. 2d 681, 695 (Wash. 1949) (finding that, “surgery is not included
7 on the list of permissible practices. Drugless healers may engage only in practices
8 permitted by statute.”) In *State v. Houck*, the court rejected an osteopath’s ability to
9 insert a hypodermic needle based on statutory authority for “mechanical and manual,”
10 manipulation explaining that, “[i]n enacting the various laws, the legislature determined
11 that practitioners in all types of healing arts, except physicians and surgeons, should be
12 ‘restricted to their particular method of healing.’ 32 Wn. 2d 681, 695 (Wash. 1949).
13

14 This is consistent with courts’ application of the broad definition of the “practice
15 of medicine” and recognition that “[w]hether actions constitute the practice of medicine
16 is dependent upon the facts and not upon the name of the procedure, its origins, or
17 legislative lack of clairvoyance.” *State v. Pac. Health Ctr., Inc.*, 135 Wn. App. 149, 160-
18 173 (2006). (finding defendants unlawful practiced medicine and acupuncture.)
19

20 **3. References to “physical” and “mechanical” modalities must be read**
21 **in the context of the Physical Therapy Practice Act**

22 The term “mechanical modalities” should be read consistent with the use of the
23 term in RCW § 18.74.010(8)(a), which refers to physical therapy as, “[e]xamining,
24 evaluating, and testing individuals with mechanical, physiological, and developmental
25 impairments, functional limitations in movement, . . .” *State v. Pac. Health Ctr., Inc.*, 135
Wn. App. 149, 159 (2006)(read statutory terms in “context with related provisions and
the statute as a whole.”) The term “mechanical impairments” is used to describe the

1 impairments of physical movement and helps explain the reference to “mechanical
2 modalities,” a paragraph later in 18.74.010(8)(b).

3 The term “mechanical and physical means” in the context of physical therapy and
4 its predecessors refer to the types of treatments expected for physical therapists, such as
5 exercise and massage. *Webster’s Dictionary*, for example, defines physical therapy as,
6 “the treatment of disease, injury, or disability by physical and mechanical means (as
7 massage, regulated exercise, water, light, heat, and electricity).”⁵ The authority to use
8 “physical” and “mechanical” modalities can only rationally be read consistent with this
9 generally understood scope of physical therapy and the Legislature’s description of
10 physical therapy as a “movement science.” RCW § 18.74.010(8).

11 **4. The PT Board’s administrative regulations do not cure Defendants’**
12 **implausible interpretation of the physical therapy scope of practice**

13 While in one paragraph Defendants assert that, “a physical or mechanical
14 modality could be any physical or mechanical technique,” they quickly attempt to
15 mitigate the obvious problem with such an expansive and illogical reading. They try to
16 patch their interpretation by claiming that, “not every physical or mechanical modality is
17 permissible...” citing to the PT Board’s rule WAC 246-915-185.⁶ Def’s SJM at 17, 18.

18 Defendants argue that under WAC 246-915-185 to be “permissible” “a physical
19 or mechanical modality must still be (1) appropriate and reasonable in terms of accepted
20 physical therapy practice, and (2) necessary for the recovery of function by the patient.”
21 Def’s SJM at 17, 18. True enough, but these “[s]tandards for appropriateness of physical
22 therapy care” serve only to clarify treatment that is *within* the statutory scope of practice

23 ⁵ *Webster’s Third New Int’l Dictionary* 1707 (unabridged ed. 2002)

24 ⁶ WAC 246-915-185 states: Standards for appropriateness of physical therapy care. (1) Appropriate,
25 skilled physical therapy treatment is treatment which is reasonable in terms of accepted physical therapy
practice, and necessary to recovery of function by the patient. The use of a nontraditional treatment by itself
shall not constitute unprofessional conduct, provided that it does not result in injury to a patient or create an
unreasonable risk that a patient may be harmed.

1 and cannot be used to justify a *statutory* interpretation that if read alone would be so
2 expansive as to allow practitioners use of virtually any physical or mechanical medical
3 device. Defendants’ need to rely on an *administrative* regulation to lend plausibility to
4 their suggested *statutory* interpretation, highlights its inherent weakness.

5 Furthermore, had the Legislature intended to include such broad authority in the
6 physical therapy statute, the PT Board would lack the legal right to curtail that authority
7 no matter how rational their motivation. *Pannell v. Thompson*, 91 Wn.2d 591, 601
8 (Wash. 1979) (“Administrative rules or regulations cannot amend or change legislative
9 enactments.”); *Dept. of Ecology v. Theodoratus*, 135 Wn.2d 582, 600 (Wash. 1998).

10 As discussed below in Section D(4), while WAC 246-915-185 is not relevant to
11 interpreting RCW § 18.74.010(8)(b), Defendants’ claim that dry needling meets WAC
12 246-915-185’s substantive criteria is also wrong.

13 **B. The narrow and cautious Legislative authorities for physical therapists to engage**
14 **in EMG and sharps debridement highlight Defendants’ flawed interpretation**

15 Defendants brief asserts that, “the practice of physical therapy includes invasive
16 procedures” including electroneuromyographic (“EMG”) examinations and “sharp
17 debridement.” Def’s SJM at 15. But the narrow and highly precautionary manner in
18 which the Legislature approved *and limited* physical therapists’ ability to conduct EMG
19 examinations and basic wound care, *i.e.* sharp debridement, undermines the claim RCW §
20 18.74.010(8)(b) broadly authorizes penetration of the skin with needles.

21 The Legislature in adopting the Physical Therapy Practice Act in 2005 only
22 allowed the removal of dead or “devitalized tissue,” and expressly prohibited “surgical
23 debridement.” RCW § 18.74.010(8)(d); RCW § 18.74.010(12). It allowed physical
24 therapists to practice sharp debridement only, “after consultation with an authorized
25 health care practitioner” and “only upon showing evidence of adequate education and
training as established by rule.” RCW § 18.74.010(8)(d). Accordingly, a physical

1 therapist now needs “[t]wenty hours of mentored sharp debridement training” or
2 comparable training. WAC § 246-915-360. Defendants’ suggestion that 20 hours of
3 training for the type of wound care many parents perform on their children absent any
4 training hardly supports that 27 hours of training is sufficient for the safe insertion of
5 acupuncture needles for dry needling. Def’s SJM at 16.

6 The Legislature included similar restrictions in authorizing physical therapists to
7 conduct EMG examinations, which does not involve any therapeutic treatment, but only
8 the diagnostic testing of neurological function. RCW § 18.74.160(4). Again, the
9 Legislature only authorized EMG examinations after “referral from an authorized health
10 care practitioner,” such as a doctor, and only upon meeting specific training and
11 education requirements adopted by the Board of Physical Therapy. RCW § 18.74.160(4).⁷
12 DOH regulations require “a minimum of four hundred hours of instruction in
13 electroneuromyographic examinations including at least two hundred needle EMG
14 studies under direct supervision from a qualified provider...” WAC § 246-915-370.

15 These cautious and limited approvals stand in radical contrast to the claim that the
16 Legislature at the same time was throwing the physical therapy door open to include “any
17 physical or mechanical technique.” Def’s SJM at 17(emp. added). Furthermore, if the
18 Legislature had intended to so broadly define the physical therapy scope of practice in
19 RCW § 18.74.010(8)(b) it would have had no reason to include any specific
20 authorizations for the practice of EMG or sharp debridement. Contrary to rules of
21 statutory interpretation, the Defendants’ reading would render both the EMG and sharp
22 debridement authorizations without meaning and superfluous. *State ex rel. Evergreen v.*
23 *WEA*, 140 Wn.2d 615, 639 (Wash. 2000); *see also C.J.C. v. Corporation of the Catholic*
24 *Bishop*, 138 Wn.2d 699, 708, 985 (Wash. 1999).

25 **C. Defendants interpretation is contrary to the relevant legislative history**

To the extent there is any question about what the Legislature intended based on

7

1 the language used in RCW § 18.74.010(8)(b) it is resolved by a review of the legislative
2 history. *City of Olympia v. Drebeck*, 156 Wn, 2d 289, 295(Wash. 2006). The legislative
3 history of RCW § 18.74.010(8) clearly supports there was no legislative intent to
4 authorize physical therapists to invasively insert needles for dry needling.

5 The scope of practice for “physical therapy” was adopted by the Legislature in
6 2005 through House Bill 1137 and included both RCW § 18.74.010(8)(b), which includes
7 the references to “physical agents and modalities” and “mechanical modalities,” as well
8 as, the limited authorizations for EMG examinations and sharp debridement. RCW §
9 18.74.160(4); RCW § 18.74.010(8)(d).⁸ In describing the current scope of practice
10 language in RCW § 18.74.010(8), the House Bill Report explained:

11 The general and non-specific description of the practice of physical therapy
12 as applying to any bodily or mental condition is replaced with more specific
13 parameters referencing the practice’s basis in movement science and
functional limitations in movement.

14 Permissible activities are redefined to include:

- 15 • examining patients to determine proper diagnoses and plans for
therapeutic interventions;
- 16 • designing and implementing therapeutic interventions, functional
17 training, manual therapy, therapeutic massage, postural control
18 devices, airway clearance techniques physical agents or modalities,
mechanical and electrotherapeutic modalities, and patient-related
instruction;
- 19 • training and evaluating the function of people wearing orthotic or
20 prosthetic devices;
- 21 • performing wound care services;
- 22 • reducing the risk of injury, impairment, functional limitations, and
disability; and
- engaging in consultation, education, and research.

23 Foster Decl., Ex. 13 (emphasis added). Nothing in the report supports Defendants’ claim
24 that the reference to “physical agents or modalities” or “mechanical modalities” was
25 Legislatively intended to authorize “any physical or mechanical technique” using
acupuncture needles or any other invasive medical device. Def’s SJM at 17(emp. added).

⁸ House Bill 1137, Chapter 501, Laws of 2005, 59th Legislature 2005.

1 This is also supported by the Department of Health analysis prepared for the
2 Legislature that evaluated and made recommendations on the original physical therapy
3 scope of practice bill language. This DOH “Sunrise Review” to the Legislature is
4 required under Washington’s Sunrise Act when a medical profession wishes to expand or
5 change its scope of practice authority. RCW 18.120 *et seq.* DOH’s bill analysis contains
6 nothing to support any intent to allow physical therapists to insert acupuncture needles.⁹
7 Foster Decl., Ex. 14. The DOH reviewed virtually the identical scope of practice
8 language that was ultimately adopted in RCW § 18.74.010(8)(b) and included the same
9 “physical agent” and “mechanical modality” language at issue. The DOH review
10 specifically addressed that the proposed bill would add spinal manipulation and the fitting
11 of orthotics into the scope of practice for physical therapy. Foster Decl., Ex. 14 at 3, 6-9.
12 There is not even a hint that the bill would authorize dry needling or acupuncture.

13 In fact, the only mention of penetrating human skin was DOH’s recommendation
14 that the Legislature remove language in the original draft bill stating, “[a] physical
15 therapist who meets further qualifications as established by rule may penetrate tissue for
16 the purpose of testing neuromuscular performance.” Foster Decl., Ex 13 at Sect. 16(5),
17 House Bill 2183, 1999, (emphasis added). While the Legislature did ultimately authorize
18 EMG examinations in the final bill language, it removed the “may penetrate tissue”
19 language from the final bill. RCW § 18.74.010(8)(b).

20 **D. Neither the PT Board’s rulemaking authority nor its regulations at WAC 246-**
21 **915-185(1) undermine Plaintiff’s claim**

22 **1. The PT Board general rulemaking authority does not pre-empt the**
23 **court’s ability to rule on the meaning of the physical therapy statute**

24 Defendants argue that “[t]he Legislature delegated to the Board the power to
25 determine whether particular procedures are within the scope of physical therapy.” Def’s
SJM at 11. Relying on RCW 18.74.023(6), which describes the PT Board’s general rule

9 DOH’s 1999 Sunrise Review considered the virtually identical scope of practice language that the
Legislature ultimately passed in 2005 as RCW § 18.74.010(8)(b). Foster Decl., Ex. 15

1 making authority, Defendants further claim that, “[w]here a question arises on the
2 appropriateness of a particular procedure, and whether that procedure may be used by
3 physical therapists, the Board is charged with making that determination.” *Id.*
4 Defendants appear to claim that the PT Board’s general rule making authority somehow
5 pre-empts the court’s ability to interpret and apply the physical therapy scope of practice
6 in RCW § 18.74.010(8)(b) under the UDA. Def’s SJM at 10-11.

7 But there are two major problems with this assertion. First, while the PT Board
8 can certainly adopt rules that help explain or clarify statutory provisions codified by the
9 Legislature, this does not somehow prohibit a court from enforcing a given statute
10 without additional regulation from the PT Board. No provision of Washington law
11 supports such a notion and Defendants cite to none.

12 Second, as supported by the most fundamental principle of administrative law, the
13 PT Board does not have authority to expand the scope of practice beyond what has been
14 defined by the Legislature. *Dept. of Ecology v. Theodoratus*, 135 Wn.2d 582, 600 (Wash.
15 1998). Even the PT’s Board’s rulemaking makes clear that the Board’s power is only,
16 “[t]o adopt rules not inconsistent with the laws of this state...” RCW 18.74.023(6).

17 This is exactly the dynamic that played out earlier this year when the Oregon
18 Court of Appeals rejected the Oregon Board of Chiropractic Examiners attempt to adopt a
19 rule to expand their scope of practice to include dry needling. *Or. Ass’n of Acupuncture
20 & Oriental Med. v. Bd. of Chiropractic Examiners*, 260 Ore. App. 676 (2014). Even after
21 recognizing the general deference an administrative agency would receive when adopting
22 rules, the court rejected the chiropractic board’s claim that dry needling was within the
23 scope of practice for “physiotherapy,” which is synonymous with “physical therapy.” *Id.*
24 at 679. If physical therapists in Washington want to expand their scope of practice it is an
25 issue for the Legislature and not an administrative agency. Washington courts have made
clear that those practicing what are claimed to be novel health care modalities that fall
within the statutory definition of medicine or acupuncture must be licensed to practice

1 medicine or acupuncture. *State v. Pac. Health Ctr., Inc.*, 135 Wn. App. 149, 160-173
2 (2006). As the court explained in finding “electrodermal testing (EDT),” constituted the
3 practice of medicine and acupuncture, “[e]ven if EDT as a separately licensed, or even
4 unregulated, health care modality is indeed an idea whose time has come, we must leave
5 that decision to the legislature.” *Id.* at 168.

6 **2. Courts are accustomed to interpreting scope of practice statutes**

7 Defendants frame this case as one of “first impression” suggesting that courts
8 have not been asked to determine “whether a particular procedure is within the scope of
9 that profession's practice.” Def’s SJM at 9. It is true that no Washington court has
10 reviewed whether dry needling was within the physical therapy scope of practice. But
11 Washington courts have ruled for almost a century on whether specific procedures were
12 within the scope of practice statutes for various medical fields since Washington’s
13 medical practice statutes were first passed. *State v. Bonham*, 93 Wash. 489, 500 (1916)
14 (osteopaths could not remove tonsils); *State v. Lydon*, 170 Wash. 354, 16 P.2d 848
15 (1932)(drugless healers could not practice surgery); *In re: Stockwell*, 28 Wn. App. 295,
16 302 (1981) (chiropractors could not dispense vitamins).

17 That the current action is brought by Plaintiff on behalf of the state as allowed by
18 the Uniform Disciplinary Act (“UDA”) does not change the fact that Washington courts
19 are no strangers to the role of addressing whether a certain act falls within the statutory
20 scope of practice for a given medical profession. RCW § 18.130.190(6).¹⁰

21 **3. Plaintiffs are not challenging WAC 246-915-185(1)**

22 Defendants attempt to mischaracterize Plaintiff’s case claiming that, “[a]pparently
23

24 ¹⁰ (6) The attorney general, a county prosecuting attorney, the secretary, a board, or any person may in
25 accordance with the laws of this state governing injunctions, maintain an action in the name of this state to
enjoin any person practicing a profession or business for which a license is required by the chapters specified
in RCW 18.130.040 without a license from engaging in such practice or operating such business until the
required license is secured. However, the injunction shall not relieve the person so practicing or operating a
business without a license from criminal prosecution therefor, but the remedy by injunction shall be in
addition to any criminal liability.

1 SSAA seeks to challenge the administrative regulation WAC 246-915-185(1) which
2 describes, “[s]tandards for appropriateness of physical therapy care,” and states that,
3 “[a]ppropriate, skilled physical therapy treatment is treatment which is reasonable in
4 terms of accepted physical therapy practice, and necessary to recovery of function by the
5 patient.” Based on this the Defendants extrapolate that Plaintiff’s case is a challenge to
6 WAC 246-915-185(1) and “seeks an end run around the APA and violates well-
7 established Washington law.” Def’s SJM at 10. They fail, however, to back up the
8 charge with any legal citation let alone a clear explanation.

9 Defendants’ argument is a confusing distraction from the real legal question at
10 issue of whether the Legislature intended to authorize the insertion of acupuncture
11 needles as a part of the physical therapy scope of practice. As an administrative
12 regulation, WAC 246-915-185(1) is irrelevant to determining the Legislature intent of
13 RCW § 18.74.010(8)(b). Furthermore, Plaintiffs complaint does not even cite to, let alone
14 challenge or seek relief in any way directed at WAC 246-915-185(1). Plaintiff similarly
15 is not challenging any action or inaction of the PT Board that would constitute an
16 “administrative action” under the Washington Administrative Procedures Act.

17 Plaintiff’s claims are squarely based on the specific statutory authority under the
18 Uniform Disciplinary Act (“UDA”). RCW § 18.130.190(6). The UDA allows “any
19 person” including Plaintiff, to bring a legal action “to enjoin any person practicing a
20 profession or business for which a license is required by the chapters specified in RCW
21 18.130.040 without a license from engaging in such practice or operating such business
22 until the required license is secured.” RCW § 18.130.190(6).¹¹ The practices of
23

24 ¹¹ (6) The attorney general, a county prosecuting attorney, the secretary, a board, or any person may in
25 accordance with the laws of this state governing injunctions, maintain an action in the name of this state to
enjoin any person practicing a profession or business for which a license is required by the chapters specified
in RCW 18.130.040 without a license from engaging in such practice or operating such business until the
required license is secured. However, the injunction shall not relieve the person so practicing or operating a
business without a license from criminal prosecution therefor, but the remedy by injunction shall be in
addition to any criminal liability.

1 medicine, physical therapy and acupuncture/East Asian Medicine are all specifically
2 included as professions within RCW 18.130.040 and persons engaging in conduct that
3 constitutes the unlicensed practice of these professions are therefore subject to
4 enforcement actions under the UDA. RCW 18.130.040(2)(a)(6), (b)(ix),(x).

5 **4. Dry needling does not meet the substantive criteria in WAC 246-915-185(1)**
6 **even if it was somehow relevant**

7 Defendants also attempt to argue dry needling is within their scope of practice
8 because it meets the “[s]tandards for appropriateness of physical therapy care” included
9 at WAC 246-915-185(1). Again, the premise for this argument is flawed because it
10 assumes that an administrative regulation could somehow authorize practices that are
11 outside the *statutory* scope of practice. But nonetheless, dry needling does not meet the
12 criteria in WAC 246-915-185(1) because dry needling is not “appropriate and
13 reasonable” and does create “an unreasonable risk that a patient may be harmed.” That
14 said, both criteria involve genuine disputed issues of fact and are inappropriate to decide
15 on summary judgment. *Hartley v. State*, 103 Wn.2d 768, 774 (1985).

16 **a. Dry needling is not “appropriate and reasonable” under Washington law**

17 Defendants claim that pursuant to WAC 246-915-185(1) dry needling is
18 “reasonable in terms of accepted physical therapy practice.” Def’s SJM at 17-20. But the
19 insertion of acupuncture needles or any needle for dry needling cannot be “appropriate
20 and reasonable” in Washington, because it is outside the scope of practice the Legislature
21 defined in RCW § 18.74.010(8)(b) and 18.74.010 (3).

22 Additionally, the PT Board has explained plainly that, “[n]othing in the physical
23 therapy statutes cited above [RCW § 18.74.010] would authorize a physical therapist to
24 perform trigger point injections or dry needling.” Foster Decl., Ex. 5. The PT Board also
25 explicitly warned Defendants that, “dry needling is not listed in the scope of practice for
Washington physical therapists.” Foster Decl., Ex. 4. Legal counsel for DOH has
similarly explained that, “dry needling is essentially acupuncture using different

1 terminology” and recognized that “the Physical Therapy Board has received informal
2 advice from the AGO [Attorney General’s Office] that dry needling is not within the
3 [physical therapy] scope of practice.” Foster Decl., Ex. 6, 18.

4 The fact that physical therapy professional associations charged with advocating
5 for the economic interests of physical therapists endorse dry needling hardly makes it an
6 appropriate or reasonable practice under Washington law. The fact that physical therapy
7 boards in some other states may have endorsed dry needling by administrative rule is
8 similarly irrelevant in light of current Washington law. While some states have approved
9 dry needling by physical therapists, others such as Tennessee, which has the virtually
10 identical statutory definition of acupuncture, has explicitly rejected claims that the
11 statutory reference to “physical agents and modalities” and “mechanical modalities”
12 authorized dry needling. Foster Sec. Decl. at Ex. 19. A Tennessee Attorney General
13 opinion explained, “nothing in subdivision 103(15)(B) clearly indicates a legislative intent to
14 include within the practice of physical therapy the invasive use of needles for therapeutic
15 purposes.” *Id.* Dry needling has also been found to be outside the practice of physical therapy
16 in states such as Illinois, Utah, and South Dakota. *Id.*

17 While not necessary to legally determine, it is instructive, however, that any
18 physical therapist purchasing acupuncture needles for dry needling does so in violation of
19 the U.S. Food and Drug Administration’s prescription warning language regarding
20 acupuncture needles legally sold in the United States today. Defendants’ do not dispute
21 that even the acupuncture needles they use contain the FDA-required warning stating:

22 Caution: Federal law restricts this device to sale by or on the order of
23 qualified practitioners of acupuncture as determined by the States.
24 Declaration of Brent Foster (“Foster Decl.”), Ex. 1 (emphasis added).

25 A photo of the box of acupuncture needles Defendants provided Plaintiff in
response to discovery includes this very language. Foster Second Decl. at Ex. 20 (this
exhibit is a replacement exhibit provided by Defendants and included originally at

1 Exhibits 1 to the first Foster Decl. but which was not well reproduced).

2 That dry needling can only be practiced by physical therapists willing to violate
3 the express FDA directives on acupuncture needles further undermines the notion that dry
4 needling is either “appropriate” or “reasonable.” As explained in Plaintiff’s Motion for
5 Summary Judgment, this restricted medical device limitation was required by FDA when
6 it regulated acupuncture needles as a Class II medical device and specifically defined
7 acupuncture needles as, “a device intended to pierce the skin in the practice of
8 acupuncture” and “to facilitate the delivery of acupuncture treatment.” 21 CFR §
9 880.5580(a). Foster Decl. at 3.

10 FDA has stated in no uncertain terms that the sale of acupuncture needles “must
11 be clearly restricted to qualified practitioners of acupuncture as determined by the
12 States.” 61 Fed. Reg. 64616 (Dec. 6, 1996) (emphasis added); 21 CFR § 880.5580(b)(1);
13 21 CFR § 801.109, provided in Ex. 3 to Foster Decl. As FDA explained, the reason it
14 restricted sales to qualified practitioners of acupuncture was that, “FDA believes that
15 information for use, including: Indications, effects, routes, methods, and frequency and
16 duration of administration; and any hazards, contraindications, side effects, and
17 precautions are commonly known to qualified practitioners of acupuncture.” *Id.*
18 Defendants do not attempt to explain the restrictive FDA language on acupuncture needle
19 packaging, the definition of an acupuncture needle in 21 CFR § 880.5580(a) or FDA’s
20 directive that acupuncture needles “must be clearly restricted to qualified practitioners of
21 acupuncture as determined by the States.” 61 Fed. Reg. 64616 (Dec. 6, 1996).

22 Defendants cite only to FDA’s general model language for FDA’s prescription
23 medical devices in 21 CFR 801.109(b)(1) which serve as the basis for FDA’s prescriptive
24 use warnings on medical devices. Def’s SJM at 13. Based on this model language
25 Defendants argue that, “the determination of which health care professionals may use the
device within the scope of their practice is explicitly and clearly left to the states.” *Id.*
While states can define who is a “qualified practitioner of acupuncture,” nothing in

1 FDA's regulations supports the notion that a state can allow sale of acupuncture needles
2 to persons who themselves strongly assert they are not practicing acupuncture.

3 **b. Dry needling creates unreasonable risks of patient harm**

4 Defendants also contend that even as a non-traditional practice, dry needling is
5 consistent with WAC 246-915-185(1), "it does not result in injury to a patient or create
6 an unreasonable risk that a patient may be harmed" and is therefore legal. Def's SJM at
7 19. Defendants make factual arguments claiming "[d]ry needling is a very low-risk
8 procedure." Def's SJM at 20. These claims raise significant questions of fact that cannot
9 be decided on summary judgment. CR 56(c).

10 While the expansion of dry-needling by physical therapists is a relatively recent
11 occurrence and tracking data for dry-needling injuries is poor, there are significant factual
12 bases for concern about dry needling risks. First, it is telling that in addition to extensive
13 course work, a person must have received at least 500 hours of "supervised clinical
14 training" before they can legally practice acupuncture in Washington. WAC 246-803-
15 230. Of this "[a]t least four hundred hours must be patient treatment." *Id.* There is no
16 basis for believing this requirement for hands on clinical experience is excessive or
17 unnecessary and stands in great contrast to the mere 27 hours of training Defendants
18 suggest is sufficient to safely engage in the same act of inserting acupuncture needles as
19 deep as 4" into patients. Such a minimum training level has never been found to be safe
20 by the PT Board and at least one PT Board member had made clear she does not believe
21 the training is sufficient. Dingle Decl. at ¶¶ 3-4.

22 Testimony by multiple experts with decades of experience in the risks related to
23 the insertion of acupuncture needles strongly supports that 27 hours of training is entirely
24 insufficient to be able to convey the practical skills needed to safely use acupuncture
25 needles over the long-term. Decl. of Dr. David Miller, ¶ 15-17; Decl. of Fujio
McPherson, ¶ 13-16; Decl. of Ted Priebe, ¶ 19; Second Decl. of Daniel Dingle.
Furthermore, under Defendants interpretation of RCW § 18.74.010(8)(b) there would not

1 be *any specific* minimal training requirement for dry needling training in Washington
2 since dry needling would be authorized outright under statute. This is important since
3 physical therapists are not required to demonstrate *any* proficiency with the safe use of
4 acupuncture needles as a condition of obtaining a physical therapy license. RCW
5 18.74.035. Additionally, while some physical therapy schools offer a dry needling course,
6 training in the safe use of acupuncture needles is not required as a condition of graduation
7 in any Washington physical therapy school. Decl. of Dr. McPherson at ¶ 16.

8 While there is no good publicly available tracking system to analyze injuries
9 caused by dry needling some high profile injuries highlight the basis for concern. In just
10 the last year, Olympic athlete Torin Yater-Wallace had his lung punctured by a Colorado
11 physical therapist performing dry needling. Foster Decl., Ex. 10. This follows an earlier
12 lung puncturing injury to another Olympic athlete during a dry needling session. Foster
13 Decl., Ex. 11.

14 Again, the issue of whether a physical therapist with 27 hours of training or no
15 training, could safely insert acupuncture needles is a factual issue that cannot be decided
16 on summary judgment. Defendants have not met their burden to prove there are no
17 genuine issues of fact to support their motion for summary judgment. *Hartley v. State*,
18 103 Wn.2d 768, 774 (1985). The issue, however, need not be decided since the text of
19 RCW § 18.74.010(8)(b) clearly does not include authority to insert acupuncture needles
20 regardless of any debate over what such risks might entail.

21 **E. There is a significant factual dispute regarding whether dry needling constitutes**
22 **acupuncture that cannot be decided on summary judgment**

23 Defendants' argument that dry needling is different and distinct from the practice
24 of acupuncture is factually inaccurate, and any determination on this dispute is clearly
25 factual and cannot be decided on summary judgment. CR 56(c). Defendants nonetheless
depend on the declaration testimony of multiple physical therapists, none of whom are
knowledgable, qualified practitioners of acupuncture, to argue that dry needling is

1 fundamentally distinct from acupuncture. They assert without even a general citation that,
2 “acupuncture is based upon the Chinese spiritual concepts of Chi and vital life energy.
3 Needles are placed into the skin along meridians though which Chi flows. Acupuncturists
4 believe that changing the flow of Chi creates a balance of yin and yang.” Def SJM, at 4.

5 This almost cartoonish explanation of acupuncture is factually incorrect, and
6 Defendants belief that dry needling is different from acupuncture stems from a lack of
7 knowledge regarding the historical development of acupuncture and the language used to
8 describe it. Acupuncture is a medical practice that began over 2,000 years ago, has
9 continually evolved over time, and has always been a physically-based medicine
10 grounded in the scientific methods of the time. Decl. of Dr. David Miller, ¶¶ 10-14;
11 Decl. of Fujio McPherson, ¶¶ 9-11; Decl. of Ted Priebe, ¶¶ 5-16; Second Decl. of Daniel
12 Dingle, ¶¶ 10-14.

13 As a starting point, the defendants agree that dry needling is based on the use of
14 acupuncture needles. Ans. ¶ 14; Kinetacore Resp. to Inter. No. 5 at 9. While Defendants
15 like to refer to these needles as “solid filiform needles,” this does not change the fact they
16 are a unique and specific medical device intended to easily pierce the skin and be inserted
17 in muscle for acupuncture. Defendant’s claim that, “[t]he only similarity between the two
18 techniques is utilization of solid filiform needles.” Def’s SJM at 4. They assert that while
19 dry needling targets “trigger points,” which they define as tender or sore points on the
20 body, acupuncture inserts needles “into the skin along meridians though which Chi
21 flows.” *Id.*

22 The Oregon Medical Board has specifically rejected Kinetacore’s claims that dry
23 needling is somehow distinct from acupuncture explaining:

24 acupuncture and dry needling use the same tool (acupuncture needle), the
25 same points, the same purpose (treating pain), and the same needling
techniques. This is why the Oregon Medical Board and its acupuncture
committee voted that “dry needling” is the practice of acupuncture. Foster
Sec. Decl. at Ex. 21.

1 While acupuncture points can certainly include “meridians”, they have for over
2 2,000 years also included the very tender or sore points dry needlers refer to as “trigger
3 points.” Decl. of Dr. Miller, ¶ 11-13; Decl. of McPherson, ¶ 13-16; Decl. of Priebe, ¶¶
4 13-14; Second Decl. of Dingle, ¶¶ 10-14. These points are known as “ashi points” and
5 their locations are not necessarily located on a meridian. Decl. of Dr. Miller, ¶ 12; Decl.
6 of Ted Priebe at ¶13; This is supported in published medical studies that have found
7 nearly complete correlation between “trigger points” and “acupuncture points.” Decl. of
8 Dr. Miller, ¶ 13. As supported by the attached declarations from Dr. Miller, a longtime
9 medical doctor and acupuncturist who has also received dry needling training, Dr.
10 McPherson, and longtime medical practitioners Mr. Priebe, and Dingle, there is strong
11 factual evidence that dry needling is not distinct from acupuncture, and there is certainly
12 enough evidence to deny Defendants motion for summary judgment, to whatever extent
13 their motion depends on this distinction. Decl. of Dr. Miller; Decl. of McPherson; Decl.
14 of Priebe, ¶¶ 13-14; Second Decl. of Dingle, ¶¶ 9-15.

15 **7. Defendants hope for some future action by the PT Board does not justify a stay**

16 Defendants obviously hope that the PT Board will at some point in the future take
17 some unspecified administrative action to find that dry needling is within the physical
18 therapy scope of practice. Def’s SJM at 11. Defendants made the same arguments six
19 months ago that they make again in their brief, suggesting that some definitive action by
20 the PT Board is imminent. Defendants’ brief surprisingly asserts that “[i]n the official PT
21 Board meeting minutes prepared for February 10, 2014, the Board began the process of
22 rulemaking regarding dry needling and the practice of physical therapy.” Def’s SJM at
23 11(emp. added). This is completely false as the Board’s minutes clearly confirm. Foster
24 Sec. Dec. at Ex 22. The PT Board meeting minutes simply reflect that the board
25 discussed dry needling and that rulemaking *was one of multiple options* the Board
considered along side with, “getting an Attorney General formal opinion,” “decide it is
not within their scope of practice,” or “table until the next meeting.” *Id.* Defendants

1 request to stay the case lacks merit for the same reasons already well articulated in
2 Plaintiff's Opposition to the Motion to Stay and Plaintiff incorporates those arguments
3 here.

4 **III. CONCLUSION**

5 For the reasons above, the court should deny Defendant's motion to stay and
6 request for summary judgment, and grant Plaintiff's Motion for Summary Judgment.

7
8 DATED this 29th day of September, 2014.

9
10 _____s/ Jason T. Leehan_____
11 **CRANE DUNHAM PLLC**
12 s/ Jason T. Leehan
13 s/ Stephen J. Crane
14 WSBA No. 42463
15 2121 Fifth Ave
16 Seattle, WA 98121
17 206-292-9090
18 scrane@cranedunham.com
19 jleehan@cranedunham.com

20 **LAW OFFICES OF BRENT FOSTER**
21 s/ Brent Foster, Pro Hac Vice
22 Oregon Bar No. 99263
23 1767 12th Street #248
24 Hood River, OR 97031
25 (541) 380-1334
foster.brent@ymail.com
Attorneys for Plaintiff

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING

STATE OF WASHINGTON *ex rel.*
SOUTH SOUND ACUPUNCTURE
ASSOCIATION, a State of
Washington non-profit corporation,

Plaintiff,

vs.

KINETACORE, a Colorado LLC doing
business in the State of Washington; **EDO
ZYLSTRA**, CEO and owner of
Kinetacore; **KERI MAYWHORT**, a
Kinetacore instructor; **EMERALD
CITY PHYSICAL THERAPY
SERVICES LLC** doing business as
**SALMON BAY PHYSICAL THERAPY
LLC**, a limited liability company; **JOHN
DOES 1-10**; and **JANE DOES 1-10**.

ORIGINAL

NO. 13-2-04894-9 SEA

**ORDER FOR PARTIAL SUMMARY
JUDGMENT**

This matter came before the Court upon Plaintiff's Motion for Partial Summary
Judgment and Defendants Motion for Summary Judgment which the parties argued before the
Court on October 10th, 2014.

The Court has reviewed and considered the following:

1. Plaintiff's Motion for Partial Summary Judgment, and the declarations from Brent
**ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 1**

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE,
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

- 1 Foster and Daniel Dingle and all supporting exhibits;
- 2 2. Defendants' Motion for Summary Judgment and supporting declarations and
- 3 exhibits;
- 4 3. Plaintiffs Response to Defendants' Motion for Summary Judgment and supporting
- 5 declarations and exhibits;
- 6 4. Defendants Response to Plaintiff's Motion for Partial Summary Judgment and
- 7 supporting declarations and exhibits;
- 8 5. Plaintiffs Reply to Defendants' Response to Plaintiffs' Motion for Partial Summary
- 9 Judgment and supporting declarations and exhibits;
- 10 6. Defendants Reply to Plaintiff's Response to Plaintiffs' Motion for Partial Summary
- 11 Judgment and supporting declarations and exhibits;
- 12 7. The parties' oral arguments before the court;

13 Based on the foregoing, and after consideration of the standard in Civil Rule 56,
14 NOW THEREFORE IT IS HEREBY ORDERED that Plaintiff's Motion for Partial Summary
15 Judgment is GRANTED and Defendants Motion for Summary Judgment is DENIED. It is
16 further declared that:

17 A. A person that "penetrates the tissues of human beings" with an acupuncture
18 needle or any other needle for purpose of "dry needling" or any similar named
19 act ("dry needling") is practicing medicine under the statutory definition
20 provided at RCW § 18.71.011(3) and is prohibited absent a physicians license
21 as required by RCW § 18.71.021; *or other statutory authority;*

22 B. ~~There is no factual dispute that defendants are not licensed physicians but have~~
23 ~~penetrated the tissues of human beings with acupuncture needles during the~~
24 ~~Kinetacore workshop and subsequent to the workshop and describe such acts as~~

25 ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 2

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE,
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 "dry needling;"

2 C. The penetration of human tissue with an acupuncture needle or any similar needle
3 used for dry needling is outside the plain text of the authorized scope of practice
4 for physical therapy as adopted by the Washington Legislature in RCW §
5 18.74.010(8);

6 D. The plain text of the physical therapy statute, applicable case law, and the
7 legislative history of RCW § 18.74.010(8) each support that there was no
8 legislative intent to authorize physical therapists to insert acupuncture needles
9 into human tissue for the purpose of dry needling or any similar purpose;

10 E. As such, physical therapists are not exempt from the requirement for a
11 physicians license pursuant to RCW § 18.71.030(4) prior to the penetration of
12 human tissue with acupuncture needles or similar needles.

13 F. Unless otherwise specifically authorized to practice acupuncture under another
14 professional licensures, such as a physician or practitioner of East Asian
15 Medicine, a licensed physical therapists lacks the legal authority to penetrate
16 human tissue with acupuncture needles, or any similar needle, for the purpose
17 of dry needling. Such act constitutes the unauthorized practice of medicine
18 which is prohibited under Washington statute. RCW § 18.71.021; RCW §
19 18.71.011(3).

20
21
22 It is further declared that:

23 6. Defendants are hereby enjoined from inserting acupuncture needles or any similar
24 needles for the purpose of dry needling in the State of Washington;

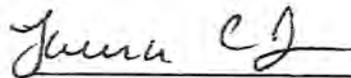
25 ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 3

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE,
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 H. Defendant Kinetacore is hereby enjoined from holding any workshops, classes or
2 similar trainings in the State of Washington that involve ~~any~~ ^{conducting} penetration of human
3 tissue with acupuncture needles or similar needles by physical therapists that lack
4 the legal authority to penetrate human tissue pursuant to the findings above.

5 E. _____
6 _____
7 _____
8 _____

9
10 Dated this 10 day of October, 2014.

11
12
13  _____

14 _____
15 C. Inveen The Honorable Laura

16 Presented by:

17 **CRANE DUNHAM PLLC**

18 s/ Jason T. Leehan

19 s/Stephen J. Crane

20 WSBA No. 42463

21 2121 Fifth Ave

22 Seattle, WA 98121

23 206-292-9090

24 scrane@cranedunham.com

25 jleehan@cranedunham.com

LAW OFFICES OF BRENT FOSTER

s/ Brent Foster, Pro Hac Vice

Oregon Bar No. 99263

Attorneys for Plaintiff

ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 4

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE,
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736



Illinois Department of Financial and Professional Regulation

Office of Legal Affairs

PAT QUINN
Governor

Manuel Flores
Acting Secretary

Richard DiDomenico
General Counsel

April 25, 2014

The Department's mission is to protect and promote the lives of Illinois consumers. With that goal in mind, the Department, through its legal counsel, considered whether Intramuscular Manual Therapy or Dry Needling is within the scope of practice of physical therapy. Due to the fact that the scope of practice for physical therapists is extremely broad, the Department reviewed both the Physical Therapy Act and the Acupuncture Practice Act. After careful consideration, it is the Department's informal opinion that Intramuscular Manual Therapy or Dry Needling does not fall within the scope of practice of physical therapy.

The main reason for this opinion is that all procedures listed in the Physical Therapy Act are non-invasive procedures. 225 ILCS 90.1 (B) states in part that physical therapy includes the evaluation or treatment of a person through the use of the effective properties of physical measures and heat, cold, light, water, radiant energy, electricity, sound, and air and use of therapeutic massage, therapeutic exercise, mobilization, and rehabilitative procedures, with or without assistive devices.

In comparison, the Acupuncture Practice Act clearly refers to treatment using needles breaking the skin, an invasive procedure. 225 ILCS 2/10 states in part that acupuncture means the evaluation or treatment of persons affected through a method of stimulation of a certain point or points on or immediately below the surface of the body by the insertion of pre-sterilized, single-use, disposable needles, unless medically contraindicated, with or without the application of heat, electronic stimulation, or manual pressure to prevent or modify the perception of pain, to normalize physiological functions of the body... Furthermore, Section 114.30 requires the successful completion of a Clean Needle Technique course and 660 hours of clinical training. 250 of the 660 hours must consist of student-performed treatment. The Acupuncture Practice Act clearly defines the standards of practice in place to perform procedures using needles.

The concern of the Department is there are no standards of practice in place for physical therapists to perform Intramuscular Manual Therapy or Dry Needling. To be included in the scope of practice, the Physical Therapy Practice Act would need to clarify the entry-level education required to perform dry needling as well as the continuing education requirement. Without specific standards of practice in place, the Department has concerns about the ability of physical therapists to competently and safely perform Intramuscular Manual Therapy or Dry Needling.

Please be advised that this letter is intended only as an informal statement reflecting the interpretation of the Department, as the Office of the Attorney General is the only office that may render official opinions regarding statutory interpretation.

Lisa A. Wade, Associate General Counsel



Oregon

John A. Kitzhaber, MD, Governor

Medical Board

1500 S.W. 1st Ave., Suite 620
Portland, OR 97201
Voice (971) 673-2700
FAX (971) 673-2670
Web: www.oregon.gov/OMB

December 7, 2011

Executive Director
Health Professional Regulatory Board

Re: Chiropractic "Dry Needling" Rule and Visiting Acupuncturists

Dear Executive Director:

In July, the Oregon Court of Appeals issued an Order suspending the practice of "dry needling" by chiropractors in the state of Oregon.

The Oregon Board of Chiropractic Examiners (OBCE) adopted an administrative rule on "dry needling" in June 2011. The acupuncturist association then challenged the rule in the Court of Appeals. The Court found that the association is "reasonably likely to prevail on judicial review" because "it appears, dry needling is substantially the same as the insertion of needles treatment modality of acupuncture."

The Order Staying the Administrative Rule remains in effect until the Court reviews the OBCE's authority to adopt a rule regulating the practice of "dry needling."

The Oregon Medical Board (OMB) regulates the practice of acupuncture. Further, any practitioner visiting the state of Oregon to demonstrate acupuncture must be approved by the OMB at least two weeks prior to the seminar, conference, or workshop where the demonstration will occur. (See OAR 847-070-0033)

It has come to the OMB's attention that "dry needling" classes have been advertised as being offered in Oregon to various licensed health professionals. These classes are advertised for both initial certification in "dry needling" and for continuing education credits. Neither these courses nor their instructors have been approved by the OMB.

Any questions regarding the legal status of "dry needling" or the OMB's requirements for practitioners demonstrating acupuncture within our state may be directed to the OMB at (971) 673-2700.

Sincerely,

Kathleen Haley, JD
OMB Executive Director

**STATE OF TENNESSEE
OFFICE OF THE ATTORNEY GENERAL**

June 19, 2014

Opinion No. 14-62

Trigger-Point Dry Needling and the Practice of Physical Therapy

QUESTION

Is Intramuscular Manual Therapy (“IMT”), also known as Trigger-Point Dry Needling, within the scope of the practice of physical therapy under the Occupational and Physical Therapy Practice Act, Tenn. Code Ann. §§ 63-13-101 to -318?

OPINION

No.

ANALYSIS

Under the Occupational and Physical Therapy Practice Act, “practice of physical therapy” means:

(A) Examining, evaluating and testing individuals with mechanical, physiological and developmental impairments, functional limitations and disability or other health and movement-related conditions in order to determine a physical therapy treatment diagnosis, prognosis, a plan of therapeutic intervention and to assess the ongoing effect of intervention;

(B) Alleviating impairments and functional limitations by designing, implementing, and modifying therapeutic interventions that include, but are not limited to, therapeutic exercise, functional training, manual therapy, therapeutic massage, assistive and adaptive orthotic, prosthetic, protective and supportive equipment, airway clearance techniques, debridement and wound care, physical agents or modalities, mechanical and electrotherapeutic modalities and patient-related instruction;

(C) Reducing the risk of injury, impairments, functional limitation and disability, including the promotion and maintenance of fitness, health and quality of life in all age populations; and

(D) Engaging in administration, consultation, education and research[.]

Tenn. Code Ann. § 63-13-103(15). IMT, or “dry needling,” involves the application of a fine, filiform needle to the neuromusculoskeletal system to restore movement, reduce pain, and address other musculoskeletal disorders.¹ Dry needling must therefore be regarded as a therapeutic intervention, but it is not listed among the therapeutic interventions identified in § 63-13-103(15)(B). Although that list is not exclusive, and includes “manual therapy,” “physical agents and modalities,” and “mechanical and electrotherapeutic modalities,” nothing in subdivision -103(15)(B) clearly indicates a legislative intent to include within the practice of physical therapy the invasive use of needles for therapeutic purposes. *See Tidwell v. Collins*, 522 S.W.2d 674, 676 (Tenn. 1975) (“The premier rule of statutory construction is to ascertain and give effect to the legislative intent.”). Furthermore, while there are no doubt distinctions to be drawn between the two, dry needling’s obvious similarity to acupuncture cannot be ignored, and physical therapists may not perform acupuncture, which is a branch of medicine. *See* Tenn. Code Ann. § 63-6-1002(a), (b).

Under Tenn. Code Ann. § 63-6-1001(7), “‘practice of acupuncture’ means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based on oriental medical diagnosis as a primary mode of therapy.” In 2005, this Office opined, precisely because acupuncture is regarded as a branch of medicine, that chiropractors may not practice a treatment modality that uses the insertion of needles to bring about the same result. *See* Tenn. Att’y Gen. Op. 05-20 (Mar. 8, 2005). That “same result” is “the promotion, maintenance and restoration of health and the prevention of disease.” Tenn. Code Ann. § 63-6-1001(2). In 2006, the legislature amended the acupuncture certification statutes to expressly except chiropractors who have satisfied certain requirements. *See* 2006 Tenn. Pub. Acts, ch. 775, § 2 (amending Tenn. Code Ann. § 63-6-1002(a)); *see also* Tenn. Code Ann. § 63-4-101(a) (“Nothing in this chapter shall be construed to authorize the chiropractic physician to practice any branch of medicine osteopathy, . . . or surgery, *acupuncture being the exception.*”) (emphasis added).

Similar legislation would be necessary in order to bring dry needling within the scope of the practice of physical therapy. *See, e.g.*, 2014 Utah Laws ch. 354 (amending physical-therapy-practice statute to include trigger-point dry needling among therapeutic interventions).² Like acupuncture, dry needling uses the

¹ “Dry needling (DN) is a skilled intervention used by physical therapists (where allowed by state law) that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments.” *Physical Therapists & the Performance of Dry Needling* 2 (Jan. 2012), available at <http://www.apta.org/StateIssues/DryNeedling/>

² This legislative change in Utah came in the wake of an opinion from the Utah Department of Commerce’s Division of Occupational and Professional Licensing that trigger-point dry needling fell outside the scope of the practice of physical therapy because the “Division’s research regarding the

insertion of needles for therapeutic purposes—to restore movement, reduce pain, and address other musculoskeletal disorders. Although current rules of the Tennessee Board of Physical Therapy allow physical therapists to perform kinesiology electromyography (invasive needle study of the muscles to determine the degree and character of a muscle during certain movements) and diagnostic electromyography (invasive needle study of multiple muscles for diagnosis of muscle and nerve disease), the purposes of these procedures are solely academic or diagnostic, and they may be performed only in a university setting or upon referral from an allopathic or osteopathic physician, a dentist, or a podiatrist. *See* Tenn. Comp. R. & Regs. 1150-01-.02(1)(b)(2)(i), (iii); *id.* 1150-01-.04(4).

ROBERT E. COOPER, JR.
Attorney General and Reporter

JOSEPH F. WHALEN
Acting Solicitor General

SARA E. SEDGWICK
Senior Counsel

Requested by:

Brigina T. Wilkerson, PT
Chair, Tennessee Board of Physical Therapy
665 Mainstream Drive
Nashville, Tennessee 37243

practice of trigger point dry needling confirms that it is the practice of acupuncture.” October 22, 2013 letter from Debra F. Hobbins, Bureau Manager, Division of Occupational and Professional Licensing, available at <http://www.acupuncturesafety.org/Resources/Documents/Utah%20DOPL.pdf>.

August 28, 2014

Steven R. Goodman, MD
LearnIMS
2325 E. Girard PL
Spokane, WA 99223

Dear Dr. Goodman,

The Oregon Medical Board (OMB) has received notification that you are planning to instruct an IMS trigger point dry needling course October 10-12, 2014 in Lake Oswego, Oregon, that is “open to physical therapists with active licenses.”

According to Oregon Administrative Rule (OAR) 847-070-0005(1), “Acupuncture” means an Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by the stimulation of specific points on the surface of the body by the insertion of needles. Acupuncture is clearly defined by its technique (inserting needles) and its purpose (treatment of disease and pain – neurological, organic or functional).

OAR 847-070-0007(1) further defines the practice of acupuncture and states that no person shall practice acupuncture without first obtaining a license from the Oregon Medical Board. The Board has defined that “dry needling” is the practice of acupuncture. Acupuncture and “dry needling” use the same tool (acupuncture needles), the same points, the same purpose (treating pain), and the same needling techniques.

The scope of practice for Oregon licensed physical therapists does not include acupuncture. Should a physical therapist in Oregon wish to perform acupuncture, they must first obtain an acupuncture license from the OMB. The Oregon Physical Therapist Licensing Board has also issued an official statement stating that “until a measure of evidence based training and education can be determined, the Board strongly advises its licensees to not perform dry needling of trigger points.”

As you currently have an inactive license status in Oregon, you must reactivate your license before practicing in any manner in Oregon. Also, the information on the course does not note that physical therapists cannot practice acupuncture in Oregon.

To comply with Oregon law, the OMB requests that you discontinue your Oregon class until you reactivate your Oregon license and the Oregon Physical Therapist Licensing Board sets rules and/or educational standards for dry needling.

Should you have any questions, please contact me at 971-673-2700.

Sincerely,

Kathleen Haley
Executive Director



American Association of Acupuncture and Oriental Medicine (AAAOM) Position Statement on Trigger Point Dry Needling (TPDN) and Intramuscular Manual Therapy (IMT)

Summary

The American Association of Acupuncture and Oriental Medicine Blue Ribbon Panel on Inter-professional Standards has determined that dry needling and any of its alternate designations, including intramuscular manual therapy, trigger point needling, functional dry needling, intramuscular stimulation or any other method by which a needle is inserted to effect therapeutic change, is, by definition, the practice of acupuncture.

Rationale

1. Acupuncture, as a procedure, is the stimulation of anatomical locations on the body, alone and in combination, to treat disease, injury, pain, and dysfunction and to promote health and wellness.
2. Acupuncture, as a procedure, includes the invasive stimulation of said locations by the insertion of needles and the non-invasive stimulation of said locations by thermal, electrical, chemical, light, mechanical or other manual therapeutic methods.
3. Acupuncture, as a therapeutic intervention and medical practice, is the study of how the various acupuncture procedures are applied in health care.
4. Trigger point dry needling, dry needling, functional dry needling, and intramuscular manual therapy, or any other pseudonym describing acupuncture procedures, are, by definition, the practice of acupuncture.
5. In the interest of public safety, non-acupuncture boards should not regulate the practice of acupuncture.

Nationally Recognized Acupuncture Standards

The AAAOM endorses the educational standards set forth by the Accreditation Commission of Acupuncture and Oriental Medicine (ACAOM). The ACAOM is the sole agency recognized by the United States Department of Education to set educational standards for the procedure and practice of acupuncture.

The AAAOM endorses the state licensure qualifying standards set forth by the National Certification Commission of Acupuncture and Oriental Medicine (NCCAOM). The NCCAOM is the sole agency recognized by the Institute for Credentialing Excellence's (ICE) National Commission on Certifying Agencies (NCCA) to qualify acupuncturists for licensure.

State regulatory boards for licensed health care professions other than acupuncture have begun to recognize the procedure and practice of acupuncture by other names, such as “dry needling” and “trigger point dry needling.” At present, this is being done primarily by physical therapy boards in an attempt to expand the scope of practice for the physical therapy profession. Scope of practice expansion attempts made in this manner preclude necessary and adequate educational and safety standards for the procedure and practice of acupuncture. Forty-four (six pending) states plus the District of Columbia have statutorily defined acupuncture and the educational and certification standards required for acupuncture licensure. Current medical literature is consistent with the definitions of both the procedure and practice of acupuncture as provided by state practice acts.¹⁻²¹

Historical Precedents

Trigger point dry needling and intramuscular manual therapy are aliases used in the marketing of a subset of acupuncture techniques described in the field of acupuncture as “ashi point needling.”² A reasonable English translation of ashi points is “trigger points”, a term used by Dr. Janet Travell in her landmark 1983 book *Myofascial Pain Dysfunction: The Trigger Point Manual*.³ Dorsher et al.,⁴ determined that of the 255 trigger points listed by Travell and Simons, 234 (92%) had anatomic correspondence with classical, miscellaneous, or new acupuncture points listed in Deadman et al.,⁵ an internationally-recognized acupuncture reference book.

Modern authorities agree and describe dry needling as acupuncture.^{6,7,8} Mark Seem discussed dry needling in *A New American Acupuncture* in 1993.⁹ Matt Callison describes dry needling in his *Motor Points Index*¹⁰ as does Whitfield Reaves in *The Acupuncture Handbook of Sports Injuries and Pain: A Four Step Approach to Treatment*.¹¹ Yun-tao Ma, author of *Biomedical Acupuncture for Sports and Trauma Rehabilitation Dry Needling Techniques*, describes dry needling as acupuncture and provides a rich historical explanation of why.¹²

C. Chan Gunn, “Acupuncture loci: A proposal for their classification according to their relationship to known neural structures,” *American Journal of Chinese Medicine*, 1976¹³ and Peter Baldry, *Acupuncture, Trigger Points and Musculoskeletal Pain: A Scientific Approach to Acupuncture for Use by Doctors and Physiotherapists in the Diagnosis and Management of Myofascial Trigger Point Pain*, 2005,¹⁴ also acknowledge dry needling procedure and practice to be equivalent to acupuncture procedure and practice.

These examples demonstrate a Western medical movement to rename the procedure and practice of acupuncture as dry needling by providers other than acupuncturists. The examples listed above affirm that there is a literary tradition acknowledging the term “dry-needling” to be synonymous with acupuncture.

Concerns

The AAAOM has the following additional specific concerns:

- 1) No standards of education have been validly determined to assure that physical therapists (PT) using TPDN are able to provide the public with a safe and effective procedure.¹⁵
- 2) Redefining identical medical procedures and thereby circumventing or obscuring established laws regarding their safe practice is irresponsible
- 3) In many states, the addition of TPDN to physical therapy practice is being determined by physical therapy regulatory boards, deleteriously circumventing transparency and public health safety protections provided by standard legislative process

The U.S. Department of Education recognizes ACAOM as the sole accrediting agency for acupuncture training institutions as well as their Master's and Doctoral Degree programs.^{16, 17} Standards of training in acupuncture are well established, and designed to support safe and effective practice.^{18, 19} Attempts to circumvent acupuncture training standards, licensing or regulatory laws by administratively retitling acupuncture as "dry needling" or any other name is confusing to the public, misleads the public as to therapeutic intervention expected, and, through lack of meaningful education and practice regulation, creates a significant endangerment to public welfare.

This actual risk of endangerment to public welfare has been investigated by at least one malpractice insurance company that has stated it will cancel policies for physical therapists "engaging in a medical procedure for which they have no adequate education or training."²⁰ Recent actions by state medical regulatory authorities have identified and acted upon the aforementioned risk.²¹

In conclusion, the AAAOM strongly urges legislators, regulators, advisory boards, advocates of public safety, and medical professional associations to carefully consider the impact of trends in scope of practice expansion issues.

¹ <http://www.ncbi.nlm.nih.gov/pubmed/15108608>

² Janz S, Adams J. Acupuncture by another name: Dry-needling in Australia. *Australian Journal of Acupuncture and Chinese Medicine*. 2011; 6(2)

³ Travell J, Simons D. *Myofascial Pain Dysfunction: The Trigger Point Manual*. Philadelphia, PA: Lippincott Williams & Wilkins; 1983.

⁴ Dorsher PT. *Trigger Points And Acupuncture Points: Anatomic And Clinical Correlations*. *Medical Acupuncture*. 2006;17(3).

⁵ Deadman P, Al-Khafaji M, Baker K. *A Manual of Acupuncture*. Kingham, Oxfordshire: Journal of Chinese Medicine Publications

⁶ When To Select Observational Studies as Evidence for Comparative Effectiveness Reviews Prepared for: The Agency for Healthcare Research and Quality (AHRQ) Training Modules for Systematic Reviews Methods Guide www.ahrq.gov Effective Health Care Program. "The AHRQ Training Modules for the Systematic Reviews Methods Guide..." *The AHRQ Training Modules for the Systematic Reviews Methods Guide: An Introduction*. Ahrq.gov. Web. 06 Feb. 2012. <<http://www.slideshare.net/AHRQEHCPProgram/the-ahrq-training-modules-for-the-systematic-reviews-methods-guide-an-introduction>>.

⁷ Alberta Heritage Foundation for Medical Research Health Technology Assessment Unit. *Acupuncture: Evidence from systematic reviews and meta-analyses* 2002 Mar. Used in glossary of "Acupuncture for Osteoarthritis." *Centers for Medicare & Medicaid Services*. Web. 14 Jan. 2012. <<http://www.cms.gov/medicare-coverage-database/details/technology-assessments-details.aspx?TAId=19>>.

⁸ *Acupuncture for Osteoarthritis*. Rockville, MD: U.S. Dept. of Health and Human Services, Public Health Service, Agency for Healthcare Research and Quality, 2003. Print. This definition is also used in the glossary of "Acupuncture for Osteoarthritis." *Centers for Medicare & Medicaid Services*. "Acupuncture for Osteoarthritis." *Centers for Medicare & Medicaid Services*. Web. 14 Jan. 2012. <<http://www.cms.gov/medicare-coverage-database/details/technology-assessments-details.aspx?TAId=19>>1

⁹ Seem M. *A New American Acupuncture: Acupuncture Osteopathy, the Myofascial Release of the Bodymind*. Boulder, CO: Blue Poppy Press; 1993.

¹⁰ Callison M. *Motor Point Index: An Acupuncturist's Guide to Locating and Treating Motor Points* San Diego, CA: AcuSport Seminar Series LLC; 2007.

¹¹ Reaves W, Bong C. *The Acupuncture Handbook of Sports Injuries & Pain*. Boulder, CO: Hidden Needle Press; 2009.

¹² Ma, Yun-tao. *Biomedical Acupuncture for Sports and Trauma Rehabilitation Dry Needling Techniques*. New York: Elsevier; 2010.

¹³ Gunn, C. Chan. Acupuncture loci: A proposal for their classification according to their relationship to known neural structures. *American Journal of Chinese Medicine* 4.No. 2 (1976): 183+. Print

¹⁴ Baldry, Peter. *Acupuncture, Trigger Points and Musculoskeletal Pain: A Scientific Approach to Acupuncture for Use by Doctors and Physiotherapists in the Diagnosis and Management of Myofascial Trigger Point Pain*. 3rd ed. Edinburgh: Elsevier/Churchill Livingstone, 2005. Print. ISBN 0 443 06644 2. Preface.

¹⁵ Commission on Accreditation in Physical Therapy Education (CAPTE) – Accreditation Handbook – November 2011

¹⁶ <http://ope.ed.gov/accreditation/>

¹⁷ <http://www.acaom.org/about/>

¹⁸ <http://www.acaom.org/documents/accreditation-manual.pdf>

¹⁹ <http://www.nccaom.org/applicants/eligibility-requirements>

²⁰ Letter from Allied Professional Services [on file at AAAOM]

²¹ Letter from the Oregon Medical Board [<http://www.oaaom.com/wp-content/uploads/2010/06/DryNeedling.pdf>]



State of Utah Department of Commerce

Division of Occupational and Professional Licensing

GARY R. HERBERT
Governor

FRANCINE A. GIANI
Executive Director

MARK B. STEINAGEL
Division Director

October 22, 2013

Curtis B. Jolley, PT, MOMT UPTA
President
Performance West Physical Therapy 1551
Renaissance Towne Drive, Suite 350 Bountiful,
Utah 84010

Dear Mr. Jolley:

This letter is written in response to your question about whether a physical therapist in Utah may practice intramuscular manual therapy, or trigger point dry needling. After meeting with Mr. Mark Steinagel, Director, Division of Occupational and Professional Licensing and Mr. Ron Kunzler, Assistant Attorney General, and reviewing the supplemental material you kindly provided, including "Description of Dry Needling in Clinical Practice: An Educational Resource Paper" dated February 2013 and the "FSBPT Dry Needling Resource Paper (Intramuscular Manual Therapy)" 4th edition, July 2013, the Division has reached a position. The position of the Division is that the performance of trigger point dry needling seems to be outside of the scope of practice of a physical therapist in the State of Utah. In fact, we feel that the statute is unclear and requires a statutory change to allow a physical therapist to perform dry needling, especially considering the relatively recent addition of "modern research" to the Acupuncture Practice Act, provided in pertinent part below:

58-72-102. Definitions.

(4) (a) "Practice of acupuncture" means the insertion of acupuncture needles and application of moxibustion to specific areas of the body based on traditional oriental medical diagnosis and **modern research** as a primary mode of therapy.

(b) Adjunctive therapies within the scope of practice of acupuncture may include:

(i) manual, mechanical, thermal, electrical, light, and electromagnetic treatments based on traditional oriental medical diagnosis and **modern research**;

(ii) the recommendation, administration, or provision of dietary guidelines, herbs, supplements, homeopathics, and therapeutic

exercise based on traditional oriental medical diagnosis and **modern research** according to practitioner training;

Trigger point dry needling is a therapeutic intervention used to treat and alleviate myofascial pain that uses a dry needle, without medication, that is inserted into a trigger point with the goal of releasing/inactivating the trigger points and relieving pain. It is used to improve

WM^w.do/ji.utah.gov * Heber M. Wells Building * 160 East 300 South * P.O. Box 146741, Salt Lake City, UT 84114-6741 telephone (801) 530-6628 • toll-free in Utah (866) 275-3675 • fax (801) 530-6511 • investigations fax (801) 530-6301

pain control, reduce muscle tension, normalize biochemical and electrical dysfunction of motor endplates, and to facilitate an accelerated return to active rehabilitation. The needles used for dry needling are the same needles used to perform acupuncture.

The scope of practice for physical therapists in Utah is established in the Physical Therapist Practice Act, Utah Code 58-24b-102 (11), It reads in relevant part as follows:

(11)(a) "Physical therapy" or "physiotherapy" means:

- (iii) formulating a therapeutic intervention plan for the treatment of a physical impairment, injury, or pain;
- (iv) assessing the ongoing effects of therapeutic intervention for the treatment of a physical impairment or injury;
- (v) treating or alleviating a physical impairment by designing, modifying, or implementing a therapeutic intervention;

(b)"Physical therapy" or "physiotherapy" does not include:

- (i) diagnosing disease;
- (ii) performing surgery;
- (iii) performing acupuncture;
- (iv) taking x-rays; or
- (v) prescribing or dispensing a drug, as defined in Section 58-37-2.

The term "therapeutic intervention" is defined as follows:

(14) "Therapeutic intervention" includes:

- (d) manual therapy, including:
 - (i) soft tissue mobilization;
 - (j) mechanical or electrotherapeutic modalities.;

Utah Code 58-24b-102 (1 1)(b) prohibits physical therapists from performing acupuncture. The Division's research regarding the practice of trigger point dry needling confirms that it is the practice of acupuncture. Therefore, the Division finds that it is outside the scope of practice of physical therapists in Utah. Our decision is purely statutory in nature. Our " intent is not to restrict the practice of physical therapists, nor is there any question about whether or not a physical therapist could be competent to perform this treatment modality. As defined in statute, it is simply prohibited.

• Because trigger point dry needling is a therapeutic intervention that includes the use of manual therapy involving soft tissue mobilization and a mechanical modality, several states have found dry needling to be within the physical therapy scope of practice; however, current Utah law does not allow it to be within the scope of practice of physical therapists in Utah,

This letter is intended as informal guidance only and does not constitute a declaratory order under the Utah Administrative Procedures Act, If you have any questions please feel free to contact me at (801) 530-6789 or by email: dhobbins@utah.gov.

Sincerely.,

Debra F. Hobbins, DTSfP, APRN, LASUDC
Bureau Manager
Utah Department of Commerce
Division of Occupational and Professional Licensing

www.dopl.utah.gov * Hebr M, Wells Building * 160 East 300 South • P.O. Box 146741, Salt Lake City, UT 84114-6741 telephone (801) 530-6628 • toll-free in Utah (866) 275-3675 • fax (801) 530-6511 ⁴ investigations fax (801) 530-6301

NOV 1 &
2013

November 13, 2013
PROFESSIONAL LICENSING

Re: Dry Needling and Violations of the U.S. Food, Drug, and Cosmetic Act (FDCA) and Food and Drug Administration Rules

Dear State Board of Physical Therapy:

I write on behalf of the National Center for Acupuncture Safety and Integrity (NCASI), a nonprofit corporation working to protect the public from the unlicensed practice of acupuncture and the illegal sale and use of acupuncture needles. NCASI is aware that a number of state boards of physical therapy have authorized physical therapists to practice what is referred to as "trigger-point dry needling" ("TPDN"), also known as "dry needling." Those promoting "TPDN" openly acknowledge that they are using labeled acupuncture needles to practice "TPDN," but claim that "TPDN" falls outside the statutory and regulatory definitions of practicing acupuncture. While specific state laws vary on the definition of the practice of acupuncture, the federal Food and Drug Administration ("FDA") strictly regulates the sale of acupuncture needles as Class II prescription medical devices under the U.S. Food, Drug, and Cosmetic Act (FDCA) only to qualified and licensed acupuncture practitioners. Specifically, FDA regulations restrict that the sale of acupuncture needles to anyone but a person *authorized to practice acupuncture and for use in acupuncture*. The sale of acupuncture needles to anyone other than a qualified and licensed acupuncture practitioner is a violation of both the FDCA and the FDA rules described below.

Please be aware that to the extent your board authorizes the use of acupuncture needles by persons who are not explicitly authorized to practice *acupuncture*, your actions are inconsistent with federal law and could expose your state board to liability in the event a person is injured by one of the practitioners your board regulates. There is no dispute that the practice of "TPDN" absolutely depends on the use of FDA-regulated acupuncture needles. Any official sanctioning of "TPDN" by a state professional board signals to potential patients that those practicing "TPDN" are qualified, trained and legally authorized to possess, purchase and use acupuncture needles, a Class II prescription medical device under FDA regulations. As a result, state regulatory and professional boards that endorse the practice of "TPDN" by persons who are not explicitly authorized to practice acupuncture is inconsistent with federal law. ■

FDA's regulation of acupuncture needles as Class II prescription medical devices

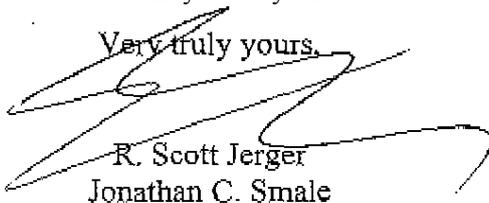
Acupuncture needles are regulated under the FDCA as Class II prescription medical devices that are subject to FDA's strict prescription sale requirements. *See* 21 CFR §; 880.5580

With this letter your board and your state have notice that to the extent your board approves or otherwise endorses the use of acupuncture needles for the practice of "TPDN" by persons who are not legally authorized to practice acupuncture you may be exposing your board to liability for endorsing a practice that involves the violation of FDA regulations and the unauthorized use of a Class II medical device.

NCASI encourages your board to carefully review the enclosed regulations and other documents related to the regulation of acupuncture needles. To the extent your board has already endorsed or approved the practice of "TPDN" by persons who are not authorized to practice acupuncture, NCASI encourages your board to reconsider such actions. If your board has yet to address the issue of "TPDN," we encourage you to take a position that is consistent with the FDA's regulation of acupuncture needles as Class II prescription medical devices.

Thank you for your careful consideration of these issues.

Very truly yours,

A handwritten signature in black ink, appearing to read "R. Scott Jerger", is written over the typed name. The signature is fluid and somewhat stylized, with a long horizontal stroke at the end.

R. Scott Jerger
Jonathan C. Smale

cc: client Enclosures

TITLE 21--FOOD AND DRUGS CHAPTER I-FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH AND
HUMAN SERVICES SUBCHAPTER H—MEDICAL DEVICES

PART 880 GENERAL HOSPITAL AND PERSONAL USE DEVICES

Subpart F—General Hospital and Personal Use Therapeutic Devices

Sec. 880-5580 Acupuncture needle.

Identification. An acupuncture needle is a device intended to pierce the skin in the practice of acupuncture. The device consists of a solid, stainless steel needle. The device may have a handle attached to the needle to facilitate the delivery of acupuncture treatment.

Classification. Class II (special controls). Acupuncture needles must comply with the following special controls:

- (1) Labeling for single use only and conformance to the requirements for prescription devices set out in 21 CFR 801.109, ,
- (2) Device material biocompatibility, and
- (3) Device sterility.

[61 FR 64617, Dec. 6,1996]

1
i **Exhibit A**
1

acupuncture needles is available in the General Hospital Branch guidance document entitled "Guidance on the Content of Premarket Notification (510(k)) Submissions for Hypodermic Single Lumen Needles" (draft), April 1993 (Ref. 4). A copy of this guidance document is available from the Division of Small Manufacturers Assistance (HFZ-220), Center for Devices and Radiological Health, Food and Drug Administration, 1350 Piccard Dr., Rockville, MD 20850-4307. 301-4436597 or 800-638-2041 and FAX 301443-8818.

Consistent with the act and the regulations, after thorough review of the clinical data submitted in the petitions, and after FDA's own literature search, on March 29, 1996, FDA sent the Acupuncture Coalition a letter (order) reclassifying acupuncture needles for general acupuncture use, and substantially equivalent devices of this generic type, from class III to class II (special controls). As required by § 860.134(b)(7), FDA is announcing the reclassification of the generic type of device. Additionally, FDA is amending part 880 (21 CFR part 880) to include the classification of acupuncture needles for the practice of acupuncture by adding new § 880-5580.

Environmental Impact

The agency has determined that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Under 21 CFR 25.24(e)(2), the reclassification of a device is categorically exempt from environmental assessment and environmental impact statement requirements. Therefore, neither an environmental assessment nor an environmental impact statement is required.

Analysis of Impacts

FDA has examined the impacts of the final rule under Executive Order 12866 and the Regulatory Flexibility Act (Pub. L. 96-354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The agency believes that this final rule is consistent with the regulatory philosophy and principles identified in the Executive Order. In addition, the final rule is not a significant regulatory action as defined by the Executive Order and so is not subject to review under the Executive Order.

The Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. Because reclassification of devices from class III to class II will relieve some manufacturers of the cost of complying with the premarket approval requirements of section 515 of the act (21 U.S.C. 360e), and may permit small potential competitors to enter the marketplace by lowering their costs, the agency certifies that the final rule will not have a significant economic impact on a substantial number of small entities. Therefore, under the

Regulatory Flexibility Act, no further analysis is required.

Paperwork Reduction Act of 1995

FDA concludes that the labeling requirements in this final rule are not subject to review by the Office of Management and Budget because they do not constitute a "collection of information" under the Paperwork Reduction Act of 1995 (Pub. L. 104—13). Rather, the proposed warning statements are "public disclosure of information originally supplied by the Federal Government to the recipient for the purpose of disclosure to the public" (5 CFR 1320.3(c)(2)).

References

The following references have been placed on display in the Dockets Management Branch (HFA—305), Food and Drug Administration, 12420 Parklawn Dr., rai, 1—23, Rockville, MD 20857 and may be seen by interested persons between 9 a.m. and 4 p.m., Monday through Friday.

1. FDA letter (order) to the Acupuncture Coalition dated March 29, 1996.
1. Classification of anesthesiology devices, development of general provisions; 44. FR 63292 at 63299, November 2, 1979,
3. Anesthesiology Devices Advisory Panel's supplemental data sheet, November 30, 1976.
4. Guidance on the Content of Premarket (510(k)) Submissions for Hypodermic Single Lumen Needles (draft), April 1993.

List of Subjects in 21 CFR Part 880

Medical devices.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, 21 CFR part 880 is amended as follows:

PART 880—GENERAL HOSPITAL AND PERSONAL USE DEVICES

1. The authority citation for 21 CFR part 880 continues to read as follows:
Authority: Sees. 501, 510, 513, 515, 520, 701 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C., 351, 360, 360c, 360e, 360j, 371).

2. New § 880.5580 is added to subpart F to read as follows:

§880.5580 Acupuncture needle.

(a) Identification. An acupuncture needle is a device intended to pierce the skin in the practice of acupuncture. The device consists of a solid, stainless steel needle. The device may have a handle attached to the needle to facilitate the delivery of acupuncture treatment.

(b) Classification, Class II (special controls). Acupuncture needles must comply with the following special controls:

- (1) Labeling for single use only and conformance to the requirements for prescription devices set out in 21 CFR 801.109,
- (2) Device material biocompatibility, and
- (3) Device sterility.

Dated: November 20, 1996.

D. B. Burlington,
Director, Center for Devices and Radiological Health.

[FR Doc. 96-31047 Filed 12-5-96; 8:45 am] BILLING

CODE 4T60-01-F

DEPARTMENT OF HOUSING AND

URBAN DEVELOPMENT

24 CFR Part 5

[Docket No. FR-4154-C-02]

R|N 2501-AC3Q

Revised Restrictions on Assistance to Noncitizens; Correction

AGENCY: Office of the Secretary, HUD.

ACTION: Interim rule, correction,

SUMMARY: On November 29, 1996 (61 FR 60535), HUD published an interim rule implementing the changes made to Section 214 of the Housing and Community Development Act of 1980 by the Use of Assisted Housing by Aliens Act of 1996. Section 214 prohibits HUD from making certain financial assistance available to persons other than United States citizens, nationals, or certain categories of eligible noncitizens. The November 29, 1996 interim rule incorrectly provided for a public comment due date of November 29, 1996. The public comment due date should have been January 28, 1997. 60 days after publication of the November 29, 1996 interim rule. The purpose of this document is to correct the due date for public comments in the November 29, 1996 rule.

; Exhibit B

Devices that were in investigational status before the enactment of the Medical Device Amendments of 1976 are not considered to have been in commercial distribution for purposes of section 513 of the Act.

After review of the information submitted in the petitions and its own literature search of safety information, FDA has determined that acupuncture needles intended for use in the practice of acupuncture by qualified practitioners as determined by the States could safely be reclassified from class III to class II with the implementation of special controls.

The special controls are compliance with 1) labeling provisions for single use only and the prescription statement in 21CFR 801,109 (restriction to use by or on the order of qualified practitioners as determined by the States), 2) device material biocompatibility, and 3) device sterility- FDA believes that information for use, including indications, effects, routes, methods, and frequency and duration of administration, and any hazards, contraindications, side effects and precautions are commonly known to qualified practitioners of acupuncture. Therefore, pursuant to section 801-109 (c), such indications do not need to be on the dispensing packaging but sale must be clearly restricted to qualified practitioners of acupuncture. Guidance on the type of information needed to support biocompatibility and sterility can be found in the existing General Hospital Branch Guidance on the content of Premarket [510 (k)] Submissions for Hypodermic Single Lumen Needles, April 1993 * A copy of this guidance is enclosed,

FDA's decision is also in keeping with but not dependent upon the recommendation of the Anesthesiology Devices Advisory Panel, published in the Federal Register of November 2, 1979 (44 FR 63299) that acupuncture needles be classified in class XI. The supplemental data sheet completed by that panel, dated November 30, 1976, listed sepsis, excessive trauma and perforation of blood vessels and organs as specific risks, and recommended restricting the device to prescription use.

Therefore, FDA, for the reasons set forth in this letter, is ordering the reclassification of the generic type of device identified on page 1, from class III to class II. Further, since the reclassification is based upon scientific evidence demonstrating that general controls and the special controls provide a reasonable assurance of safety and effectiveness, the labeling requirements of the 1973 Federal Register document no longer apply to acupuncture needles intended for use in the practice of acupuncture by qualified practitioners. However, before acupuncture needles can be legally marketed, they must be the subject of a cleared premarket notification [510(k)] submission.

; Exhibit B

TITLE 21--FOOD AND DRUGS CHAPTER I—FOOD AND DRUG ADMINISTRATION DEPARTMENT OF HEALTH
AND HUMAN SERVICES SUBCHAPTER H—MEDICAL DEVICES

PART 801 -- LABELING

Subpart D—Exemptions From Adequate Directions for Use

Sec. 801.109 Prescription devices.

A device which, because of any potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use is not safe except under the supervision of a practitioner licensed by law to direct the use of such device, and hence for which "adequate directions for use" cannot be prepared, shall be exempt from section 502(f)(1) of the act if all the following conditions are met:

(a) The device is:

- (1) (i) In the possession of a person, or his agents or employees, regularly and lawfully engaged in the manufacture, transportation, storage, or wholesale or retail distribution of such device; or
- (ii) In the possession of a practitioner, such as physicians, dentists, and veterinarians, licensed by law to use or order the use of such device; and
- (2) Is to be sold only to or on the prescription or other order of such practitioner for use in the course of his professional practice.

(b) The label of the device, other than surgical instruments, bears:

- (1) The statement "Caution; Federal law restricts this device to sale by or on the order of a _____ the blank to be filled with the word "physician", "dentist", "veterinarian", or with the descriptive designation of any other practitioner licensed by the law of the State in which he practices to use or order the use of the device; and
- (2) The method of its application or use.

(c) Labeling on or within the package from which the device is to be dispensed bears information for use, including indications, effects, routes, methods, and frequency and duration of administration, and any relevant hazards, contraindications, side effects, and precautions under which practitioners licensed by law to administer the device can use the device safely and for the purpose for which it is intended, including all purposes for which it is advertised or represented; *However*, That such information may be omitted from the dispensing package if, but only if, the article is a device for which directions, hazards, - warnings, and other information are commonly known to practitioners licensed by law to use the device. Upon written request, stating reasonable grounds therefor, the Commissioner will offer an opinion on a

In conformance with the requirements for prescription devices set out in 21 Code of Federal Regulations (CFR) 801.109, acupuncture needles are to be sold only to "*qualified, practitioners of acupuncture* as determined, by the States" (emphasis added). Accordingly, labeling on the package from which acupuncture needles are to be dispensed bears the prescription statement "Caution; Federal law restricts this device to sale by or on the order of *qualified practitioners of acupuncture* as determined by the States" (emphasis added).

SAMPLE LABELS

(1) AcuMaster-brand acupuncture needles (Manufactured in China)

The prescription labeling on a dispensing package of AcuMaster-brand acupuncture needles states:

CAUTION FOR U.S. ONLY; Federal law restricts this device to sale by or on the order of *qualified practitioners of acupuncture* as determined by the States.

(Emphasis added.)

(2) Carbo-brand acupuncture needles (Manufactured in China)

The prescription labeling on a dispensing package of Carbo-brand acupuncture needles states;

Caution; Federal law restricts this device to sale by or on the order of *qualified practitioners of acupuncture* as determined by the States.

(Emphasis added.)

(3) DBC-brand acupuncture needles (Manufactured in Korea)

The prescription labeling on a dispensing package of DBC-brand acupuncture needles states:

Caution: Federal law restricts this device to sale by or on the order Of *qualified practitioners of acupuncture* as determined by the States.

(Emphasis added.)

(4) Dongbang-brand acupuncture needles (Manufactured In Korea)

The prescription labeling on a dispensing package of Dongbang-brand acupuncture needles states;

Caution; Federal law restricts this device to sale by or on the order of *qualified practitioners of acupuncture* as determined by the States.

(Emphasis added.)

(5) Seirin-brand. acupuncture needles (Manufactured in Japan)

The prescription labeling on a dispensing package of Seirin-brand acupuncture needles states:

Caution: Federal law restricts this device to sale by or on. the order of *qualified practitioners of acupuncture* as determined by the States.

(Emphasis added.)



Dry needling letter

Leslie Adrian <LAdrian@aon.fsbpt.org>
To: "cba@fsbpt.org" <cba@fsbpt.org>

Tue, **Dec 3**, 2013 at 7:59 AM

To all Administrators,

The Federation has retained a law firm who specializes in FDA issues and are working with them to determine an appropriate course of action. We are also in contact with APTA and trying to coordinate our efforts. The issue is a bit complex, so we expect it will take some time before we have any specific information to share with our member boards. Until then, we would recommend that licensing boards not respond to the letter. We wil! keep you informed as much as possible along the way. If you would please share this information with your board members, we would appreciate it. Please feel free to contact me if you have any questions.

Thank you,

Leslie

Leslie Adrian, PT, DPT, MS, MPA
Director of Professional Standards
Federation of State Boards of Physical Therapy
124 West Street South, 3rd floor
Alexandria, VA 22314
703-299-3100 ext 233
703-239-3110 Fax
www.fsbpt.org

This message and any attachments may contain confidential and privileged material that is for the sole use of the intended redpict(s), If you are not an intended reapiant you are hereby notified that disclosing, copying, distributing or taking any action in reliance on the contents of this email or its attachments is strictly prohibited. If you have received this email-in ertor, please destroy it and notify the Federation immediately by sending an email to seauity(\$fobpt.otg,

Next DOPL board meeting

Lindi Gordon <lindsigordon@gmail.com>

Wed, Oct 16, 2013 at 11:46 AM

To: Debra Hobb/ns <dhobbirt5@utah.gov>, Shirlene Kimball <skimball@utah.gov>, Kim Cohee <Kim.Cohee@hsc.utah.edu>, Kim Reld <kreidpt@hotmail.com>, "annehj@comcast.net" <annehj@comcast.net>, Trent Casper <jtcas'perl@gmail.com>

Hello all, .

I was curious if there is a possibility we could review the wording in the practice act and rules regarding PTA duties and responsibilities?

The reason I ask, is because there are a few PTs that have asked me to clarify the limitations of the PTA and when I double checked the act/rules, there was no specific wording. I was not able to attend the UPTA , conference this past weekend, but know there was some talk on the subject, just not detailed information from what I was told.

Debra, Is it too much of a hassle to modify wording?....

Thank you,

Lindi



December 15, 2009

Ms. Kathleen Haley
Executive Director
State of Oregon Medical Board
1500 SW 1st Ave., Suite 620
Portland, OR 97201-5847

Dear Ms. Haley:

We are writing on behalf of Allied Professionals Insurance Company, a Risk Retention Group (“APIC”). APIC is a federal risk retention group that provides malpractice insurance to physical therapists. It has come to APIC’s attention that the Oregon Physical Therapist Licensing Board recently determined that the technique of “dry needling” falls within the scope of practice of physical therapy. This determination concerns APIC not only on a malpractice perspective, but also for its effect on public health and safety.

According to the World Health Organization, the term “acupuncture” means to puncture with a needle. “Dry needling” is a term that was developed to define the technique of placing an acupuncture needle into a muscle trigger point rather than injecting the trigger point with lidocaine or cortisone. Dry needling focuses on releasing muscle tension by treating specific trigger points, alleviating nerve tissue irritation by reducing the nerve impulse, or stimulating local blood supply where it may be naturally poor, such as the junction between tendons or ligaments and bone. It became known a “dry” needle because nothing was injected. Dry needling is a derivative of acupuncture and defined by the World Health Organization as “acupuncture.”

In fact, one of the pioneers of the dry needling technique, Chan C. Gunn, stressed that many trigger points were close to or identical to acupuncture points. Mr Gunn believed that Western practitioners would better accept the technique if the point locations were described in anatomical rather than traditional Chinese medical terms.¹

Proponents of the addition of dry needling to the scope of physical therapy maintain that trigger point dry needling does not have any similarities to acupuncture other than using the same tool. These same proponents of the technique redefine traditional Chinese medicine as being based on a traditional system of energetic pathways and the goal of acupuncture to balance energy in the body. They emphasize the channel relationship of acupuncture points, de-emphasize or completely exclude the use of ASHI points, and emphasize that acupuncture is based on the energetic concepts of Oriental medicine diagnosis. They therefore define dry needling as different and distinct from acupuncture because it is based on Western anatomy.²

¹ Gunn, CC et al. *Spine*, 1980

² Hobbs, Valerie, DiplOM, LAc, *Dry Needling and Acupuncture Emerging Professional Issues*

However, these proponents fail to recognize that acupuncture schools teach both “western” neurophysiological concepts along with “traditional” meridian concepts. As such, acupuncturists are highly trained within both fields of medicine. In fact, the profession of Chinese medicine utilizes neurophysiological principles. As such, there is no such distinction between “eastern” and “western” acupuncture.

Dry needling certainly is a contentious issue. However, the issue needs to be ultimately viewed from the perspective of public health and safety. Currently, the leading dry needling courses being offered in the United States include the Travell Series through Myopain Seminar in Maryland, and dry needling courses offered by the Global Education of Manual Therapists located in Colorado.

The Travell Series is comprised of an 80-hour course on myofascial trigger points and a 36-hour course on dry needling. The course is designed for licensed healthcare practitioners including acupuncturists.³ The dry needling course offered by the Global Education of Manual Therapists is a 27.5 hour introductory course with an option for another 27.5 hour level two seminar.⁴

Licensed acupuncturists typically receive at least 3000 hours of education.⁵ The dry needling courses currently being offered, including the Travell Series and the courses offered by the Global Education of Manual Therapists, not only allow physical therapists to use needles on patients without sufficient training, but constitute a public health hazard.

California, Hawaii, New York, North Carolina, and Tennessee, all prohibit physical therapists from performing dry needling. In addition, the state of Florida disallows physical therapists from using any technique which ruptures the skin.

In California, physical therapists recognize that invasive procedures clearly move beyond the scope and training of physical therapy. In some instances, they hire licensed acupuncturists to treat patients. Many physical therapists respect the fact that use of needles is both an invasive procedure beyond the professional scope of physical therapy and is directly related to the practice of acupuncture.

According to Ben Massey Jr., PT, MA, the Executive Director of the North Carolina Board of Physical Therapy Examiners, “Dry needling is a form of acupuncture. In North Carolina, a practitioner who performs acupuncture must have a license from the North Carolina Board of Acupuncture.”⁶

Oregon defines “acupuncture” as “Oriental health care practice used to promote health and to treat neurological, organic or functional disorders by the *stimulation of specific points*”

³ <http://www.myopainseminars.com/seminars/travell/index.html>

⁴ <http://www.gemtinfo.com/physical-therapy/Trigger-Point-Dry-Needling-Level-II-Training/page18.html>

⁵ <http://aaaonmonline.org/pressroom.asp?pagenumber=48266>

⁶ <http://aaaonmonline.org/pressroom.asp?pagenumber=48266>

1851 East First Street, Suite 1160 · Santa Ana CA 92705 · 800-860-8330 · 714-571-1863 (FAX)

*on the surface of the body by the insertion of needles...*⁷ (Emphasis added). As discussed above, dry needling focuses on releasing muscle tension by treating specific trigger points, alleviating nerve tissue irritation by reducing the nerve impulse, or stimulating local blood supply where it may be naturally poor. As such, dry needling falls squarely within the Oregon definition of “acupuncture”, as it involves the insertion of needles on the surface of the body to stimulate specific points.

Physical therapy state boards of Maryland, New Mexico, New Hampshire and Virginia have determined that dry needling falls within the scope of physical therapy in those states. However, the Oregon statute defining “acupuncture” is distinguishable from these states’ statute.

For example, the New Mexico Acupuncture and Oriental Medicine Practice Act defines acupuncture as “the use of needles inserted into and removed from the human body for the prevention, cure or correction of any disease, illness, injury, pain, or other condition by controlling and regulating the flow and balance of energy and functioning...”⁸

Proponents of the addition of dry needling to the scope of physical therapy point out that dry needling is not to control and regulate the flow and balance of energy and is not based on Eastern esoteric and metaphysical concepts. As such, based on the definition of “acupuncture” as set forth in the New Mexico Acupuncture and Oriental Medicine Practice Act, the physical therapy state board determined that dry needling falls within the scope of physical therapy practice.

However, unlike the New Mexico statute, ORS 677.757 is not narrowly tailored to limit the practice of “acupuncture” to the control and regulation of the flow and balance of energy and functioning.

Moreover, the Oregon Physical Therapist Licensing Board Administrative Rules does not provide for any statutory authority to physical therapists to perform dry needling.⁹ In fact, ORS 848-040-0100(8) provides that “Physical therapy intervention’ means a treatment or procedure and includes but is not limited to: therapeutic exercise; gait and locomotion training; neuromuscular reeducation; manual therapy techniques (including manual lymphatic drainage, manual traction, connective tissue and therapeutic massage, mobilization/manipulation of soft tissue or spinal or peripheral joints, and passive range of motion); functional training related to physical movement and mobility in self-care and home management (including activities of daily living (ADL) and instrumental activities of daily living (IADL)); functional training related to physical movement and mobility in work (job/school/play), community, and leisure integration or reintegration (including IADL, work hardening, and work conditioning); prescription, application, and, as appropriate, fabrication of devices and equipment (assistive, adaptive, orthotic, protective, or supportive); airway clearance techniques; integumentary repair and protective techniques; electrotherapeutic modalities; physical agents and mechanical modalities;

⁷ ORS 677.757(1)(a)

⁸ New Mexico Statutes Annotated 1978, Chapter 61, Professional and Occupational Licenses, Article 14A, Acupuncture and Oriental Medicine Practice 3, Definitions

⁹ ORS 848-040-0100(8)

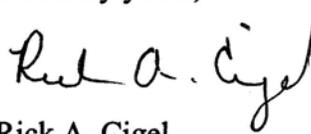
and patient related instruction and education.” For the Oregon Physical Therapy Licensing Board to determine that dry needling falls within the scope of practice for its physical therapists means that the Oregon Physical Therapy Licensing Board is ignoring the definition of “acupuncture” in ORS 677.757, and is making a policy to include dry needling by a rule, rather than leaving the physical therapy profession to sponsor and pass a bill that explicitly changes state physical therapy law.

Additionally, the Oregon Physical Therapy Licensing Board’s reliance on ORS 848-040-0145 (2), which provides that “A physical therapists or physical therapist assistant shall perform, or attempt to perform physical therapy interventions only with qualified education and experience in that intervention”¹⁰, to justify that dry needling is within in scope of physical therapy is not only overreaching but almost irresponsible and dangerous. The Oregon Physical Therapist Licensing Board Administrative Rules do not provide further standards or guidelines regarding dry needling education and/or certification. As such, it is impossible to determine what is considered “qualified education and experience” in dry needling. It is a public health hazard to allow physical therapists to use needles on patients without sufficient training.

Based on the foregoing, APIC will not provide malpractice insurance for any physical therapist who inserts needles and/or utilizes the technique of dry needling.

Thank you for your professional courtesies in this regard. Should you have any further questions or concerns, please do not hesitate to contact me.

Sincerely yours,



Rick A. Cigel
Counsel

¹⁰ ORS 848-040-0145(2)

1851 East First Street, Suite 1160 · Santa Ana CA 92705 · 800-860-8330 · 714-571-1863 (FAX)



Council of Colleges of
Acupuncture and Oriental Medicine

Council of Colleges of Acupuncture and Oriental Medicine*

Position Paper on Dry Needling

It is the position of the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) that dry needling is an acupuncture technique.

Rationale

A recent trend in the expansion in the scopes of practice of western trained health professionals to include “dry needling” has resulted in redefining acupuncture and re-framing acupuncture techniques in western biomedical language. Advancement and integration of medical technique across professions is a recognized progression. However, the aspirations of one profession should not be used to redefine another established profession.

In addition proponents of “dry needling” by non-acupuncture professionals are attempting to expand trigger point dry needling to any systemic treatment using acupuncture needles and whole body treatment that includes dry needling by using western anatomical nomenclature to describe these techniques. It is the position of the CCAOM that these treatment techniques are the *de facto* practice of acupuncture, not just the adoption of a technique of treatment.

Terminology

The invasive procedure of dry needling has been used synonymously with the following terms:

Trigger Point Dry Needling

Manual Trigger Point Therapy, when using dry needling

Intramuscular Dry Needling

Intramuscular Manual Therapy, when using dry needling

Intramuscular Stimulation, when using dry needling

History

The system of medicine derived from China has a centuries-long continuous distinct practice with an extensive literature over 2000 years old. After President Nixon’s visit to China in the early 1970s, public interest in and demand for

* Contact Person: Valerie Hobbs, MSOM, LAc (VHobbs@acupuncturecollege.edu).

acupuncture resulted in the establishment of first-professional degrees in acupuncture in the United States. Today over 50 accredited¹ first-professional colleges teach a diversity of styles of health care utilizing acupuncture, Chinese herbology, manual techniques such as tuina (Chinese therapeutic massage), nutrition, and exercise/breathing therapy. Individuals who attain this degree undergo a rigorous training program at a minimum standard of three academic years that contains 450 hours in biomedical science (biology, anatomy, physiology, western pathology, and pharmacology), 90 hours in patient counseling and practice management, and 1365 hours in acupuncture. Of the 1365 hours in acupuncture, 660 hours must be clinical hours.

Acupuncture is a system of medicine that utilizes needles to achieve therapeutic effect. The language used to describe and understand this effect is not limited and is articulated in both traditional and modern scientific terms. The National Institutes of Health has recognized the efficacy of acupuncture in its consensus statement of 1997² and continued funding of research. It is clear that other professions such as physical therapy and others also recognize the efficacy of acupuncture and its various representations such as dry needling due to the fact that they are attempting to use acupuncture and rename it as a physical therapy technique.

Dry needling is an acupuncture technique

As a system of treatment for pain, acupuncture relies on a category of points derived from the Chinese language as “*ashi*” (阿是) points. “*Ashi*” point theory describes the same physiological phenomenon identified as “trigger points,” a phrase coined by Dr Janet Travell³ and dates to the Tang Dynasty (618-907). While Dr. Travell coined the phrase “trigger point”, the physiological phenomenon has been long known to acupuncturists. Dr. Travell herself had contact with acupuncturists and chiropractors interested in acupuncture in the Los Angeles area in the 1980s. Dr. Mark Seem, author of *A New American Acupuncture*⁴, discussed the similarity of their techniques in the 1990s.⁵

Modern contributors from the field of acupuncture in the specialization of dry needling techniques are:

Dr. Mark Seem, Ph. D., L. Ac., published the textbook *A New American Acupuncture* covering the topic of dry needling in 1993. His books have been published for over two decades.

Matt Callison, L. Ac., is the founder of the Sports Medicine Acupuncture® certification program and the author of *Motor Points Index*. The continuing education certification program is available to licensed acupuncturists through a private seminar company and through postgraduate studies at the New England School of Acupuncture.

Whitfield Reaves, L. Ac. is the author of *The Acupuncture Handbook of Sports Injuries and Pain: A Four Step Approach to Treatment*. He also offers a

postgraduate continuing education program in Sports Acupuncture only for licensed acupuncturists.

From the above sources it is apparent that acupuncture has an established history of using treatment utilizing what are now labeled trigger points.

Documented practice of “dry needling” by acupuncturists

The National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), the certifying board for acupuncture, completed a job task analysis in 2003 and again in 2008. The analysis documented the prevalence of actual use of dry needling techniques, i.e. the treatment of trigger points or motor points with acupuncture needles, by practicing acupuncturists. In 2003, 82% of acupuncturists surveyed used needling of trigger points in patients that presented with pain. Of the patients that present for acupuncture treatment, it is estimated that 56% present with trigger point pain. The others present for non-pain conditions such as non-trigger point pain, digestive disorders, infertility and many other conditions. The other 18% of acupuncturists used acupuncture needling techniques in non-trigger point locations. These findings document that acupuncturists are well trained to use and have consistent historical usage of trigger and motor point “dry needling” treatment. Dry needling represents a substantial daily practice among American acupuncturists.

History of “dry needling” in North America

Dr. Chan Gunn, M.D., is the founder of dry needling in Canada. He wrote in 1976, “As a first step toward acceptance of acupuncture by the medical profession, it is suggested that a new system of acupuncture locus nomenclature be introduced, relating them to known neural structures.”⁶ One may reasonably infer from this statement that Dr. Gunn believed that in order for acupuncture to be accepted in Western medicine, the technique would need to be redefined. Using a different name for the same technique does not rise to the level of creating a new technique. Dr. Chan Gunn’s dry needling seminars are only four days in length.

Jan Dommerholt has published extensively on the technique and teaches dry needling to both western trained health professionals and licensed acupuncturists, but his teaching has been focused on the profession of Physical Therapy (PT). He argues that dry needling is a new emerging western technique described in western scientific terms. He is also attempting to redefine acupuncture based solely on eastern esoteric concepts.

A current author and provider of dry needling courses, Yun-tao Ma, Ph.D., extends dry needling beyond trigger points to include acupuncture points. He describes the points according to the neuroanatomical location and effects and calls them “Acu reflex” points. It is this adaptation and renaming of acupuncture to provide total body treatment that poses the greatest risk to the public, as it circumvents established standards for identical practice, i.e., acupuncture, without the rigorous training of acupuncture and the licensing of such.

It is the position of the CCAOM that any intervention utilizing dry needling is the practice of acupuncture, regardless of the language utilized in describing the technique.

State Board of Medicine complaints against acupuncturists for dry needling

In 2009, a physical therapist submitted a complaint to the Maryland Board of Acupuncture concerning the use of the term dry needling in chart notes by an acupuncturist. The Maryland Board of Acupuncture correctly dismissed the complaint because the procedure was done by a licensed acupuncturist trained in the use of dry needling, *i.e.*, acupuncture.

In filing the complaint, the physical therapist was not asserting that the acupuncturist caused any harm or potential of harm to the patient. Rather, the physical therapist asserted that the acupuncturist used proprietary language that was unique to physical therapy, when in fact the acupuncturist was using language that was common across professions. The Little Hoover Commission, in its 2004 report to the California legislature concluded, “interactions with other health care providers, including collaboration and referrals, as well as with many members of the public, benefit from the use of common, Western-based diagnostic terminology”⁷

Summary Position of the CCAOM on Dry Needling

It is the position of the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) that dry needling is an acupuncture technique.

It is the position of the CCAOM that any intervention utilizing dry needling is the practice of acupuncture, regardless of the language utilized in describing the technique.

Adopted November 2010
Updated May 2011

¹ The Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) is recognized by the U.S. Department of Education to accredit colleges of acupuncture and Oriental medicine and authorizes such colleges to confer Master’s level first-professional degrees.

² <http://consensus.nih.gov/1997/1997Acupuncture107html.htm>.

³ Travel, Janet G., and David G. Simons. Myofascial pain dysfunction: the trigger point manual. Lippincott Williams & Wilkins, 1983, Print.

⁴ Seem, Mark. *A new American acupuncture: acupuncture osteopathy, the myofascial release of the bodymind*. Blue Poppy Press, 1993. Print.

⁵ Private communication of October, 2007 with Whitfield Reaves, L. Ac., who attended study groups with Dr. Travell in the 1980s, and in a letter from Dr. Mark Seem to Jan Dommerholt November 11, 2007. Seem relates his invitation and demonstration of acupuncture “dry needling” techniques to Dr. Travell in New York City in the 1990s.

⁶ Gunn, CC, Ditchburn FG, King MH, Renwick GJ, *Acupuncture loci: a proposal for their classification according to their relationship to known neural structures*, *Am J Chin Med*, 1976 Summer; 4(2): 183-95.

⁷ Milton Marks “Little Hoover” commission on California State Government Organization and Economy by the UCSF Center for the Health Professions, *Acupuncture in California: Study of Scope of Practice*, May 2004, pg. 13.

August 15, 2016

Written Statement to the Sunrise Review Committee of the Washington State Department of Health in Opposition to the Inclusion of the Acupuncture Procedure known as “Dry Needling” in the Scope of Practice for Physical Therapy

This statement is submitted by the Council of Colleges of Acupuncture and Oriental Medicine (Council) in opposition to the proposed expansion of scope for physical therapy to include dry needling, a procedure that is part of acupuncture practice. Since its founding in 1982, the Council has been the national membership association for accredited acupuncture colleges and programs in the U.S.¹ The Council’s membership currently consists of 56 colleges in 21 states, three of which are located in Washington State.²

The Council and the American Association for Acupuncture and Oriental Medicine (AAAOM) have taken the position that “dry needling” is the practice of acupuncture.³ The Council urges the Sunrise Review Committee to review these position papers and the discussion therein concerning the historical origins of dry needling in the “ashi” point theory of Chinese medicine, the existence of a supportive acupuncture literary tradition, and the documented use of the acupuncture procedure of dry needling by modern acupuncturists. In 2016, the Federation of Chinese Medicine Societies issued a statement defining the myofascial trigger points as “actually channel points, extra points, and ASHI points” and concluding “dry needling is actually [the] ‘re-discovery’ of acupuncture and moxibustion of traditional Chinese Medicine”⁴ This is not a professional turf war, but an attempt by physical therapists to appropriate the regulated profession of acupuncture.

Physical therapists have misled the public by attempting to use biomedical terminology to describe and distinguish a technique that is inherently part of acupuncture practice. The curriculums of the Council’s member colleges make no such distinction. The idea that acupuncturists use energetic language and physical therapists use biomedical terminology, or that acupuncturists use meridian points only and that trigger points are something different from

¹ See www.ccaom.org.

² The Council’s member colleges in Washington State are the following: Bastyr University (Kenmore, WA), Middle Way Acupuncture Institute (Mt. Vernon, WA), and Seattle Institute of Oriental Medicine (Seattle, WA).

³ See http://www.ccaom.org/downloads/CCAOM_Position_Paper_May_2011_Update.pdf (CCAOM position paper) and http://c.ygcdn.com/sites/www.aaaomonline.org/resource/resmgr/docs/aaaom-tpdn-position_stmt-031.pdf?hhSearchTerms=%22dry+and+needling%22 (AAAOM position paper).

⁴ See

http://mp.weixin.qq.com/s?__biz=MzA3MDM5NTkyOA==&mid=408809208&idx=1&sn=f04b7b30de7966ee84f1dd2243fd3fe7&scene=1&srcid=03100Rxj6moXd4CkCaWGSVvu#rd.

acupuncture points, and that for these reasons dry needling is not acupuncture, is false and has no correlation to actual standards or practice in the acupuncture field.

In addition, the American Academy of Medical Acupuncture, while acknowledging the controversy concerning the definition of dry needling, nevertheless unequivocally deems dry needling to be an invasive procedure which, if included in the scope of practice of physical therapists, “unnecessarily [exposes] the public to serious and potentially hazardous risks.”⁵ “The AAMA strongly believes that, for the health and safety of the public, this procedure should be performed only by practitioners with extensive training and familiarity with routine use of needles in their practice and who are duly licensed to perform these procedures, such as licensed medical physicians or licensed acupuncturists. In our experience and medical opinion, it is inadvisable legally to expand the scope of physical therapists to include dry needling as part of their practice.”⁶ Elsewhere in its position paper, the AAMA details some of the specific adverse events and substantial medical injuries that may occur from dry needling that is performed by an inadequately trained practitioner. As noted by the AAMA, “in the worse case scenario, vital organs can be pierced, resulting in complex medical situations or even death.”

At its June 2016 meeting, the American Medical Association (AMA), noting that “lax regulation and nonexistent standards surround this invasive procedure,” adopted a policy statement on dry needling declaring that “physical therapists and other non-physicians practicing dry needling should – at a minimum – have standards that are similar to the ones for training, certification and continuing education that exist for acupuncture.”⁷ The AMA’s formally adopted resolution states that “dry needling [is] an invasive procedure and. . . should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.”⁸

The Council understands that physical therapists in Washington State wish to include dry needling in the scope of practice of physical therapy with only 55 hours of training in this procedure (SB 6374). This amount of training is wholly inadequate to ensure public safety. As noted by the AAMA in its policy statement concerning dry needling, “acupuncture, like Western Medicine, is a complex subject. It cannot be mastered in a weekend or in a month.” The physician members of the AAMA who practice acupuncture must complete 300 hours of didactic and clinical education and training in acupuncture.

The Federation of State Boards of Physical Therapy commissioned the *Analysis of Competencies for Dry Needling by Physical Therapists*, which is also known as the HumRRO Report.⁹ The document is unusual in its non-disclosure that five of the seven Task Force

⁵ AAMA Policy on Dry Needling, <http://www.medicalacupuncture.org/Portals/2/PDFs/AAMADryNeedlingPolicyOct15.pdf>.

⁶ *Id.*

⁷ See <http://www.ama-assn.org/ama/pub/news/news/2016/2016-06-15-new-policies-annual-meeting.page>.

⁸ Resolution 223 (Dry Needling is an Invasive Procedure), <http://www.aapmr.org/docs/default-source/advocacy/final-ama-annual-june-2016-meeting-report-copy.pdf?sfvrsn=0>.

⁹ See

https://www.apta.org/uploadedFiles/APTAorg/Advocacy/State/Issues/Dry_Needling/AnalysisCompetenciesforDryNeedlingbyPT.pdf [hereinafter cited as *HumRRO Report*].

members^{10 11 12 13} used to develop the report have a financial interest as instructors or owners in for-profit providers of dry needling education for physical therapists. The report, and testimony by physical therapists in support of their continued use of inadequate weekend-length programs, concluded that 86% of the competencies needed to perform dry needling are competencies contained in existing physical therapy programs. These competencies involve the general evaluation and delivery of care and have no relevance to dry needling. As the ability to take a patient history and evaluate a patient for physical therapy does not confer knowledge or skill about needling therapies, the comparative statement that physical therapists lack only 14% of dry needling competencies is meaningless. Additional problems with the report include the following:

1. The basic definition of dry needling adopted by the report¹⁴ is not restricted to trigger point therapy and could include every needling technique in acupuncture, including auriculotherapy and microsystems such as scalp acupuncture as long as they are defined in biomedical terms. Therefore, the definition of dry needling adopted by the report is overly broad and vague. It is impossible to define all the competencies needed under an overly broad definition because without a content standard, all the related job tasks and knowledge competencies cannot be reliably identified.
2. The report identifies 16 dry-needling-specific knowledge competencies that comprise the 14% of the additional competencies that must be gained in post-graduate coursework. It is important to note that when physical therapists state they already have within their programs 86% of the competencies needed, they have completely left out any competencies related to the attainment of skills or supervised clinical experience necessary to perform dry needling. All of the deficient competencies are knowledge-based. In a single footnote, the report states that “although additional training is needed for the development of psychomotor skills...there does not appear to be widespread agreement regarding the minimum of practice hours necessary...Variation across individuals in terms of their aptitude, education, experience, and clinical specialization results in different rates of development.”¹⁵ In other words, the report fails to identify ANY hours that are needed for skill attainment. With the insertion of 3-inch needles into a human body as the core skill being taught, the failure to identify the amount of clinical practice necessary underscores the inherent bias in the report.

¹⁰ See <http://myopainseminars.com/directors-faculty/> and <http://myopainseminars.com/seminars-travell-dry-needling-courses>. Joseph Donnelly and Michelle Layton are instructors for Myopain Seminars.

¹¹ See <http://www.kinetacore.com/physical-therapy/Keri-Maywhort-PT-DPT/page233.html> and <http://www.kinetacore.com/physical-therapy/Overview-of-Dry-Needling-Functional-Dry-Needling-Courses/page150.html>.

¹² <http://www.kinetacore.com/physical-therapy/JJ-Thomas-MPT-CMTPT/page287.html>.

¹³ <http://www.kinetacore.com/physical-therapy/Edo-Zylstra-PT-DPT-MS-OCS-IMSp/page240.html>.

¹⁴ *HumRRO Report* at 1.

¹⁵ *Id.* at 13.

3. The report is based on doctoral-level competencies. Only an estimated 32% of licensed physical therapists are trained at the doctoral level.^{16 17 18 19 20 21} This report does not apply to 68% of physical therapists in practice. Since dry needling education courses are not limited to doctorally-trained physical therapists, and less than a third of currently licensed physical therapists have attained the educational level upon which the report is based, the report cannot be used to support the proposed expanded scope expansion for all licensed physical therapists.
4. Independent certification bodies usually carry out the development of a job task analysis and competencies for professional practice in order to avoid bias. Since this report relies on for-profit vendor experts, avoids altogether the issue of a lack of an educational standard in the field, and fails to set any minimum hours for skills training, none of its conclusions can be depended upon for policy-making to promote public safety.

A professionally trained acupuncturist who graduates from a nationally accredited acupuncture college in the U.S. must complete between 1500-2000 hours of education and training *solely in acupuncture*.²² In the interest of public safety, physical therapists who wish to utilize the acupuncture procedure of dry needling should be required to complete an acupuncture education and training program at an institution accredited by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM), the accrediting agency recognized by the U.S. Department of Education for colleges and programs of acupuncture. Short of this level of training, physical therapists should not be using an acupuncture needle as part of their scope of practice to perform dry needling acupuncture.

The Council respectfully requests the Sunrise Review Committee to take into consideration the above points in light of the serious public safety issues at stake in the attempt by physical therapists in Washington State to expand their scope of practice to include the acupuncture technique of dry needling without having completed adequate training.

¹⁶ This estimate was drawn from currently available statistics. The various state boards of physical therapy may keep an exact number of licensed DPTs, but this data is not readily available to the public. Between 2001-2014, there were 49,405 graduates of DPT programs. The Federation of State Boards of Physical Therapy (FSBPT) reports that 1% of graduates fail to pass licensing exams. Therefore the number of graduates who were eventually licensed can be reduced by 494 to 48,911. This number is reduced by 2.5% for attrition to an estimated number of currently practicing DPTs at 48,170. Added to this are the 15,000 graduates of tDPT programs for a total of 63,170. The American Physical Therapy Association estimates the number of licensed PTs at 198,000. Therefore the number of all licensed physical therapists who are doctorally trained would be 63,170/198,000 or 32%.

¹⁷ <http://www.capteonline.org/AggregateProgramData/Archive/>

¹⁸ <https://www.fsbpt.org/FreeResources/NPTEPassRateReports/NPTEGraduationYearReports.aspx>

¹⁹ <http://www.apta.org/WorkforceData/>. The PT profession has not gathered statistics on attrition. They have used figures of 3.5%, 2.5% and 1.5% to calculate projections of surplus/shortage in projected workforce. The middle number was used here.

²⁰ <http://www.apta.org/PostprofessionalDegree/TransitionDPTFAQs/>. Number 13.

²¹ <http://www.apta.org/WorkforceData/>

²² For a comparison of the amount of education and training a professionally trained acupuncturist receives solely in acupuncture compared to that received by other health care providers (including physical therapists) who may use acupuncture as part of their practice, see http://www.ccaom.org/downloads/CCAOM_KnowYourAcu.pdf.

Sincerely,

A handwritten signature in black ink, appearing to read "Valerie Hobbs". The signature is written in a cursive, flowing style.

Valerie Hobbs, MSOM, LAc
Chair, CCAOM Legislative Committee

8/12/2016

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Sunrise Reviews
P.O. Box 47850
Olympia, WA 98504-7850

Email: sunrise@doh.wa.gov

Dear Ms. Thomas and Washington State Sunrise Review Committee members:

I am a practicing physical therapist in North Carolina and have practiced for 21 years. I am also a licensed acupuncturist. I attended and graduated a fully accredited and credentialed school in New Mexico and have been practicing for 16 years. I have also attended a PT "dry needling" seminar in November 2013 and February 2014, so I feel qualified to comment on whether physical therapists should be allowed to include this type of acupuncture into their scope of practice. Under the current proposal, I believe they should not.

Acupuncture is the use of a filiform needle for therapeutic purpose; dry needling is defined as the same and is often referred to "Biomedical Acupuncture" or "Myofascial Trigger Point Dry Needling." As practiced by physical therapists it is the identical technique used in acupuncture called Ashi (ah yes) needling for the treatment of tight, ropey, and painful areas in the musculoskeletal system. Ashi technique is one of many classical East Asian and western techniques and theories used when performing acupuncture.

In North Carolina, a 54-hour dry needling certification course is available to physical therapists. The course is split over two weekends. After the first weekend course, participants are expected to independently conduct 100 acupuncture/dry-needling treatments (not hours), before taking the second weekend course. There is no oversight, supervision, or clinical guidance during this time. After completing the second weekend course, physical therapists are allowed to practice acupuncture/dry needling. No further continuing education requirement is needed. As an experienced acupuncturist and physical therapist, I found this course to be an introduction to needling at best. This course creates a false sense of competence for physical therapists and a liability to their patients. Many of the supporting research references were from acupuncture studies. I would also like to note that the instructor made the comment during the first class of wishing the North Carolina Physical Therapy board hadn't talked him into a fifty-four hour course. He thought twenty-seven hours of training would be sufficient.

In order to ensure patient safety and efficacy, there are well-vetted acupuncture standards for training, practice, and certification. Licensed acupuncturists receive at least 2000 hours of training. 660 hours are specific to the use of a filiform needle.

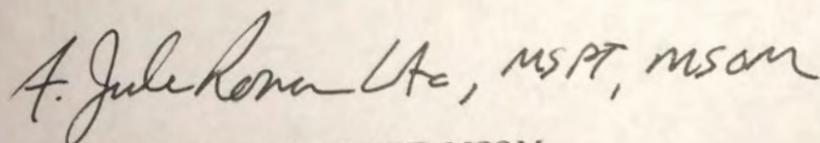
Students are supervised by qualified instructors and certified via psychometrically sound testing by a third party national organization; the industry standard for medical doctors to practice acupuncture is 300 hours of training with examination.

Other health professions wishing to incorporate acupuncture into their scope of practice should adhere to existing professional standards, and didactic and practicum requirements in order to ensure patients receive safe, high quality, effective healthcare.

There are currently no independently vetted training programs for dry needling, no established and validated dry needling curricula, and no means of assessing the competence of teachers in the field. In addition, North Carolina there are no continuing education requirements once a certification for dry needling is obtained.

The Sunrise Committee should reject the proposal outright from the physical therapists in Washington State at this time.

Sincerely,



A. Jude Roman LAc., MSPT, MSOM



DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL
3630 STANLEY ROAD
JBSA FORT SAM HOUSTON, TEXAS 78234-6100

REPLY TO
ATTENTION OF

MCCS-HGP

30 July 2016

MEMORANDUM FOR Sunrise Hearing

SUBJECT: Dry needling training for physical therapists

1. I just moved to WA State and am retiring from 20 years U.S. Army service. For the past 7 years I have served as Research Director and Associate Professor at the U.S. Army- Baylor Doctoral Program in Physical Therapy where I have taught dry needling to both our entry-level physical therapist students and post-professionally to Army, Air Force, Navy, Public Health Service, and VA physical therapists. Moreover, I was a part of the team that set the nation-wide dry needling credentialing and training standard for physical therapists throughout the military.

2. Safety is our utmost priority in dry needling training for physical therapists within the military. Based on reviews of dry needling and acupuncture literature¹ our largest concerns are the very rare occurrence of serious adverse events including pneumothorax (punctured lung), systemic infection, and nerve injury. Therefore, our 3 day basic and 3 day advanced post-professional dry needling courses are centered on a review of relevant 3-dimensional anatomy and clean needle technique (sterile needles, alcohol preparation, and wearing gloves). Since our entry level doctoral physical therapy (DPT) training includes 218 hours of gross and musculoskeletal anatomy (including cadaveric dissection), 83 hours of physiology, 60 hours of neuroscience, and comprehensive instruction and testing in sterile and clean technique, these 3 day courses are simply a brief review with specific instruction on needle insertion techniques that avoid important anatomic structures (such as the lungs, arteries, and nerves).

3. This comprehensive training in human musculoskeletal anatomy far exceeds the hours included in entry-level acupuncture training or even medical school. The single study to date published on adverse outcomes in physical therapists performing dry needling² found no serious adverse events in any of the over 7600 dry needling treatments performed. These data support the safety of physical therapists performing dry needling and match observations from my many years of clinical experience with military physical therapists.

4. The chronic pain epidemic in the U.S. costs in excess of \$560 billion annually in healthcare expenses, and lost productivity.³ For the past 5 years I have dedicated my research to physiologic and clinical outcomes associated with dry needling. I have received over \$1,000,000 in grant funding and have published (or in the process of publishing) approximately 20 manuscripts on studies investigating dry needling on the effects of patients and Soldiers with chronic musculoskeletal pain. My intent is to

Office Symbol

SUBJECT: Same as on first page

continue this impactful line of research at Eastern Washington University. I am confident that the results can improve outcomes for both acupuncture and dry needling treatment for patients with chronic musculoskeletal pain in the future.

5. For any questions regarding this memorandum or if I can help in any way, please contact me at 210-722-3671 or shanekoppenhaver@mac.com

6. References:

1. Kalichman, L. & Vulfsons, S. Dry needling in the management of musculoskeletal pain. *J Am Board Fam Med* 23, 640–6 (2010).
2. Brady, S., McEvoy, J., Dommerholt, J. & Doody, C. Adverse events following trigger point dry needling: a prospective survey of chartered physiotherapists. *J. Man. Manip. Ther.* 22, 134–140 (2014).
3. Gaskin, D. J. & Richard, P. The Economic Costs of Pain in the United States. *J. Pain* 13, 715–724 (2012).



SHANE KOPPENHAVER, PT, PhD
Lieutenant Colonel, U.S. Army
Director/Associate Professor
U.S. Army Baylor University Doctoral
Program in Physical Therapy
Adjunct Faculty, Eastern Washington
University Physical Therapy Program

BLUE MOUNTAIN ORTHOPAEDICS, P.S.
Scott B. Hutson, M.D.

Orthopaedic and Arthroscopic Surgery and Sports Medicine

8/15/2016

To Whom It May Concern;

I have been in practice as an orthopedic surgeon for over 30 years and at least 20 years ago I learned about the technique of "dry needling" from the pain clinic at the University of Washington. I have found that to be an extremely valuable adjunct treatment of my patients. I was very thankful when a number of years ago my physical therapist was trained in the technique began using it in his practice. We have found it very useful in patients with chronic myofascial issues. When this is added to the typical massage techniques it allows them to progress to functional exercises much sooner and leads to a much quicker recovery to function. I have been very disappointed with the controversy that has surrounded the use of this technique by physical therapists in the last few years and hope that this can be resolved in a positive manner and we can move forward with this very valuable means of patient care.



Scott B. Hutson, MD

1017 South Second, Suite 1 • Walla Walla, WA 99362 • Phone (509) 525-4900 • Fax (509) 522-3886

**Washington State Department of Health
Dry Needling Sunrise Review Hearing - August 2nd
Testimony by Sunrise Review Applicant Dr. Jan Dommerholt**

Note: Following the testimony (1), I have added some thoughts based on the comments made during the meeting (2)

The department pulled the written testimony from this submission but left (2) thoughts based on comments during the meeting. Dr. Dommerholt's testimony can be found in Appendix C - Public Hearing Comments.

2. My response to some of the comments

Several opponents to dry needling by physical therapists made rather misleading and misinformed statements, which could potentially misdirect the committee. Very few comments did have validity and need further exploration

- Multiple acupuncturists brought up that dry needling by physical therapists would constitute a public health hazard. Most argued that they were mostly concerned about the safety of the public, while only one acupuncturist stated that he was mostly concerned about “the survival of the field of acupuncture.” In my testimony, I believe I have argued convincingly against the “public health hazard” argument. Whether the field of acupuncture will survive has nothing to do with whether physical therapists will be allowed to use the technique of dry needling.
- An acupuncturist discussed several cases with adverse events. One of those cases involved a physical therapist, who had used dry needling on a patient’s calf muscles. Following the treatment, the patient went into a whirlpool tank and developed a severe infection. Mr. Moore suggested that the infection was the result of incompetent use of dry needling by the physical therapist. Once again, let us look at the facts. I was an expert witness in this legal case and can only conclude that the acupuncturist misrepresented the facts. While dry needling may have provided a pathway for microbes to enter the patient’s muscles, the cause of the infection was the dirty whirlpool and not the dry needling. Another case he referenced involved a schoolteacher in Maryland who alleged that she had suffered a nerve injury as a result of dry needling by a physical therapist. Following the dry needling session, this schoolteacher did contact me directly to ask for advice. I recommended consulting with a Maryland-licensed neurologist. Following the consultation, the physician concluded that there was no evidence of any nerve lesion. Another case he cited involved a Canadian athlete who suffered injury after having been treated with dry needling by a massage therapist, which has no relevancy to this debate. He did mention one case of a pneumothorax experienced by an Olympic athlete in Colorado and that is indeed the only case with merit. A physical therapist was responsible for causing the pneumothorax. As I mentioned in my testimony, the major liability or malpractice insurance for physical therapists has issued statements that dry needling does not pose an increased risk. While every pneumothorax is one too many, there will always be inherent risks of using invasive procedures, whether these are performed by a physical therapist, a physician or an acupuncturist.

- One of the acupuncturists reported that a colleague acupuncturist attended a dry needling course taught by one instructor with 60 participants. I am very familiar with this report and have communicated with the acupuncturist who attended the course and who reported this on her online acupuncture blog. The instructor of that course happened to be an acupuncturist and not a physical therapist. The course used to be called Biomedical Acupuncture until dry needling became more popular and the instructor changed the name to Dry Needling. Clearly, it is irresponsible to teach any hands-on course, and in particular a course with invasive therapies, with only one instructor and 60 students. However, the Washington State Board of Physical Therapy already has procedures in place to accredit courses. It is my advice to the committee to include a recommendation that every dry needling course program must be thoroughly evaluated prior to approval for continuing education credit. Among the criteria should be the instructor-student ratio, the experience of the instructor, the course content, etc. My continuing education company, Myopain Seminars, sets very high standards for its instructors. The instructors of our dry needling courses have passed our certification examinations, have at least 10 years of clinical experience and have a combination of
 - * A minimum of 5 years of clinical dry needling experience
 - * A PhD degree or a transitional DPT degree
 - * Fellowship status in the American Academy of Orthopedic Manual Physical Therapists
 - * OCS certified
 - * A minimum of 5 years of teaching experience in a master or doctoral physical therapy program

In addition, we maintain an instructor - student ratio of 1:10, which has been proven to be sufficient for safe and effective dry needling instruction.

- One person who testified stated that he was an instructor at Bastyr and that he was certified in the Gunn IMS approach, which is the predominant dry needling course program in Canada. I am also certified in the Gunn IMS Approach. He continued to argue that physical therapists should have at least the same education of 300 hours (!) to use dry needling as physicians who learn the full scope of acupuncture practice. Yet, the Gunn program consists of only 54 hours of training. As stated, nearly all physiotherapists in Canada have completed the Gunn Approach and they are performing dry needling on a daily basis without being a threat to the public safety of their patients.
- Another instructor at Bastyr argued that every aspect of dry needling by physical therapists is exactly the same as the practice of acupuncture. I assume that he has never attended a dry needling course by one of the

major dry needling course providers in the USA, as every acupuncturist who has attended the dry needling courses by Myopain Seminars has stated that dry needling is entirely different from dry needling. As recent as two weeks ago, an acupuncture instructor of the TriState College of Acupuncture in New York City attended our DN-1 course and she confirmed that there was very little similarity between the acupuncture courses taught at her institute and the dry needling offered by Myopain Seminars.

- Several acupuncturists argued that the so-called ashi points are the same as trigger points. One cited the work of Peter Dorsher suggesting 95% overlap, even though he did not mention Dorsher's name. See

Dorsher, P, 2006. Trigger points and acupuncture points: anatomic and clinical correlations. *Med Acupunct*, 17, 21-25.

Dorsher, PT, 2008. Can classical acupuncture points and trigger points be compared in the treatment of pain disorders? Birch's analysis revisited. *Journal of Alternative and Complementary Medicine*, 14, 353-359.

Dorsher, PT & Fleckenstein, J, 2008. Trigger points and classical acupuncture points part 1: Qualitative and quantitative anatomic correspondences. *Dt Ztschr f Akup*, 51, 15-24.

Yet, they omitted the work by world-renowned acupuncturists Steve Birch who has studied this topic in great detail. In his publications he established that at best, there is only an 18-19% overlap between ashi points and trigger points. See

Birch, S, 2003. Trigger point--acupuncture point correlations revisited. *Journal of Alternative and Complementary Medicine*, 9, 91-103.

Birch, S, 2008. On the impossibility of trigger point-acupoint equivalence: a commentary on Peter Dorsher's analysis. *Journal of Alternative and Complementary Medicine*, 14, 343-345.

- One acupuncturist assured us that she would provide details about why the Adverse Events study by Brady et al and the HUMBRO study commissioned by the Federation of State Boards of Physical Therapy would be invalid. I would like to remind the committee that the Brady et al study was published in one of the most prestigious manual therapy journals in the world after going through an independent peer review process. The HUMBRO study was reviewed in detail by Ms. J.J. Thomas and was conducted by a highly regarded research company.
- A physical therapist mentioned an adverse events study by White and suggested that the study would support dry needling by physical therapists. I feel I need to clarify that statement as the study was of physicians and physical therapists practicing Western Medical Acupuncture in the UK, which is not exactly the same as dry needling as practiced in the US. The reference for that study is:

White, A, Hayhoe, S, Hart, A & Ernst, E, 2001. Survey of adverse events following acupuncture (SAFA): a prospective study of 32,000 consultations. *Acupuncture in medicine : journal of the British Medical Acupuncture Society*, 19, 84-92.

- The same physical therapist mentioned studies by Witt et al about the adverse events in acupuncture. Those references are:

Witt, CM, Pach, D, Brinkhaus, B, Wruck, K, Tag, B, Mank, S & Willich, SN, 2009. Safety of acupuncture: results of a prospective observational study with 229,230 patients and introduction of a medical information and consent form. *Forsch Komplementmed*, 16, 91-97.

Witt, CM, Pach, D, Reinhold, T, Wruck, K, Brinkhaus, B, Mank, S & Willich, SN, 2010. Treatment of the adverse effects from acupuncture and their economic impact: A prospective study in 73,406 patients with low back or neck pain. *Eur J Pain*.

- Peuker et al have argued that adverse events in acupuncture could be prevented if acupuncturists had better knowledge of anatomy. The reference is

Peuker, ET, White, A, Ernst, E, Pera, F & Filler, TJ, 1999. Traumatic complications of acupuncture. Therapists need to know human anatomy. *Archives of Family Medicine*, 8, 553-558.

I would like to remind the committee that physical therapists have superior knowledge of anatomy and the musculoskeletal system compared to all other medical providers other than orthopedic surgeons.

- One of the committee members mentioned the clean needle technique, which is a strategy in the education of acupuncturists. Physical therapists are not necessarily familiar with “clean needle techniques”, but every physical therapist has studied and is very familiar with the OSHA Blood Borne Protocol. According to Regulations (Standards - 29 CFR) published by the US Occupational Safety and Health Administration as these dictate standard physical therapy practice. I would like to point out that although all US schools of acupuncture include instruction in clean needle techniques, a close review of these guidelines suggests that the US Clean Needle Technique Guidelines (National Acupuncture Foundation 2009) are not always consistent with Blood borne Pathogen Regulations (Standards - 29 CFR) published by the US Occupational Safety and Health Administration (United States Department of Labor) and with guidelines published by the US Centers for Disease Control and Prevention (Ehrenkranz & Alfonso 1991). According to the Blood borne Pathogen Regulations (Standards - 29 CFR), ‘gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin;...’ (United States Department of Labor). The US Clean Needle Technique Guidelines recommend that the practitioner who wishes to ‘close the hole’ uses a clean, dry cotton ball and does not mention gloves (National Acupuncture Foundation 2009). In other words, I do not recommend that clean needle techniques are recommended for physical therapist using the dry needling technique in clinical practice as 1. the approach may not be consistent with the OSHA Blood borne Pathogen Regulations (Standards - 29 CFR).
- Lastly, one acupuncturist stated that “dry needling is based on acupuncture.”

However, the dry needling technique I teach historically has nothing to do with acupuncture. Instead, dry needling is a modification of trigger point injections as taught by Dr. Janet Travell and Dr. David Simons, authors of the Trigger Point Manual. Dr. Travell was President Kennedy and President Johnson's White House physician and she developed the myofascial pain constructs, the medical management strategies, and injection technique. Drs. Travell and Simons were my mentors. When Dr. Travell developed her techniques, she was not aware of any acupuncture literature, nor did she consult with acupuncturists. In fact, after she published her 1983 textbook on myofascial pain, a few prominent acupuncturists approached her and considered the myofascial pain concepts to be "the missing link in their acupuncture practice." One of those acupuncturists published his own book incorporating trigger point concepts and he referred to his newly defined approach in acupuncture as the "new American acupuncture."¹⁵

¹⁵ Seem, M 2007 A new American acupuncture; acupuncture osteopathy. Boulder, Blue Poppy Press.

Washington State Department of Health

Dry Needling Sunrise Review Hearing - August 2nd Testimony by Sunrise
Review Applicant Jennifer J. Thomas, MPT, CMTPT

Note: Following Testimony (A) I have included some additional insight on questions that were brought up during the hearing (B)

The department removed Jennifer J. Thomas' testimony but left (B) additional insight on questions that were brought up during the hearing. Her testimony can be found in Appendix C - Public Hearing Summary.

1 of 7

B. Answers to Questions from The Hearing:

Are the terms Acupuncture and Dry Needling synonymous terms?

My Acupuncture colleagues testified that dry needling and acupuncture are synonymous terms. Identifying the literal definition of dry needling is important to understand the differences between each of our professions and how they use the technique. The literal definition of dry needling is “the use of a needle without an injectate”. Acupuncturists use “a needle without an injectate” but that doesn't mean everyone who uses a needle without an injectate is performing acupuncture. It is the method of its application and the manner in which a “dry needle” is used that dictates one's compliance with his/her professional scope of practice.

To better explain this, let's look at the fundamentals of each profession through the definitions in the Washington State Law. By looking at the Law, it is clear that the fundamental differences in our professions lie in the differences in our training, evaluation, and application of a unique method, not our use of one tool or another.

Washington State Law describes each profession as such:

Physical Therapy Law 18.74.010 states that Physical Therapy “*is based on **movement science** and means:*

Examining, evaluating, and testing individuals with mechanical, physiological,

*and developmental impairments, **functional limitations in movement**, and disability or other health and **movement-related** conditions in order to determine a diagnosis, prognosis, plan of therapeutic intervention, and to assess and document the ongoing effects of intervention”.*

Acupuncture Law 18.06.010 states that, “*East Asian Medicine means a health care service utilizing **East Asian medicine diagnosis and treatment**”, and further recognizes that, “acupuncturists licensed by the state of Washington engage in a system of medicine to maintain and promote wellness and to prevent, diagnose, and treat **disease drawing upon the experience, learning, and traditions originating in East Asia, which include more than acupuncture alone.**”*

The question at The Sunrise Hearing was to determine if dry needling by a Physical Therapist is within the Physical Therapy scope of practice. A Physical Therapist utilizes dry needling as part of their overall treatment plan. This plan is derived from Western Medical concepts (mainly from Trigger Point research and neuromusculoskeletal educational foundations), based on movement science, and is directed towards

restoring movement and addressing mechanical, physiological, and developmental impairments, as well as functional limitations in movement or movement related conditions. When we align this application of dry needling to the scope of practice in the Physical Therapy Law above, it brings clarity to the issue. It highlights that a physical therapists performing dry needling in this manner is in no way providing a treatment that is based on Eastern medicine or principles, or performing “acupuncture”, as defined by the Washington State Law.

The Acupuncture Law recognizes that East Asian Medicine providers do not solely perform acupuncture as part of their profession, just as dry needling is not the only technique a Physical Therapist uses to treat Neuromusculoskeletal and movement related dysfunction. For the purposes of understanding the role that overlap has in scope of practice amongst professions, let us compare a few techniques used both by Acupuncturists and Physical Therapists for their similarities. Please refer to the table above, and take note that Acupuncturists utilize techniques such as cupping and dermal friction technique. Both of these methods have been used in the Physical Therapy arena since its origin, yet these techniques have never been argued as “out of either profession’s scope of practice”. Additionally, acupuncturists commonly use acupressure techniques, where pressure is applied to a “tender point”. There were statements that indicated that acupuncture points and trigger points have a 95% correlation rate. If we subscribe to this statement (which has actually been discounted by other literature), then we must also surmise that when an acupuncturist treats an acupuncture point they are also treating the Neuromusculoskeletal system, an area that could be considered the primary realm of a Physical Therapist.

Acupuncture Law:

RCW 18.06.010

Definitions.

The following terms in this chapter shall have the meanings set forth in this section unless the context clearly indicates otherwise:

(1) **"East Asian medicine" means a health care service utilizing East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders and includes the following:**

(a) **Acupuncture, including the use of acupuncture needles or lancets to directly and indirectly stimulate acupuncture points and meridians;**

(b) Use of **electrical, mechanical**, or magnetic devices to stimulate acupuncture points and meridians;

(c) Moxibustion;

(d) **Acupressure;**

(e) **Cupping;**

(f) **Dermal friction technique;**

(g) **Infra-red;**

(h) Sonopuncture;

(i) Laserpuncture;

(j) Point injection therapy (aquapuncture);

(k) Dietary advice and health education based on East Asian medical theory, including the

Despite this, the physical therapy community is not suggesting to prohibit the East Asian Medicine community from treating acupressure points. Acupuncturists/pressurists are well trained in their methods and are entitled to provide treatments that correspond with their training despite the fact that there is crossover with other professions.

Physical therapists are also well educated and trained in their methods and are entitled to provide techniques that fall under their areas of expertise. The Acupuncture Law recognizes this formally when they state in 18.06.045 that,

"Nothing in this chapter shall be construed to prohibit or restrict: (1) the practice by an individual credentialed under the laws of this state and performing services within such an individual's authorized scope of practice".

Since Physical Therapists are only utilizing dry needling in the capacity that falls under the realm of their expertise (Neuromusculoskeletal dysfunction as it relates to movement) and not utilizing dry needling from an East Asian Medical perspective, it is clear that they should not be prohibited from performing dry needling in this particular application. Should they ever claim to perform techniques that are outside the realm of the definition of Physical Therapy, *then* they would be outside of their scope of practice.

Why do acupuncturists require so much "supervised training" in addition to the learning process, and why is the trend in physical therapy education on dry needling across the country not the same?

There are many reasons to explain why the two educational tracts are different, and why it makes sense for them to be different. The Doctorate in Physical Therapy degree requires such a vast understanding of the fundamentals of their "trade" prior to graduation. Because of this, Physical Therapists enter continuing education courses in dry needling with a very different foundation from an Acupuncturist. The heavy focus on

Anatomy, Physiology, Biomechanics, Neurology, Kinesiology, Histology, Medical Science, universal precautions and medical red flags (including prevention of transmission of infection and blood borne pathogens) respiratory therapy, and more acquired during Physical Therapy School give background knowledge relevant to the application and learning of the dry needling technique in the Physical Therapy setting.

Given a Physical Therapist's training and doctorate level education, it is not surprising that the HumRRO study found that 86% of the knowledge that Physical Therapists need to know to safely learn dry needling is already learned at the time of graduation from an accredited school. Given the fact that the dry needling scope in Physical Therapy only includes the use of the needle to treat the neuromusculoskeletal system as it relates to movement impairment, pain, and functional limitations, it makes sense that the extensive schooling described above prepares them so well for learning the technique itself.

In contrast, a student entering an Acupuncture school is not required to have taken a single anatomy course prior to admission into the program. For example, The Seattle Institute of Oriental Medicine states,
“Effective for this upcoming Fall 2016, entering students are no longer required to have taken an Anatomy & Physiology course prior to entry. The school is shifting to having this training be part of the initial instruction at SIOM.”

A physical therapist enters an educational track in dry needling after already having a foundation of over 9500 contact hours during their professional education, including 1500 hours of supervised clinical education. They have already built the foundation for understanding aspects of anatomy, physiology, kinesiology, etc needed to dry needle safely to treat neuromusculoskeletal impairments and movement dysfunction

Lastly, an Acupuncturist enrolled in a program of East Asian Medicine enters into this program with relatively no background necessary relative to their trade, and in doing so, they are also learning an entire method of evaluation and treatment that includes more than Acupuncture, and is different than “dry needling” in the neuromusculoskeletal approach (as a Physical Therapist would be learning). They are learning a philosophy to evaluate and treat a variety of ailments, disease pathologies, and organ, energy, meridian dysfunction from scratch from an Eastern Medicine perspective. They are learning things that are outside of a Physical Therapist's scope of practice. A Physical Therapist enrolled in a dry needling course is learning an adjunctive technique that complements other current methods of treatment in their scope of practice, which they have already learned, implemented, and mastered through their baseline education in physical therapy. The physical therapist has already mastered the method; they are just learning an additional skill that follows a method of treatment already in place in Physical Therapy practice.

Why was the task force in the HumRRO study made up of Physical Therapists instead of dry needling experts from other fields of study?

There were seven individuals selected to participate on the Task Force based on their depth and breadth of experience and education in dry needling. Their years of professional experience performing dry needling ranged from five to fourteen. All participants were licensed Physical Therapists with a minimum of fourteen total years of experience in Physical Therapy and a maximum of 31. Five participants possessed Doctorate level degrees (i.e., DPT); one had a Master's level degree (i.e., MPT/MSPT), and one had a Bachelor's degree. All were certified to practice dry needling, and five were currently serving in an educational or training role (e.g., faculty, instructor) providing dry needling instruction in addition to their clinical employment as Physical Therapists. One was a full-time faculty member.

Physical Therapists were chosen rather than professionals from other fields of study because the intent of the study was to determine the criteria necessary for a Physical Therapist, not another professional, to learn to safely dry needle.,. Standards needed to be measured on the training that a Physical Therapist receives both in their baseline educational programs and their continuing education in dry needling. If HumRRO used professionals from another field of study to measure this content, it would not give valid or accurate data. Other professions do not have the experience or knowledge necessary to understand a Physical Therapist's requirements.

While 7 members of a task force may seem like a small number to some, and suggest room for bias towards a certain outcome, it is important to remember that the experienced research group, HumRRO, organized the study in a way that avoided bias by individuals. The task force simply helped analyze the data that had already been gathered by HumRRO from the Background Study and by the Practitioner Survey. The Background Survey took information from over 30 respected sources including peer reviewed literature and publications, and resulted in nearly 1,000 pieces of data relevant to dry needling. The practitioner survey included the perspective of over 350 Physical Therapists from a variety of settings and experience levels. The results you see in the study were organized individually by HumRRO based on the data from all 3 components of the study, not just by 7 dry needling experts. When we (the task force) analyzed the data, it was presented to us in a way that we did not have a picture of the end result. HumRRO literally asked us line by line to rate each item on importance, safety, and relevance to our practice of dry needling. The task force analyzed each piece of data at various levels, and it was subject to an objective review, followed by a discussion amongst the experts. It was then given a final review by the task force, before the content was impartially organized by HumRRO, separate and independent from the task force.

I note that the extensive and referenced report prepared by the Physical Therapy Association of Washington does not make mention of two important papers that call into question, and in fact refute, the theoretical basis for “dry needling” of tissues said to contain “trigger points”.

As I am a co-author of both papers, I request that due consideration be given to their content before a decision is made as to whether or not “dry needling” comes within the scope of practice of PTs.

I have also attached a copy of our Letter to the Editor of the Journal of Bodywork and Movement Therapies which was written in response to an article by Drs Gerwin and Dommerholt.

John Quintner. Physician in Rheumatology and Pain Medicine
Arthritis and Osteoporosis WA



LETTER TO THE EDITOR

Response to Dommerholt and Gerwin: Did we miss the point?



The human understanding when it has once adopted an opinion draws all things else to support and agree with it. And though there be a greater number and weight of instances to be found on the other side, yet these it either neglects or despises, or else – by some distinction sets asides and rejects, in order that by this great and pernicious determination the authority of its former conclusion may remain inviolate.

[Francis Bacon (1620) from *Novum Organum*, Book 1, Aphorism XLVI]

Beauty, it is said, is in the eye of the beholder. Clearly, when we gaze upon the field of “myofascial pain due to trigger points”, we (Quintner et al., 2014) see a landscape that is different from that appreciated by Dommerholt and Gerwin (2015). They conclude that “Quintner et al. have not succeeded in providing sufficient evidence that the current TrP hypotheses (sic) should be rejected.”

Now it is up to the discerning reader to decide between two polar views on which is the better theory for the clinical phenomena of pain and tenderness in apparently normal musculoskeletal tissues. Dommerholt and Gerwin assert, “... insufficient evidence is to be taken that further studies are needed ...”, by which it is clear that they continue to adhere to the proposition that “trigger points” exist and are responsible for these phenomena. We have taken a different view, that sufficient work has been done to test that proposition and that no further work based on it is likely to resolve the issue of the better explanatory model.

It is not appropriate for us to reiterate our argument here. We will however respond to three themes in Dommerholt and Gerwin’s paper:

- The question of bias
- With what do they in fact disagree?
- How scientific inquiry works

DOI of original article: <http://dx.doi.org/10.1016/j.jbmt.2015.01.009>.

<http://dx.doi.org/10.1016/j.jbmt.2015.02.008>

1360-8592/© 2015 Elsevier Ltd. All rights reserved.

The question of bias

The very nature of an opinion piece that questions dogma is one of bias. Why would we go to the trouble of articulating our views if we had not come to the conclusion that “the conventional wisdom” has been found wanting? If by “bias”, Dommerholt and Gerwin imply that our fundamental rejection of the “trigger point” construct means that we ignore studies that uncritically accept it, then we wear that as a badge of epistemological courage.

Pain medicine still has much established bias; until the Enlightenment, Medicine itself was similarly full of bias, of explanatory models based on myth, mystery and mendacity. So-called bias in the present context really refers to a way of looking at the world, or the German word *Weltanschauung*. For example, theists and non-theists interpret the world differently depending on their bias. The question remains, which view is closer to the truth?

With what do Dommerholt and Gerwin in fact disagree?

We invite the reader to examine these statements by Dommerholt and Gerwin, and to identify how these authors disagree with us:

- “In spite of years of research into the nature of myofascial pain and significant gains especially during the last decade, several aspects remain elusive and are not well understood. A distinct mechanistic understanding of this disorder does not yet exist.”
- “We acknowledge that there has not been a study to demonstrate the minimal essential features of the TrP needed to identify it for diagnosis and treatment purposes.”
- “... there has never been a credible anatomic pathology associated with myofascial TrPs.”
- “We agree that there are few outcome studies of good quality and although some studies showed reduction in pain scores and pressure pain thresholds, the literature has neither convincingly supported or refuted the effectiveness of some invasive and non-invasive modalities beyond placebo.”

- “We agree with Quintner et al. that studies of the efficacy of TrP interventions have shown such marked statistical heterogeneity that it can be difficult to evaluate outcomes.”

Yet Dommerholt and Gerwin upbraid us for not “... providing any alternative studies specifically done on the pain phenomena that is attributed to TrPs.”

How scientific inquiry works

Dommerholt and Gerwin are critical of our use of “theory” and “hypothesis” and claim that we have used them in a non-scientific manner:

“Scientific inquiry commonly starts with observations, followed by the development of hypotheses, which through experiments are confirmed, modifies, or refuted. Through repeated experimental testing of the hypothesis it is continually refined until a theoretical basis can be constructed that addresses different aspects of the hypothesis. The end goal of the process is to construct a scientific theory. Few, if any, phenomena in medicine have reached the stage of scientific theory, including the existing TrP hypothesis.”

As we do not agree with that formulation of method, let us return to basics.

A theory is an explanation for a set of observations. The explanatory power of a theory varies directly as its degree of support from different lines of evidence. The *theory* of myofascial pain seeks to explain the *phenomena* of pain and tenderness in apparently normal soft musculoskeletal tissue by invoking the *hypothesis* that “trigger points” exist in “myofascial” tissues. These “trigger points” are said to be the origin of nociception that is experienced as pain.

That hypothesis has been tested time and time again, along the lines of “If there are trigger points, then x, y, or z will be found or will happen.” This is the logical construct: “If P, then Q”. However, no evidence (x, y, z) that supports the existence of trigger points has been found – experimentally, empirically, or predictively. The logical inference is: Not Q, therefore not P. As such P, the hypothesis, is rejected. The hypothesis is now seen to have been only a conjecture. As myofascial pain theory is fundamentally based on that hypothesis, it too must be rejected.

However, Dommerholt and Gerwin (and indeed others) adhere to the logical positivist approach of seeking to confirm a hypothesis by repeated observations (and interpretations) based on the assumption that the theory is correct. They support using the hypothesis beyond the intended purpose of generating testable ideas, to directly inform treatment. Then, in a classical circular reasoning process, they ascribe largely anecdotal positive treatment effects as confirmation of the hypothesis. This is patently wrong.

By contrast, we argue that this approach continues to treat the conjecture as if it were true. But if the fundamental tenet of a theory is flawed – that is, it is shown to be only conjecture – then no amount of data can rectify this. The proposition, “All swans are white” is not confirmed by repeated observations of white swans: it is refuted by the observation of a black swan. We adhere to the Popperian view that, despite substantial research efforts there is no credible evidence either that “trigger points” exist or that “myofascial tissue” is the primary origin of nociception. Therefore the theory that generated this hypothesis is faulty and should be rejected.

In summary, observations lead to theory. Hypotheses are deduced from theory. Refutation of (the claims made by) a hypothesis should lead to modification of the theory. In this way, even cherished theories can be contested.

According to this argument, perhaps we should have advanced our alternative explanatory model for the phenomena in question as a *theory* rather than a hypothesis. The theory is that the phenomena reflect altered central nociception. A deduction from this theory is the hypothesis that pain and hypersensitivity may arise secondary to altered functions of nociceptive axons in response to a variety of factors, such as mechanical insult leading to inflammation. It is up to the pain community to test this hypothesis.

Dommerholt and Gerwin have extensively reiterated arguments based on a false premise. We are not persuaded that we have made scientific or logical errors in our thesis. It is time to shine the light of critical inquiry elsewhere in pursuit of explanations for these clinical phenomena.

References

- Dommerholt, J., Gerwin, R.D., 2015. A Critical Evaluation of Quintner et al: missing the Point. *J. Bodyw. Mov. Ther.* 19 (2), 193–204. <http://dx.doi.org/10.1016/j.jbmt.2015.01.009>.
- Quintner, J.L., Bove, G.M., Cohen, M.L., 2014. A critical evaluation of the trigger point phenomenon. *Rheumatology* 54, 392–399.

John L. Quintner, FFPMANZCA *

Arthritis and Osteoporosis WA, Shenton Park, Perth, WA, Australia

Geoffrey M. Bove, DC, PhD

University of New England College of Osteopathic Medicine, Biddeford, ME, USA

E-mail address: geoffreybove@gmail.com (G.M. Bove)

*Milton L. Cohen, MD FRACP FFPMANZCA
St Vincent's Clinical School, UNSW Australia, Sydney, New South Wales, Australia*

E-mail address: m.cohen@unsw.edu.au (M.L. Cohen)

*Corresponding author.

E-mail address: jqu33431@bigpond.net.au (J.L. Quintner)

Controversy Corner

Referred Pain of Peripheral Nerve Origin: An Alternative to the "Myofascial Pain" Construct

John L. Quintner, M.B., B.S., M.R.C.P. and
*Milton L. Cohen, M.B., B.S., M.D., F.R.A.C.P.

St. John of God Medical Centre, Perth, Western Australia, and *St. Vincent's Hospital, Sydney, and University of New South Wales, Sydney, New South Wales, Australia

Abstract: The theory of myofascial pain syndrome (MPS) has been constructed around the trigger point (TrP), a region within a muscle from which local and remote pain can be evoked by palpation. Although their pathophysiology is obscure, TrPs have been regarded as the cause of myofascial pain. Spread and chronicity of pain are attributed to the activation of latent, secondary, and satellite TrPs. Although it lacks internal validity, this tautological concept has given rise to a system of empirical treatment that has been uncritically accepted by many. However, not only does the anatomical distribution of pain referred from TrPs bear a close relationship to the course of peripheral nerves, but the pain of MPS is also similar to nerve trunk pain, which is an example of somatic referred pain. Pain of peripheral nerve origin can be present without neurological deficit and with normal findings on conventional electrodiagnostic examination. In contrast to the theory of MPS, which considers the TrPs to be sites of primary hyperalgesia, this article argues that all MPS phenomena are better explained as secondary hyperalgesia of peripheral neural origin.

Key Words: Myofascial pain syndrome—Neuropathic pain—Hyperalgesia—Epistemology.

Although painful conditions of varying degrees of severity involving the soft tissues (i.e., muscles, tendons, ligaments, and peripheral nerves) occur frequently, their underlying pathogenesis is poorly understood. During the 19th century, these conditions were called *muscular rheumatism* or *fibrositis* to distinguish them from conditions such as *articular rheumatism*, which primarily involve joints (1). Chronic forms of muscular rheumatism were attrib-

uted to inflammation of a "peculiar" kind affecting the fibrous tissues around joints; this inflammation was found in tendons, bursae, ligaments, fascia, nerve sheaths, muscles, and periosteum (2). Others only used the term *rheumatism* when they wished to denote the presence of nonspecific inflammation involving voluntary muscle fibers (1,3).

In the early part of this century, the English neurologist Gowers (4) championed the concept of "fibrositis" as a painful inflammatory disorder of the fibrous structure of muscle spindles (at that time the only known sensory structures in muscle). He taught that "fibrositic" inflammation could spread by direct fascial extension to involve nearby tendons, joints, and nerve sheaths (interstitial neuritis), thus unifying the two conceptual models of the

Manuscript submitted October 12, 1993; revision received February 16, 1994; accepted April 6, 1994.

Address correspondence and reprint requests to Dr. J. Quintner, St. John of God Medical Centre, 175 Cambridge Street, Wembley, WA 6014, Australia.

19th century. By the 1930s his views had gained general acceptance. The committee on "arthritis and allied conditions" appointed by the British Medical Association in 1933 recognized the following subgroups of fibrositis: intramuscular and fascial; periarticular; bursal and tenosynovial; subcutaneous (panniculitis); and perineuritic (5). The clinical sequelae attributed to "perineuritis" included radiating pain, paresthesiae, cutaneous hyperesthesia, tenderness in muscles and joints in the sensory area served by the nerves involved, and tenderness over the site of the nerve itself, which was attributed to the involvement of the *nervi nervorum*. Motor and sensory impairments were uncommon (5).

Over the next 50 years, clinicians attempting to unravel the complex nature of muscular rheumatism focused their attention on palpatory findings in and around voluntary muscles, almost to the exclusion of a possible contribution to pain from peripheral nerves or other tissues. The concept of the "fibrositic nodule," described as "an area in the substance of a muscle or its tendinous sheath which gives rise to pain either in the same locality or referred to a distance when stimulated" (6), was discarded when it became clear that it lacked pathological support (7). In addition, as knowledge of spinal disc pathology increased, it was argued that so-called fibrositic lesions in muscles could be explained as secondary or referred phenomena (8).

However, those who still adhered to the belief that many localized or regional chronic pain syndromes are attributable to more subtle pathological changes occurring solely within voluntary muscle put forward the construct of the *myofascial pain syndrome* (9). More recently, another, competing, construct has been redefined to account for chronic and widespread musculoskeletal pain, namely *fibromyalgia syndrome* (10). The main diagnostic criterion for this syndrome is the presence of a defined number of "tender points" at predetermined anatomical sites. We have argued elsewhere that this construct conveys no pathophysiological insights, having been derived by a process of circular argument (11). Moreover, some authors have recognized that there may be considerable clinical overlap between the two syndromes (12,13). In view of the controversial and complex nature of these pain syndromes, a critical analysis of the prevailing hypotheses is justified to clarify the situation.

In this article, the hypothesis that pain arising from trigger areas within muscles is of primary myofascial origin is critically examined. It will be

shown on epistemological, clinical, and pathophysiological grounds that the myofascial pain syndrome (MPS) construct is invalid and that the phenomena it purports to explain are better understood as secondary hyperalgesia of peripheral neural origin.

THE "MYOFASCIAL PAIN" CONSTRUCT

The major sources for the synthesis provided herein are the principal writings of the proponents of MPS (9,14-19).

Definition and basic phenomenology

Myofascial pain has been described as "the most common cause of chronic pain" (17). Introduced in 1952 after a decade of research, and developed since by Travell and her co-workers (9,15), MPS has been defined as a regional pain syndrome with two major components: (a) the trigger point, a localized area of deep muscle tenderness or hyperirritability; and (b) a predictable, discrete reference zone of deep aching pain, which may be located in the immediate region of or remote from the trigger point (TrP), may be quite extensive, and is worsened by palpation of the TrP.

Trigger points have been described in skin, joint capsules, ligaments, and periosteum as well as in muscles and their fasciae. Myofascial TrPs are said to be located within palpable taut bands, purported to represent shortened muscle fibers. On "snapping" palpation or needling of a myofascial TrP, a local twitch response can be elicited. This clinical sign is accompanied by an irritable electromyographic response. A muscle containing a TrP exhibits antalgic inhibition when tested for strength and is also intolerant to stretch. In a seeming contradiction, muscle stretching is recommended as being efficacious treatment for myofascial pain. Relief of pain requires "inactivation" of the relevant trigger area, by physical (needling or stretch) or chemical (local anesthetic) means.

Travell and Simons (15) insist that the "specific muscle or muscle group that causes the symptoms should be identified." More recently, Simons (19) has defined MPS as "*primarily* a dysfunction of one or more specific muscles" (emphasis added). The constancy of distribution of pain referred from individual muscles is said to enable the clinician to "work backward" and thus locate the TrP(s) responsible for particular pain patterns.

One of our main criticisms of the construct of myofascial pain is that its major proponents have

incorporated their preferred hypothesis of causation within the definition. As will be shown elsewhere in this article, this error in reasoning has limited the discussion of other explanations for the various clinical phenomena observed in these syndromes.

Metaphysics of trigger points

The TrP is said to "cause" (16) or have "the propensity to cause" (18) or "the responsibility for causing" (17) local and referred pain. It has even been suggested that TrPs may at times "refer" hypoesthesia or anesthesia instead of pain (19). Trigger points may be "active," "latent," "satellite," or "secondary." Active TrPs are more likely to be found in musculature of the neck, shoulder, and pelvic girdles and in the muscles of mastication. They can occur in multiple locations in any one muscle; their site(s) can vary from person to person and their irritability is said to vary from hour to hour and from day to day.

A TrP is considered latent or dormant if it is not "causing" referred pain. Latent TrPs can be found in asymptomatic subjects, in whom the TrPs are nonetheless said to restrict movement and cause weakness in the affected muscle (20). Latent TrPs are said to accumulate with advancing age (14).

Satellite TrPs are those that can be found in muscles within the pain-reference zone of another TrP. Secondary TrPs develop in muscles that are either synergists or antagonists of the muscle that contains the primary TrP. Synergists are said to be overloaded when they substitute for the affected muscle and antagonists are said to be overloaded when they counter its tautness.

Initiation

It was originally proposed that myofascial TrPs may be initiated by "direct trauma to muscle or joint, chronic muscular strain, chilling of fatigued muscle, acute myositis, arthritis, nerve root injury, visceral ischemia or dyskinesia, and hysteria" (9). These same factors, plus resumption of normal activity after periods of immobility, are also said to be capable of activating latent TrPs. A latent TrP may even be activated during therapy: as one set of muscles is being stretched, their antagonists, which presumably contain the latent TrP, are shortening.

Myofascial pain is now mainly ascribed to an initial insult to muscle fibers, either from macrotrauma or repetitive microtrauma (16). The consequences of such an insult may include release of such sub-

stances as histamine, serotonin, kinins, and prostaglandins which may then activate nociceptors and cause reflex muscle contraction.

However, this proposition of muscle injury lacks empirical support. Muscle pain and damage following eccentric contractions have been extensively studied (21). In normal subjects, complete recovery is the rule and no long-lasting effects have been noted. Unless muscle strains are severe (e.g., complete tears) or associated with deep hematoma formation, recovery is complete. Severe distraction or contusion injuries are common in sport but no evidence has been presented that such well-defined acute injuries are antecedents of MPS. Furthermore, electromyography of painful muscles (22) and thermographic studies of the tissues overlying them (23) have not demonstrated abnormalities in TrPs. Muscle biopsy studies of TrPs have also been largely unrewarding in terms of muscle inflammation or damage (18).

Perpetuation

The chronicity of pain that follows the activation of a myofascial TrP has been explained by a feedback cycle maintained by bombardment of the central nervous system (CNS) by impulses from TrPs themselves: that is, they become self-perpetuating. However, remote lesions in joints or chronic visceral disease and dysfunction may also provide noxious input into this cycle, as may emotional stimuli, chronic infection, various metabolic disturbances, and even dietary deficiencies (14).

As the painful muscles in MPS are electrically silent, the presence of muscle spasm that may reflect ectopic impulse formation seems most unlikely (22). Furthermore, the efferent arm of the proposed vicious cycle has been tested. Mense (24) found that γ -motoneuron activity was diminished rather than increased in muscles with carrageenan-induced injury and concluded that the proposed vicious-circle models "have to be considered as working hypotheses rather than explanations of known mechanisms."

Spread

Spread of pain is attributed to latent TrPs being activated or to active myofascial TrPs "metastasizing" to sites within or outside of the pain-reference zone of the original TrP(s) (18). Travell (14) postulated a chain reaction whereby an ever-increasing number of satellite TrPs come into being, causing complex overlapping patterns of pain.

Reliability of TrP phenomena

When blinded as to diagnosis, those expert in the field of MPS were able to detect active TrPs in only 18% of examinations of subjects with a MPS diagnosis (25). In the same study, expert assessments for taut bands and muscle twitch responses were also found to be unreliable. These findings call into question the internal validity of the construct.

Treatment

Inactivation of the TrP by physical and chemical means would be predicted if the TrP is indeed a site of primary hyperalgesia. However, reports of the efficacy of this approach are only anecdotal; inactivation has not been subjected to formal trial. Furthermore, the persistence of using the recommended approach in the face of clinical inefficacy, along with the continuing failure over time to reveal a reasonable anatomical or pathophysiological basis for so doing, is not only irrational but also fails to acknowledge powerful placebo effects (26) and the wider psychosocial context of chronic pain (27).

Objections to MPS construct

The definition of MPS incorporates a preferred hypothesis of causation. This logical error has resulted in a system of diagnosis and treatment that has become popular but remains entirely anecdotal. Moreover, the proposition that myofascial pain and TrPs are intimately related constitutes circular reasoning: that is, by virtue of its form this proposition must always be true (Table 1).

In their efforts to preserve the centrality of the myofascial TrP, myofascial pain theorists have allowed the number and nature of predisposing, precipitating, and perpetuating factors to be opened and to encompass the full spectrum of etiology, including the untestable psychogenic level. (16,17). This serves only to perpetuate the circularity of the reasoning.

Perhaps in an attempt to provide external valid-

TABLE 1. *Problems with the MPS hypothesis*

Definition of syndrome incorporates hypothesis of causation. TrPs lack clinical reliability and validity.
Predisposing, precipitating, and perpetuating factors are legion.
Histological, biochemical, and electrical evidence of primary muscle pathology is lacking.
There is no support for the MPS hypothesis from animal experimental models or human muscle injuries.
Trigger points are an operational concept elevated to the status of theory by circular reasoning.

ity, researchers have said that TrPs arise from muscle damage, despite electrical silence and the lack of histological or biochemical evidence. Furthermore, there is neither support from an animal experimental model (24) nor from studies of human muscle injury (21). Trigger points are nonetheless said to be maintained via the CNS, not only by their own activity but also by a legion of processes associated with afferent neural input. Spread of pain is attributed to the activation of latent TrPs or to the metastasis of TrPs. This teleological argument is physiologically unsound.

Taken together, the tenets of the MPS construct arise out of circular reasoning, which should condemn MPS as epistemologically unacceptable.

"MYOFASCIAL PAIN" VERSUS PERIPHERAL NEURAL PAIN

The argument that follows explores a putative relationship between "myofascial pain" and pain of peripheral neural origin. We show that the explanation for peripheral neural involvement in MPS, which depends on nerve compression by "taut bands," is speculative and unconvincing. Application of current concepts of the physiology of nociception can lead to an alternate construct.

Differential diagnosis of MPS

The differential diagnosis of myofascial pain, as proposed (14,16), includes a variety of painful and somewhat loosely defined neurological conditions such as thoracic outlet syndrome (28), radiculopathies, and polyneuropathies. Their differentiation from myofascial pain is said to be facilitated by the presence of accompanying neurological deficits (particularly those matching a peripheral nerve or root distribution) and electrodiagnostic abnormalities (15). Although a fundamental distinction has been made between TrP pain (deep and aching) and pain of peripheral neural origin (prickling, tingling, and numbing), Dalton and Jull (29) were not able to distinguish between somatogenic and neurogenic cervicobrachial pain when they relied solely on the characteristics of pain. Moreover, peripheral neural pain can occur without neurological deficit (30) and without conventional electrodiagnostic abnormality (31).

By contrast, when neurological deficit (often accompanied by electrodiagnostic abnormality) accompanies MPS, it has been ascribed to peripheral nerve entrapment by the taut band containing the

TrP (16,19). The taut band is said to cause an overall shortening of the involved muscle, which then, in turn, can lead to a "secondary" nerve entrapment syndrome (32). The dual propositions that neurogenic mechanisms can activate myofascial TrPs and that myofascial TrPs can cause neurogenic pain add up to a circular argument. Furthermore, the neurological literature does not include the TrP taut band as a recognized anatomical cause of entrapment neuropathy (33,34).

However, on clinical grounds alone, there appears to be an intimate relationship between MPS and defined neuropathology. This relationship is worth exploring in terms of current understanding of nociceptive mechanisms.

Characteristics of myofascial pain

The pain attributed to myofascial TrPs is described as deep, dull, and aching, varying in intensity from mild to severe and occurring either at rest or only on motion (Table 2). These are the characteristics of deep somatic pain. By the 1930s, it had been long known that pain arising in deeply situated joints was often referred to anatomically distant structures. The seminal clinical experiments carried out by Lewis (35) and Kellgren (36) convincingly demonstrated the same phenomenon for pain arising in other deep musculoskeletal tissues, such as muscles, ligaments, and periosteum.

According to Kellgren (36), "The diffuse pain from a given muscle is always distributed within certain regions, though the distribution within these limits varies from individual to individual, and according to the part of the muscle stimulated" and "pain from muscle may be confused with pain arising from other deep structures such as joints and testis."

Some caution is therefore necessary before a mechanically provoked pain response is attributed to a particular structure or structures. Afferents from muscles that are the sites of referred pain and tenderness are the very ones that converge centrally onto spinal neurones that could be involved in processing information from a region of deep damage, thus leading to central summation effects (37).

Vasoconstriction, hypoesthesia, dermatographia, and hyperhidrosis have been observed in the skin overlying a region of deep pain. These phenomena appear to be reflexly induced concomitants of somatic referred pain (38).

Peripheral neural pain

The connective tissues of human peripheral nerves are well-innervated. They derive their nerve supply from axons within the nerve and from fibers accompanying the extrinsic vessels that provide its nutrition (39). As well as regulating intraneural microcirculation, this intrinsic nerve system, the nervi nervorum, is thought to have a nociceptive function (40).

Two types of pain, present singly or in combination, have been described in patients with peripheral neuropathy: "nerve trunk pain" and "dysesthetic pain" (41). The former pain has been described as aching, knifelike, or tender, whereas the latter has been described as burning, tingling, searing, crawling, drawing, or electric. Nerve trunk pain is therefore indistinguishable from pain described as myofascial (see Table 2). Nerve trunk pain has been attributed to increased activity in mechanically or chemically sensitized nociceptors within the nerve sheath, while dysesthetic pain has been attributed to damaged nociceptive afferent axons themselves.

TABLE 2. Comparison of peripheral neural pain with myofascial pain

Clinical feature	Myofascial pain syndrome	Peripheral neural pain: nerve trunk variety
Pain descriptors	Deep, dull, aching	Deep, aching; can be accompanied by dysesthetic pain
Tenderness		
Local	Trigger points (in muscle): active or latent	Nerve trunk (localized); e.g., site of entrapment
Remote	Trigger points: satellite or secondary	Somatic referred
Associated phenomena	Sympathetic dysfunction; neurological deficit (if nerve is entrapped by taut band)	Sympathetic dysfunction; neurological deficit; neuropathic phenomena, including allodynia and hyperalgesia
Electrodiagnostic abnormality	Usually absent	Usually absent
Therapeutic implications	Desensitization (inactivation) of trigger points	Nerve decompression; treatment of neuropathic pain

The Clinical Journal of Pain, Vol. 10, No. 3, 1994

Nerve trunk pain characteristically follows the course of the involved nerve, which is found to be tender, whereas dysesthetic pain is felt in its peripheral sensory distribution (41). However, when pain of nerve origin is severe, it can be felt in regions outside the sensory distribution of the particular nerve (33,34).

Peripheral neural pain may be associated with neurological deficit, but it can be accompanied by a hyperesthetic syndrome, which includes both allodynia (pain due to a normally nonpainful stimulus) and hyperalgesia (an increased response to a normally painful stimulus) (42-44). The term *peripheral neuropathic pain* has recently been suggested to embrace the combination of positive and negative symptoms in patients in whom pain is due to pathological changes or dysfunction in peripheral nerves or nerve roots (45).

Pain with the characteristics of "nerve trunk pain" has been described by patients with irritative cervical (46) and lumbar (47) radicular lesions, with brachial neuropathy (40), and following peripheral nerve injury (48).

Most nerve pain syndromes commence with symptoms more in keeping with an irritative than a destructive process (49,50). Local tenderness is commonly found over nerve trunks at sites of entrapment or metabolic insult; this tenderness has been attributed to sensitization of free nerve endings within neural connective tissue (*nervi nervorum*) (40). Such specific tender points over peripheral nerves, palpation of which could cause distant pain, was reported over a century ago (51). It has recently been suggested that radiating pain and other sensory phenomena could originate from ectopic neural pacemaker nodules formed at a site of entrapment (52). Tenderness has also been noted over motor bands (zone of innervation) and muscles in association with cervical and lumbar radicular pain without gross physical signs of denervation (53). Neuropathic pain states are frequently accompanied by abnormalities in functioning of the sympathetic nervous system (54).

Referred neural pain

Intraneural stimulation of muscle fascicles within the median and ulnar nerve trunks of normal volunteers has been shown to refer pain both distally to muscles within the innervation territories of each nerve, and proximally to deep structures (muscle and bone) in segmentally related regions outside the innervation territory of each nerve (55,56).

Recounting his personal and clinical experience, Ochoa (57) described both local elbow pain and referral of pain into the ipsilateral scapular region following mechanical stimulation of an entrapped ulnar nerve at the elbow. In his own and the other cases, none of the distal symptomatology typical of ulnar neuropathy was present.

Thus, peripheral neural tissue is a rich source of local and potential referred pain.

Anatomical concordance of myofascial TrPs and peripheral nerves

Some TrPs said to be myofascial could be situated in an adjacent hyperalgesic nerve trunk. For example, the discrete upper-limb pain syndromes attributed to TrPs in the middle finger extensor, the extensor carpi radialis, and the supinator muscles can equally be attributed to TrPs in the radial or posterior interosseous nerve trunks. The TrP said to be situated in the pronator teres muscle coincides with the median nerve, and the pain projected therefrom into the thenar muscles follows the course of the median nerve in the forearm. TrPs in the flexores digitorum referring pain into the hand may represent a tender compressed median nerve in the proximal forearm. MPSs in the shoulder girdle region may represent entrapment of the suprascapular nerve, the long thoracic nerve, the axillary nerve, and the dorsal scapular nerve, as the pain-reference zone of the TrPs follow the course of these nerves. In the lower limb, MPSs have been attributed to TrPs close to the sciatic, tibial, and superficial and deep peroneal nerves.

ALTERNATIVE EXPLANATIONS FOR MPS PHENOMENA

Alternative explanations for MPS phenomena are summarized in Table 3.

TrPs as sites of secondary hyperalgesia

The weight of evidence does not support myofascial TrPs as the anatomical sites of pain origin. By contrast, the presence of hyperalgesia in muscles that are structurally and electrically normal suggests that it must be secondary (referred) hyperalgesia (58). This hyperalgesia could be due to peripheral mechanisms such as antidromic activation or sensitization of nociceptive afferents (59) or, more likely, to a state of central sensitization, including spontaneous firing and expansion of the receptive fields of nociceptive dorsal horn neurones (60).

TABLE 3. Pathophysiological explanations for the phenomena of myofascial pain syndrome

Phenomenon	MPS theory explanation	Preferred explanation
Hyperalgesia Spread of pain	TrPs (primary hyperalgesia) Activation of latent, satellite, or secondary TrPs; nerve entrapment by taut bands	Secondary (referred) hyperalgesia Sensitization of nervi nervorum; altered central nociception; enlarged receptive fields
Intolerance of muscles to stretch	Contracture of taut band	Reflex spasm secondary to nociception elsewhere, e.g., peripheral nerve
Chronicity	Self-perpetuation; many other factors	Maintenance by nociception elsewhere; central sensitization
Cutaneous correlates Hypoesthesia Vasomotor and sudomotor	Nerve entrapment by taut bands Reflex efferent phenomena	Nerve compression itself Reflex efferent phenomena

Spread of pain

Latent, metastasizing, and secondary TrPs lack supporting evidence, as does nerve entrapment by taut bands. The spread of pain is more likely to be the consequence of altered central nociceptive processes and enlarged receptive fields in response to ongoing nociception or ectopic impulse generation (60).

Intolerance of muscle to stretch

The taut bands described in muscles containing TrPs may represent reflex spasm secondary to nociception in structures innervated by the same spinal segment (8). The intolerance to stretch could also be explained as a reflex response to the stretching of adjacent hyperalgesic neural tissue.

Chronicity of pain

MPS theorists attribute chronicity of pain to the self-perpetuating propensity of TrPs, usually in the presence of an assortment of other factors such as a short leg, poor posture, somatoform pain disorder, chronic infection, and secondary gain—all of which are teleological arguments. Alternatively, it has been shown that the altered central processing held responsible for secondary hyperalgesia may be maintained by nociception elsewhere possibly including, of course, peripheral neural structures (61).

Hypoesthesia

There are two explanations for hypoesthesia in MPS theory: compressive neuropathy by a taut band or a referred phenomenon reflecting the downward modulation of receptive fields in the pain-reference zone of the TrP (19). Irrespective of the particular entrapping mechanism, it is accepted that hypoesthesia results from the loss of sensory afferents due to nerve compression at the site of an entrapment (33). However, hypoaesthesia has also

been attributed to a functional block occurring at spinal or higher levels associated with a peripheral neural pain state (43).

Vasomotor and sudomotor disturbances

Disturbances of sympathetic efferent function that have been described in association with MPS have also been recognised as reflexly induced accompaniments of neuropathic pain states.

CONCLUSION

The construct of MPS, as proposed to explain chronic, deep, aching, poorly localized pain, not only lacks internal and external validity but also is epistemologically unsound. The emphasis on the primacy of the TrP phenomenon has directed attention away from other possible explanations. By contrast, there are anatomical and physiological grounds to suggest that the phenomenon of the TrP, on which depends the theory of MPS, is better understood as a region of secondary hyperalgesia of peripheral nerve origin. This proposition is testable to achieve external validity for the described clinical phenomena.

REFERENCES

1. Reynolds MD. The development of the concept of fibrositis. *J Hist Med Allied Sci* 1983;38:5-35.
2. Aitken W. *The science and practice of medicine*. Vol 2. London: Charles Griffen and Company, 1866:6-37.
3. Flint A. *Clinical medicine: a systemic treatise on the diagnosis and treatment of diseases*. London: Churchill, 1879: 629-30.
4. Gowers WR. Lumbago: its lessons and analogues. *Br Med J* 1904;1:117-21.
5. Bach F. *The rheumatic diseases: their recognition and treatment*. London: Cassell, 1935:48-66.
6. Copeman WSC. Aetiology of the fibrositic nodule: a clinical contribution. *Br Med J* 1943;2:263-4.
7. Collins DH. Fibrositis and infection. *Ann Rheum Dis* 1940; 2:114-26.

8. Elliott FA. Aspects of "fibrositis." *Ann Rheum Dis* 1944;4:22-5.
9. Travell J, Rinzler SH. The myofascial genesis of pain. *Postgrad Med* 1952;11:425-34.
10. Wolfe F, Smythe H, Yunus MB, Bennett RM, Bombardier C, Goldenberg DL, Tugwell P, et al. The American College of Rheumatology 1990 criteria for the classification of fibromyalgia. Report of the multicentre criteria committee. *Arthritis Rheum* 1990;33:160-72.
11. Cohen ML, Quintner JL. Fibromyalgia syndrome, a problem of tautology. *Lancet* 1993;342:906-9.
12. Bennett RM. Current issues concerning management of the fibrositis/fibromyalgia syndrome. *Am J Med* 1986;81(suppl 3A):15-8.
13. Smythe H. Links between fibromyalgia and myofascial pain syndromes. *J Rheumatol* 1992;19:842-3.
14. Travell J. Myofascial trigger points: a clinical view. In: Bonica JJ, Albe-Fessard D, eds. *Advances in pain research and therapy: Proceedings of the first world congress on pain, Florence*. (Vol 1) New York: Raven Press, 1976;919-26.
15. Travell JG, Simons DG. Myofascial pain and dysfunction. In: *The trigger point manual*. Baltimore: Williams & Wilkins, 1983.
16. Simons DG, Travell JG. Myofascial pain syndromes. In: Wall PD, Melzack R, eds. *Textbook of pain*. 2nd ed. Edinburgh: Churchill Livingstone, 1989;368-85.
17. Friction JR. Myofascial pain syndrome: characteristics and epidemiology. In: Friction JR, Awad E, eds. *Advances in pain research and therapy: Myofascial pain and fibromyalgia friction*. (Vol 17) New York: Raven Press, 1990:107-27.
18. Bennett RM. Myofascial pain syndromes and the fibromyalgia syndrome: a comparative analysis. *J Manual Med* 1991;6:34-45.
19. Simons DG. Muscle pain syndromes. *J Manual Med* 1991;6:3-23.
20. Sola AE, Rodenberger ML, Gettys BB. Incidence of hypersensitive areas in posterior shoulder muscles. *Am J Phys Med* 1955;34:585-90.
21. Mills KR, Newham DJ, Edwards RHT. Muscle pain. In: Wall PD, Melzack R, eds. *Textbook of pain*. 2nd ed. Edinburgh: Churchill Livingstone, 1989:420-32.
22. Durette MR, Rodriguez AA, Agre JC, Silverman JL. Needle electromyographic evaluation of patients with myofascial or fibromyalgic pain. *Am J Phys Med Rehabil* 1991;70:154-6.
23. Swerdlow B, Dieter JNL. An evaluation of the sensitivity and specificity of medical thermography for the documentation of myofascial trigger points. *Pain* 1992;48:205-13.
24. Mense S. Considerations concerning the neurobiological basis of muscle pain. *Can J Physiol Pharmacol* 1991;69:610-6.
25. Wolfe F, Simons DG, Friction J, Bennett RM, Goldenberg DL, Gerwin R, Hathaway D, et al. The fibromyalgia and myofascial pain syndromes: a preliminary study of tender points and trigger points in persons with fibromyalgia, myofascial pain syndrome and no disease. *J Rheumatol* 1992;19:944-51.
26. Peck C, Coleman G. Implications of placebo theory for clinical research and practice in pain management. *Theor Med* 1991;12:247-70.
27. Loeser JD. What is chronic pain? *Theor Med* 1991;12:213-25.
28. Cuetter AC, Bartoszek DM. The thoracic outlet syndrome: controversies, overdiagnosis, overtreatment, and recommendations for management. *Muscle Nerve* 1989;12:410-9.
29. Dalton PA, Jull GA. The distribution and characteristics of neck-arm pain in patients with and without a neurological deficit. *Aust J Physiother* 1989;35:3-8.
30. Lindblom U. Neuralgia: mechanisms and therapeutic prospects. In: Benedetti C, Chapman CR, Moricca G, eds. *Advances in pain research and therapy: Recent advances in the management of pain*. (Vol 7). New York: Raven Press, 1984:427-38.
31. Dyck PJ. Invited review: limitations in predicting pathological abnormality of nerves from the EMG examination. *Muscle Nerve* 1990;3:371-5.
32. Hong C-Z, Simons DG. Response to treatment for pectoralis minor myofascial pain syndrome after whiplash. *J Musculoskeletal Pain* 1993;1:89-131.
33. Stewart JD, Aguayo AJ. In: Dyck PJ, Thomas PK, Lambert EH, eds. *Peripheral neuropathy*. 2nd ed. Vol 2. Philadelphia: Saunders, 1984:1435-57.
34. Lundborg G, Dahlin LB. The pathophysiology of nerve compression. *Hand Clin* 1992;8:215-27.
35. Lewis T. Suggestions related to the study of somatic pain. *Br Med J* 1938;1:321-5.
36. Kellgren JH. Observations on referred pain arising from muscle. *Clin Sci* 1938;3:175-90.
37. Wall PD. The mechanisms of pain associated with cervical vertebral disease. In: Hirsch C, Zotterman Y, eds. *Cervical pain*. Oxford: Pergamon Press, 1971:201-10.
38. Feinstein B, Langton JNK, Jameson RM, Schiller F. Experiments on pain referred from deep somatic tissues. *J Bone Joint Surg* 1954;36A:981-97.
39. Hromada J. On the nerve supply of the connective tissue of some peripheral nervous components. *Acta Anat* 1963;55:343-51.
40. Thomas PK. Pain in peripheral neuropathy: clinical and morphological aspects. In: Culp WJ, Ochoa J, eds. *Abnormal nerves and muscles as impulse generators*. New York: Oxford University Press, 1982:553-67.
41. Asbury AK, Fields HL. Pain due to peripheral nerve damage: an hypothesis. *Neurology* 1984;34:1587-90.
42. Lindblom U. Neuralgia: mechanisms and therapeutic prospects. In: Benedetti C, Chapman CR, Moricca G, eds. *Advances in pain research and therapy: Recent advances in the management of pain*. (Vol. 7). New York: Raven Press, 1984:427-38.
43. Lindblom U, Verrillo RT. Sensory functions in neuralgia. *J Neurol Neurosurg Psychiatry* 1979;42:422-35.
44. Ochoa J. Pain in local nerve lesions. In: Culp, WJ, Ochoa J, eds. *Abnormal nerves and muscles as impulse generators*. New York: Oxford University Press, 1982:568-87.
45. Devor M, Rappaport ZH. Pain and pathophysiology of damaged nerve. In: Fields HL, ed. *Pain syndromes in neurology*. Oxford: Butterworth Heinemann, 1990:47-83.
46. Elliott FA, Kremer M. Brachial pain from herniation of cervical intervertebral disc. *Lancet* 1945;1:4-8.
47. Dyck PJ. Sciatic pain. In: Watkins RG, Collis JS, eds. *Lumbar discectomy and laminectomy*. Rockville: Aspen, 1987:5-14.
48. Sunderland S, Kelly M. The painful sequelae of injuries to peripheral nerves. *Aust N Z J Surg* 1948;18:75-118.
49. Pratt NE. Neurovascular entrapment in the regions of the shoulder girdle and posterior triangle of the neck. *Phys Ther* 1986;66:1894-900.
50. Swash M, Schwartz M. *Neuromuscular diseases: a practical approach to diagnosis and management*. 2nd ed. Berlin: Springer-Verlag, 1988:125-49.
51. Nothnagel H. On neuritis in relation to its diagnosis and pathology. In: Volkmann R, ed. *Clinical lectures on subjects connected with medicine, surgery, and obstetrics by various German authors*. London: New Sydenham Society, 1877:201-36.
52. Devor M. Neuropathic pain and injured nerve: peripheral mechanisms. *Br Med Bull* 1991;47:619-30.
53. Gunn CC. "Prespondylosis" and some pain syndromes following denervation sensitivity. *Spine* 1980;5:185-92.
54. Ochoa JL, Torebjörk E, Marchettini P, Sivak M. Mechanisms of neuropathic pain: cumulative observations, new

- experiments and further speculation. In: Fields HL, Dubner R, Cervero F, Jones LE. eds. *Advances in pain research and therapy: Proceedings of the fourth world congress on pain, Seattle*. (Vol 9). New York: Raven Press, 1985:431-50.
55. Marchettini P, Cline M, Ochoa JL. Innervation territories for touch and pain afferents of single fascicles of human ulnar nerve. *Brain* 1990;113:1491-500.
 56. Torebjörk HE, Ochoa JL, Schady W. Referred pain from interneural stimulation of muscle fascicles in the median nerve. *Pain* 1984;18:145-56.
 57. Ochoa JL. Neuropathic pains, from within: personal experiences, experiments, and reflections on mythology. In: Dimitrijevic MR, Wall PD, Lindblom U, eds. *Recent achievements in restorative neurology*. 3. *Altered sensation and pain*. Basel: Karger, 1990:100-11.
 58. Hardy TD, Wolff HG, Goodell H. Experimental evidence on the nature of secondary hyperalgesia. *J Clin Invest* 1950;29:115-40.
 59. Xavier AV, Farrell CE, McDanal J, Kissin I. Does antidromic activation of nociceptors play a role in sciatic radicular pain? *Pain* 1990;40:77-9.
 60. Dubner R. Neuronal plasticity in the spinal and medullary dorsal horns: a possible role in central pain mechanisms. In: Casey KL, ed. *Pain and central nervous system disease: the central pain syndromes*. New York: Raven Press, 1991:143-55.
 61. Gracely RH, Lynch SA, Bennett GJ. Painful neuropathy: altered central processing maintained dynamically by peripheral input. *Pain* 1992;51:175-94.

Review

doi:10.1093/rheumatology/keu471

A critical evaluation of the trigger point phenomenonJohn L. Quintner¹, Geoffrey M. Bove² and Milton L. Cohen³**Abstract**

The theory of myofascial pain syndrome (MPS) caused by trigger points (TrPs) seeks to explain the phenomena of muscle pain and tenderness in the absence of evidence for local nociception. Although it lacks external validity, many practitioners have uncritically accepted the diagnosis of MPS and its system of treatment. Furthermore, rheumatologists have implicated TrPs in the pathogenesis of chronic widespread pain (FM syndrome). We have critically examined the evidence for the existence of myofascial TrPs as putative pathological entities and for the vicious cycles that are said to maintain them. We find that both are inventions that have no scientific basis, whether from experimental approaches that interrogate the suspect tissue or empirical approaches that assess the outcome of treatments predicated on presumed pathology. Therefore, the theory of MPS caused by TrPs has been refuted. This is not to deny the existence of the clinical phenomena themselves, for which scientifically sound and logically plausible explanations based on known neurophysiological phenomena can be advanced.

Key words: nerve, muscle, referred pain, pain mechanisms, philosophy of science.

Rheumatology key messages

- The theory of myofascial pain based on trigger points is conjecture that has been put forward as established knowledge.
- The key phenomenon of muscle tenderness demands a robust plausible explanation based on neurobiology.
- Clinicians cannot ignore the important role of contextual factors when evaluating outcomes of their treatment for myofascial pain syndrome.

Introduction

The phenomena of muscle pain and tenderness in the absence of obvious disease are well recognized but poorly understood. Myofascial pain syndrome (MPS) is a popular explanatory model, which posits a local (muscle) origin of nociception called the trigger point (TrP) and advocates local treatment, primarily direct manipulation of TrPs using manual pressure or needles, the latter with and without injectate [1, 2]. These forms of treatment are being practised worldwide by physicians, physical therapists, chiropractors and various unlicensed and unregulated practitioners [3].

But does the evidence support these concepts? Are the hypotheses generated by MPS theory scientifically

sound? And are treatments based on this theoretical model beneficial?

This article will show that the theory is flawed both in reasoning and in science. In seeking a resolution, two testable hypotheses are identified that point the way to neuroscientific explanations for the observed clinical phenomena.

Evolution of MPS theory

It has long been believed that muscle pain might originate from focal lesions within connective tissues [4, 5]. The initial description put forward by Stockman [6] was of fibrositic nodules, which were suggested to harbour low-grade inflammation that activated sensory fibres innervating muscle spindles and the interstitial tissues between muscle fibres. However, Stockman's claim that 'the essential lesion is a chronic inflammatory hyperplasia of white fibrous tissue in patches' [7] has never been confirmed [8].

An infective aetiology of such nodules was proposed, but other conjectures included microtrauma, exposure to environmental extremes, nerve root irritation and psychoneurosis [8, 9].

¹Rheumatology and Pain Medicine, Mount Claremont, Perth, Western Australia, ²University of New England, College of Osteopathic Medicine, Biddeford, Maine, USA and ³Pain Medicine and Rheumatology, St Vincent's Clinical School, University of New South Wales Australia, Sydney, New South Wales, Australia

Submitted 7 August 2014; revised version accepted 23 October 2014.

Correspondence to: John L. Quintner, Rheumatology and Pain Medicine, Mount Claremont, 28 Bentley Close, WA 6010, Australia. E-mail: jqu33431@bigpond.net.au

Kraus (cited by Simons [2]) speculated that palpable muscle hardening of unknown cause could set up a reflex increase in muscle tension, resulting in a pain-reflex-pain self-perpetuating cycle that could be disrupted by ethyl chloride sprayed onto the overlying skin or by local injections of anaesthetic. Pain theorists William Livingstone [10] and John Bonica [11] favoured this vicious circle hypothesis, as did others [12, 13].

Speculation took a new turn when Travell and Rinzler [4] conceptualized that pain felt in voluntary muscles is myofascial in origin. Their claim, that 'trigger areas in myofascial structures can maintain pain cycles indefinitely' [4], was reminiscent of the vicious circle hypothesis.

Travell and Simons formalized the construct of 'myofascial pain arising from trigger points' [14]. Not only were TrPs described in exactly the same way as fibrositic nodules had been, but it was also asserted that they could potentially develop within every voluntary muscle and in multiple locations within a given muscle.

The theory of MPS comprised two essential components: the TrP, a localized area of tenderness or hyperirritability deep within voluntary muscle; and a predictable discrete zone of deep aching pain, which could be located in the immediate region of or remote from the TrP, and which was worsened by palpation of the TrP [4, 14].

Travell and Simons [14] composed anatomical charts of TrPs and their characteristic pain referral patterns. However, it appears that their diagrams had 'sometimes been chosen arbitrarily, there being no accepted standard' [15].

Located within palpable taut bands, TrPs were said to represent shortened (contractured [16]) muscle fibres. On snapping palpation or insertion of a needle, a local twitch response could be elicited, which was accompanied by an irritable EMG response [14]. In contrast to a normal muscle, one containing a TrP was said to exhibit both antalgic inhibition when tested for its strength, and intolerance to passive stretch.

To explain the puzzling onset of pain in ostensibly lesion-free tissues, Travell and Simons [14] found it necessary to invent the latent TrP, a site of potential tenderness within a muscle unassociated with spontaneous pain but having the potential to be activated by a myriad of factors, within or outside the body. In an attempt to extend the theory to explain more widespread pain, they claimed that TrPs could self-propagate to become secondary TrPs in other muscles and even to metastasize throughout the bodily musculature.

The recent conjecture that peripheral pain generators can reside within muscles (i.e. myofascial tissues), and be responsible not only for spontaneous pain but also for the initiation and maintenance of profound changes within the CNS (known as central sensitization) rests upon these dubious premises [17, 18]. Similarly, prominent rheumatologists are among those who maintain that TrPs are responsible for the initiation and maintenance of the syndrome of chronic widespread pain (FM) [17-23].

Beliefs in TrP theory and the associated concept of MPS continue to be strongly held [24], despite the fact

that such beliefs exemplify circular reasoning: TrPs cause myofascial pain because painful muscles contain them [25].

Review of the evidence

Clinical diagnosis

An extensive review identified at least 19 different sets of diagnostic criteria used for the MPS/TrP syndrome, and concluded there was a lack of consistency and consensus on case definition [26]. The authors suggested that until reliable diagnostic criteria had been established, 'there is a need for greater transparency in research papers on how a case of MTrP [*sic*] pain syndrome is defined, and claims for effective interventions in treating the condition should be viewed with caution' [26]. A similar study found that the diagnosis of MPS from putative TrPs was based on a clinical test of unknown reliability and validity with no accepted reference standard [27].

In studies of inter-examiner reliability, examiners were given the muscle to palpate with or without an accompanying diagnosis [28-31]. In one study, extensive training coupled with the use of an algometer resulted in examiner agreement that the phenomenon could be localized [29]. Another study reported that the assessments of an individual examiner were consistent from one test to another [31], and that more experience in assessment leads to better inter-examiner agreement [30]. These studies suggest that when shown where a problem may exist, examiners may agree. However, when blinded as to diagnosis, those who claimed expertise in the field were unable to detect putative TrPs in the majority of subjects with a MPS diagnosis [32]. In this study, there was virtually no inter-examiner reliability for either putative TrPs or taut bands. This finding questions the reliability of the diagnostic criteria used by these experts. More recent studies [33, 34] have also reported poor inter-examiner diagnostic reliability and poor methodological quality [35].

In summary, physical examination cannot be relied upon to diagnose a condition that is supposed to be defined by that physical examination. That is, the pathognomonic criterion for making the diagnosis of MPS is unreliable.

Pathology

The first histological analysis of fibrositic nodules reported diffuse inflammatory changes [9]. These findings were not confirmed, although tender muscles contained increased extracellular fluid [36]. The authors suggested that the resulting turgor might explain the observed finding of mechanical tenderness.

The term myogelosis describes a change in muscle structure analogous to TrPs [37]. Samples taken from unfixed cadavers following detection of such areas showed altered histology [37], but the clinical relevance to the findings on palpation is unknown.

Tissue biochemistry

Shah *et al.* [38, 39] employed microdialysis to sample tissue fluid within and near to a palpated trigger zone in trapezius muscles in patients with a diagnosis of TrPs and also in normal pain-free subjects. Samples were taken from the following regions: normal (no pain, no TrP), active (pain and TrP detected) and latent (no pain, TrP detected). Samples were also taken from asymptomatic gastrocnemius muscles. Elevated levels of calcitonin gene-related peptide (CGRP), substance P (SP), norepinephrine, TNF- α , IL-1, IL-6 and low pH were reported in fluid from all sampled regions of symptomatic patients. However, elevated levels were also found in uninvolved, control muscle areas.

These reported alterations in biochemical milieu are consistent with inflammation due either to tissue damage or to altered peripheral nerve function, in contrast to pathology necessarily being in the tissue sampled [40, 41].

EMG studies

In one study, EMG examination of TrPs failed to provide evidence of ongoing denervation or focal muscle spasm [42]. But another study did report spontaneous electrical activity (i.e. endplate noise and spikes) in regions considered to be TrPs in patients with chronic tension headache and pericranial muscle tenderness [43].

Simons *et al.* [44] addressed the question of whether endplate noise and spikes arise from normal endplates by performing EMG on 25 patients who met the ACR 1990 criteria for FM and 8 pain-free subjects in whom latent TrPs had been identified by manual palpation of taut bands and characteristic referral of pain [*sic*] [45, 46]. Unfortunately, the researchers conflated the TrPs of MPS and the tender points of FM, another issue yet to be resolved [47]. They concluded that endplate noise is characteristic of but not restricted to TrPs, and that the finding could not be considered a reliable diagnostic criterion [45, 46].

An alternative interpretation of these EMG findings is that insertional and spontaneous activity (i.e. endplate noise) from single muscle fibres generated by the activation of i.m. nerve termini irritated by the needle was being recorded [48]. Nonetheless, it is still asserted that spontaneous electrical activity is one of the characteristics of myofascial TrPs [49].

Imaging studies

Seven patients with a 3-year history of myofascial pain associated with the presence of a taut band in the upper trapezius muscle were examined using magnetic resonance elastography [50]. A signature chevron-like pattern was reported, with its leading edge coincident with the physician-identified taut band. The authors did not offer diagnostic criteria nor make any comment on the relationship of a taut band to a TrP. A subsequent study of eight subjects, four of whom were said to have MPS and four of whom did not, is open to the same criticism [51].

Attempts were made to visualize TrPs using diagnostic US of the anterior abdominal wall of 10 patients [52]. The points in question appeared as a mixed echogenic area in the rectus abdominis muscle that became prominent on injection of local anaesthetic solution [52]. They conceded that the findings could have been coincidental. Also, the image presented is consistent with the normal sonographic appearance of abdominal muscles [53].

In another study, 44 patients with acute cervical pain and at least one putative TrP identified by palpation in the upper trapezius were evaluated using sonoelastography and Doppler imaging [54]. The authors claimed to have measured TrP size and to have distinguished normal muscle from active and latent TrPs. Although the data on which these assertions were made were not presented, the authors found no correlation between claimed TrP area and pain pressure threshold. The absence of pain-free control subjects is yet another flaw. These methodological concerns do not lend credibility to the findings.

Animal models

Animal models are often informative about pathophysiology in ways that are impossible to demonstrate in humans. To be considered relevant, models must have symptomatic and/or pathological similarities to the condition being studied. For TrP research, no such model exists.

Simons and Stolov [55] biopsied ostensibly normal canine muscles, seeking to correlate palpated taut bands with morphological and histological changes. The findings were negative, given that there was no indication of pain or a pathological condition present prior to these studies. The researchers observed 'rubbing palpation produced a transient contraction which could be primarily responsible for the sensation of a hardness palpated in the dog muscles' [55]. This is the myotatic reflex, which correlates with the twitch response also evocable on palpation of normal human muscle [56].

Based upon the conjecture that '... latent TrPs can be identified in almost all skeletal muscles of normal adults' [14], a rabbit model of TrPs was proposed [57, 58]. Rabbit leg muscles were palpated until they exhibited a myotatic reflex. Such muscles were considered to contain taut bands and, by assumption, TrPs. A number of papers have since been published using this model [58–65], but have not offered evidence of clinical relevance.

Delayed onset muscle soreness

Studies of delayed onset muscle soreness (DOMS) have been undertaken using eccentric exercise to cause symptoms, in both humans and animals. Although DOMS has been related to TrPs in only one study [66], this model was proposed for MPS [67]. The relevant experiment was performed in humans and used eccentric exercise of the extensor digitorum of the middle finger [66]. Following the development of DOMS, the muscle was palpated, revealing a tender band judged to be taut. However, since the muscle itself is a band, relating the description to TrPs seems meaningless. It should be noted that DOMS is

self-limiting, whereas whatever phenomenon is occurring with chronic muscle-related pain is not. The relevance of DOMS to TrPs remains unclear.

Integrated hypothesis

Dommerholt *et al.* [68, 69] postulated that low-level isometric muscle contraction or eccentric or submaximal concentric contractions could result in muscle dysfunction or damage, and that the formation of TrPs would follow. According to Gerwin *et al.* [70], excessive release of acetylcholine from dysfunctional neuromuscular endplates might be responsible for the taut band phenomenon (i.e. focal muscle contraction modulated by muscle spindle afferents) and that these bands could in turn produce muscle ischaemia, apparently by compressing adjacent capillaries supplying the muscle. This physiological process could precipitate an energy crisis in the relevant working muscle, which would respond by releasing pro-inflammatory molecules, thereby activating nociceptive neurons. Although there is no experimental evidence in support of this hypothesis, others [71, 72] have accepted the motor endplate and the energy crisis theories of tonic muscle hyperactivity and TrP formation.

Recent studies of induced muscle pain in humans has not provided evidence for a reflex increase in fusimotor drive and spindle discharge [73, 74]. In fact, persistent musculoskeletal pain is associated with decreased agonist muscle tone [75]; in other words, digital pressure or other stimuli that evoke pain will decrease the tone of the muscle stimulated. The validity of the paradigm that correlates endplate activity or noise with pain arising from the TrP became further suspect when it was reported that injection of botulinum toxin A in the region of a TrP had no effect on pain intensity or mechanical pain thresholds, but did significantly reduce motor endplate activity and the EMG interference pattern [76]. Finally, the vicious circle hypothesis has now been laid to rest by microneurographic recordings in humans performed during sustained muscle pain [73, 74]. The integrated hypothesis remains conjecture in the face of conflicting data.

Treatment

Non-invasive interventions that have been advocated include compression of the TrP, spray and stretch, transcutaneous electrical stimulation and, more recently, high-intensity focused US [77]. Invasive treatments have included injection of local anaesthetic agents, injection of CSs, injection of botulinum toxin, needle acupuncture and dry needling [78].

In their systematic review, Cummings and White [79] were unable to find evidence that needling therapies have any specific effect. Their later review of 1517 studies found only seven that were of high enough quality for meaningful analysis [80]. Rickards [81] also found limited strength of evidence for any treatment of TrPs.

Another review remarked upon the heterogeneity of the populations being treated, and the lack of widely accepted standard diagnostic criteria for MPS [82].

This review also concluded that there was insufficient evidence to support the use of most interventions.

A systematic review of botulinum toxin A for TrP treatment located 21 randomized controlled trials, with 12 eligible for consideration but only five suitable for inclusion, and concluded that the current evidence does not support any therapeutic value [83]. Again, these authors reported that the data were limited and that the patient populations were heterogeneous.

These studies provide little evidence that dry needling of TrPs is associated with a treatment effect compared with standard care [3]. They are based on small sample sizes, uncertainty as to whether TrPs were the sole cause of pain, as well as neglect of technical issues such as the variability in the location of TrPs and the depth of needle insertion.

With these results in mind, why do many clinicians insist that their treatments work? One explanation is that the treatments are rarely performed in an isolated fashion; that is, treatment is accompanied by manual therapy, home exercises and stretching.

Contextual effects could explain the plethora of anecdotal responses to treatment [84, 85]. This is not unexpected when a medical treatment with high face validity is based solely on practical experience rather than reflecting a rational approach based on pathogenesis. Apparent effectiveness of any treatment may be attributed to the natural history of the particular problem being treated, regression to the mean, and the expectation of something being done to the area in question. This can lead to the fallacy known as *post hoc ergo propter hoc* (after this, therefore because of this), when the treatment offered in fact had nothing to do with the pathogenesis of the condition towards which it was directed. A recent study comparing dry needling with manual compression, in which there was no control group, exemplifies this critical methodological issue [86].

One common factor shared by most therapies is that they elicit pain at the site of their application; that is, they are noxious stimuli. If they do work, this similarity suggests a common mechanism of action. One possible mechanism is counterirritation, or application of a competing noxious stimulus [87, 88]. It is not surprising that a noxious stimulus applied in the region where pain is experienced, whether or not there is local pathology present at that site, would elicit a transient reduction in pain intensity by recruiting those higher order brain regions responsible for anti-nociception [89, 90]. In conclusion, the vast majority of studies and meta-analyses do not support the prediction from MPS theory that focal treatment of TrPs is effective.

An impasse

In 1976, Simons hoped that: 'It would now appear possible to resolve much of the conflicting data of the past by carefully distinguishing trigger from reference zones, and acute from chronic lesions using modern electrodiagnostic, biochemical, histochemical, and ultramicroscopic techniques' [1]. Some three decades later, he conceded

that acceptance of the concept of TrPs had been hampered by two outstanding considerations: the lack of a diagnostic gold standard and the lack of generally recognized pathogenesis [91].

We propose that sufficient research has been performed to allow TrP theories to be discarded. The scientific literature shows not only that diagnosis of the pathognomonic feature of MPS (the TrP) is unreliable, but also that treatment directed to the putative TrP elicits a response that is indistinguishable from the placebo effect. As these conclusions refute MPS, formulating a plausible scientific explanation for pain perceived by patients as coming from their muscles remains a challenge.

Towards explaining the clinical phenomena

In our opinion, current neuroscientific hypotheses can form the basis for collaborative scientific investigation to explain the clinical phenomena. We offer two for consideration, neither of which relies on local pathophysiology.

Neuritis model

Nerve inflammation as a source of pain was discussed in the 19th century [92–97], but focused research on nerve inflammation as a primary disease aetiology has been limited.

Quintner and Cohen [25] hypothesized that the TrP was an area of what was then called secondary hyperalgesia occurring in muscles that are structurally and physiologically unimpaired. Noting the remarkable proximity of TrPs to known peripheral nerves, these authors argued that sensitization of the axons within the nerves, possibly by inflammation, may inform the underlying mechanism. Subsequent research has emerged in support of this hypothesis.

Focal inflammation of peripheral nerves leads to ectopic axonal mechanical sensitivity and spontaneous discharge of some but not all of the nociceptors within the inflamed nerve [98–101]. These changes can be expected to lead to focal areas of neurogenic inflammation and possibly to sensitization in the muscle innervated. If confirmed, they can inform further investigation that might be highly relevant to explaining the phenomenon of chronic muscle pain.

Referred pain and tenderness (allodynia)

Kellgren [102–104] reported the critical observation that, in addition to referred pain, referred tenderness could be induced by targeted injections of hypertonic saline into tissues such as interspinous ligaments, periosteum, cancellous bone, or voluntary muscle. His studies and those of others [105, 106] showed that nociception in deep tissues can induce the phenomena of remote localized pain and tenderness. This relegates the TrP to being a site of secondary allodynia reflecting altered central nociceptive mechanisms [107].

Conclusion

The construct of MPS caused by TrPs remains conjecture. All working hypotheses derived from this conjecture have been refuted and therefore the theory can be discarded. In contrast, evolving insights into the neurobiology of nociception and pain suggest plausible hypotheses that form a basis for advancing knowledge and therapeutics in this challenging area.

Disclosure statement: The authors have declared no conflicts of interest.

References

- 1 Simons DG. Muscle pain syndromes—Part II. *Am J Phys Med* 1976;55:15–42.
- 2 Simons DG. Muscle pain syndromes—Part I. *Am J Phys Med* 1975;54:289–311.
- 3 Dunning J, Butts R, Mourad F *et al*. Dry needling: a literature review with implications for clinical practice guidelines. *Phys Ther Rev* 2104;19:252–65.
- 4 Gowers WR. A lecture on lumbago: its lessons and analogues. *Br Med J* 1904;i:117–21.
- 5 Travell J, Rinzler SH. The myofascial genesis of pain. *Postgrad Med* 1952;11:425–34.
- 6 Stockman. A discussion on fibrositis. *Proc R Soc Med* 1913;6:36–9.
- 7 Stockman R. *Rheumatism and arthritis*. Edinburgh: W. Green 1920.
- 8 Copeman WS. A clinical contribution to the study of the aetiology of the fibrositic nodule. *Ann Rheum Dis* 1943;3:222–6.
- 9 Copeman WS, Ellman P, Kersley GD. Aetiology of chronic rheumatism. *Br Med J* 1947;1:347.
- 10 Livingstone WK. Post-traumatic pain syndromes: an interpretation of the underlying pathological pathophysiology. *Western J Obstetrics Gynaecol* 1938;46:426–34.
- 11 Bonica JJ. Management of myofascial pain syndromes in general practice. *J Am Med Assoc* 1957;164:732–8.
- 12 Elliott FA. Aspects of “fibrositis”. *Ann Rheum Dis* 1944;4:22–5.
- 13 Johansson H, Sojka P. Pathophysiological mechanisms involved in genesis and spread of muscular tension in occupational muscle pain and in chronic musculoskeletal pain syndromes: a hypothesis. *Med Hypotheses* 1991;35:196–203.
- 14 Travell JG, Simons DG. *Myofascial pain and dysfunction: the trigger point manual*. Baltimore: Williams and Wilkins, 1983.
- 15 Lewit K. The needle effect in the relief of myofascial pain. *Pain* 1979;6:83–90.
- 16 Dommerholt J. Dry needling – peripheral and central considerations. *J Man Manip Ther* 2011;19:223–7.
- 17 Giamberardino MA, Affaitati G, Fabrizio A *et al*. Effects of treatment of myofascial trigger points on the pain of fibromyalgia. *Curr Pain Headache Rep* 2011;15:393–9.

- 18 Ge HY. Prevalence of myofascial trigger points in fibromyalgia: the overlap of two common problems. *Curr Pain Headache Rep* 2010;14:339–45.
- 19 Staud R, Nagel S, Robinson ME *et al.* Enhanced central pain processing of fibromyalgia patients is maintained by muscle afferent input: a randomized, double-blind, placebo-controlled study. *Pain* 2009;145:96–104.
- 20 Alonso-Blanco C, Fernandez-de-las-Penas C, Morales-Cabezas M *et al.* Multiple active myofascial trigger points reproduce the overall spontaneous pain pattern in women with fibromyalgia and are related to widespread mechanical hypersensitivity. *Clin J Pain* 2011;27:405–13.
- 21 Wang C, Ge HY, Ibarra JM *et al.* Spatial pain propagation over time following painful glutamate activation of latent myofascial trigger points in humans. *J Pain* 2012;13:537–45.
- 22 Gerwin RD. A review of myofascial pain and fibromyalgia—factors that promote their persistence. *Acupunct Med* 2005;23:121–34.
- 23 Granges G, Littlejohn G. Prevalence of myofascial pain syndrome in fibromyalgia syndrome and regional pain syndrome: a comparative study. *J Musculoskel Pain* 1993;1:19–35.
- 24 Mense S, Simons DG, Russell IJ. *Muscle pain: understanding its nature, diagnosis and treatment.* Philadelphia: Lippincott, Williams & Wilkins, 2001.
- 25 Quintner JL, Cohen ML. Referred pain of peripheral nerve origin: an alternative to the “myofascial pain” construct. *Clin J Pain* 1994;10:243–51.
- 26 Tough EA, White AR, Richards S *et al.* Variability of criteria used to diagnose myofascial trigger point pain syndrome—evidence from a review of the literature. *Clin J Pain* 2007;23:278–86.
- 27 Lucas N, Macaskill P, Irwig L *et al.* Reliability of physical examination for diagnosis of myofascial trigger points: a systematic review of the literature. *Clin J Pain* 2009;25:80–9.
- 28 Bron C, Franssen J, Wensing M *et al.* Interrater reliability of palpation of myofascial trigger points in three shoulder muscles. *J Man Manip Ther* 2007;15:203–15.
- 29 Sciotti VM, Mittak VL, DiMarco L *et al.* Clinical precision of myofascial trigger point location in the trapezius muscle. *Pain* 2001;93:259–66.
- 30 Myburgh C, Lauridsen HH, Larsen AH *et al.* Standardized manual palpation of myofascial trigger points in relation to neck/shoulder pain: the influence of clinical experience on inter-examiner reproducibility. *Man Ther* 2011;16:136–40.
- 31 Al-Shenqiti AM, Oldham JA. Test-retest reliability of myofascial trigger point detection in patients with rotator cuff tendonitis. *Clin Rehabil* 2005;19:482–7.
- 32 Wolfe F, Simons DG, Friction J *et al.* The fibromyalgia and myofascial pain syndromes: a preliminary study of tender points and trigger points in persons with fibromyalgia, myofascial pain syndrome and no disease. *J Rheumatol* 1992;19:944–51.
- 33 Hsieh CY, Hong CZ, Adams AH *et al.* Interexaminer reliability of the palpation of trigger points in the trunk and lower limb muscles. *Arch Phys Med Rehabil* 2000;81:258–64.
- 34 Lew PC, Lewis J, Story I. Inter-therapist reliability in locating latent myofascial trigger points using palpation. *Man Ther* 1997;2:87–90.
- 35 Myburgh C, Larsen AH, Hartvigsen J. A systematic, critical review of manual palpation for identifying myofascial trigger points: evidence and clinical significance. *Arch Phys Med Rehabil* 2008;89:1169–76.
- 36 Brendstrup P, Jespersen K, Asboe H. Morphological and chemical connective tissue changes in fibrositic muscles. *Ann Rheum Dis* 1957;16:438–40.
- 37 Windisch A, Reitingner A, Traxler H *et al.* Morphology and histochemistry of myogelosis. *Clin Anat* 1999;12:266–71.
- 38 Shah JP, Phillips TM, Danoff JV *et al.* An *in vivo* micro-analytical technique for measuring the local biochemical milieu of human skeletal muscle. *J Appl Physiol* 2005;99:1977–84.
- 39 Shah J, Danoff J, Desai M *et al.* Biochemicals associated with pain and inflammation are elevated in sites near to and remote from active myofascial trigger points. *Arch Phys Med Rehabil* 2008;89:16–23.
- 40 Mense S. Algesic agents exciting muscle nociceptors. *Exp Brain Res* 2009;196:89–100.
- 41 Chiu IM, von Hehn CA, Woolf CJ. Neurogenic inflammation and the peripheral nervous system in host defense and immunopathology. *Nat Neurosci* 2012;15:1063–67.
- 42 Durette MR, Rodriguez AA, Agre JC *et al.* Needle electromyographic evaluation of patients with myofascial or fibromyalgic pain. *Am J Phys Med Rehabil* 1991;70:154–6.
- 43 Hubbard DR, Berkoff GM. Myofascial trigger points show spontaneous needle EMG activity. *Spine* 1993;18:1803–7.
- 44 Wolfe F, Smythe HA, Yunus MB *et al.* The American College of Rheumatology 1990 criteria for the classification of fibromyalgia. Report of the Multicenter Criteria Committee. *Arthritis Rheum* 1990;33:160–72.
- 45 Simons DG. Do endplate noise and spikes arise from normal motor endplates? *Am J Phys Med Rehabil* 2001;80:134–40.
- 46 Simons DG, Hong CZ, Simons LS. Endplate potentials are common to midfiber myofascial trigger points. *Am J Phys Med Rehabil* 2002;81:212–22.
- 47 Bennett RM, Goldenberg DL. Fibromyalgia, myofascial pain, tender points and trigger points: splitting or lumping? *Arthritis Res Ther* 2011;13:117.
- 48 Katirji B. Clinical electromyography. In: Bradley WG, Daroff RB, Fenichel GM, Jankovic J, eds. *Neurology in clinical practice.* Philadelphia: Butterworth Heinemann, 2004:491–520.
- 49 Ge HY, Fernandez-de-Las-Penas C, Yue SW. Myofascial trigger points: spontaneous electrical activity and its consequences for pain induction and propagation. *Chin Med* 2011;6:13.
- 50 Chen Q, Bensamoun S, Basford J *et al.* Identification and quantification of myofascial taut bands with magnetic resonance elastography. *Arch Phys Med Rehabil* 2007;88:1658–61.
- 51 Chen Q, Basford J, An KN. Ability of magnetic resonance elastography to assess taut bands. *Clin Biomech* 2008;23:623–9.

- 52 Niraj G, Collett BJ, Bone M. Ultrasound-guided trigger point injection: first description of changes visible on ultrasound scanning in the muscle containing the trigger point. *Br J Anaesth* 2011;107:474–5.
- 53 Gokhale S. Sonography in identification of abdominal wall lesions presenting as palpable masses. *J Ultrasound Med* 2006;25:1199–209.
- 54 Ballyns JJ, Shah JP, Hammond J *et al.* Objective sonographic measures for characterizing myofascial trigger points associated with cervical pain. *J Ultrasound Med* 2011;30:1331–40.
- 55 Simons DG, Stolov WC. Microscopic features and transient contraction of palpable bands in canine muscle. *Am J Phys Med* 1976;55:65–88.
- 56 Castro AJ, Merchut MP, Neafsey EJ *et al.* Neuroscience: an outline approach. Missouri: Mosby Inc., 2002:111–26.
- 57 Hong CZ, Torigoe Y. Electrophysiological characteristics of localized twitch responses in responsive taut bands of rabbit skeletal muscle fibers. *J Musculoskel Pain* 1994;2:17–43.
- 58 Chen KH, Hong CZ, Kuo FC *et al.* Electrophysiologic effects of a therapeutic laser on myofascial trigger spots of rabbit skeletal muscles. *Am J Phys Med Rehabil* 2008;87:1006–14.
- 59 Hong CZ, Torigoe Y, Yu J. The localized twitch responses in responsive taut bands of rabbit skeletal muscle fibres are related to the reflexes at spinal cord level. *J Musculoskel Pain* 1995;3:15–33.
- 60 Simons DG, Hong CZ, Simons LS. Prevalence of spontaneous electrical activity at trigger spots and at control sites in rabbit skeletal muscle. *J Musculoskel Pain* 1995;3:35–48.
- 61 Chen JT, Chen SM, Kuan TS *et al.* Phentolamine effect on the spontaneous electrical activity of active loci in a myofascial trigger spot of rabbit skeletal muscle. *Arch Phys Med Rehabil* 1998;79:790–4.
- 62 Chen JT, Chung KC, Hou CR *et al.* Inhibitory effect of dry needling on the spontaneous electrical activity recorded from myofascial trigger spots of rabbit skeletal muscle. *Am J Phys Med Rehabil* 2001;80:729–35.
- 63 Kuan TS, Chen JT, Chen SM *et al.* Effect of botulinum toxin on endplate noise in myofascial trigger spots of rabbit skeletal muscle. *Am J Phys Med Rehabil* 2002;81:512–20.
- 64 Hsieh YL, Chou LW, Joe YS *et al.* Spinal cord mechanism involving the remote effects of dry needling on the irritability of myofascial trigger spots in rabbit skeletal muscle. *Arch Phys Med Rehabil* 2011;92:1098–105.
- 65 Fu Z, Hsieh YL, Hong CZ *et al.* Remote subcutaneous needling to suppress the irritability of myofascial trigger spots: an experimental study in rabbits. *Evid Based Complement Alternat Med* 2012;2012:353916.
- 66 Itoh K, Okada K, Kawakita K. A proposed experimental model of myofascial trigger points in human muscle after slow eccentric exercise. *Acupunct Med* 2004;22:2–12.
- 67 Hayashi K, Ozaki N, Kawakita K *et al.* Involvement of NGF in the rat model of persistent muscle pain associated with taut band. *J Pain* 2011;12:1059–68.
- 68 Bron C, Dommerholt JD. Etiology of myofascial trigger points. *Curr Pain Headache Rep* 2012;16:439–44.
- 69 Dommerholt J, Bron C, Franssen J. Myofascial trigger points: an evidence-informed review. *J Man Manip Ther* 2006;14:203–21.
- 70 Gerwin RD, Dommerholt J, Shah JP. An expansion of Simons' integrated hypothesis of trigger point formation. *Curr Pain Headache Rep* 2004;8:468–75.
- 71 Giamberardino MA, Affaitati G, Fabrizio A *et al.* Myofascial pain syndromes and their evaluation. *Best Pract Res Clin Rheumatol* 2011;25:185–98.
- 72 Niddam DM, Chan RC, Lee SH *et al.* Central representation of hyperalgesia from myofascial trigger point. *Neuroimage* 2008;39:1299–306.
- 73 Birznieks I, Burton AR, Macefield VG. The effects of experimental muscle and skin pain on the static stretch sensitivity of human muscle spindles in relaxed leg muscles. *J Physiol* 2008;586:2713–23.
- 74 Fazalbhoy A, Macefield VG, Birznieks I. Tonic muscle pain does not increase fusimotor drive to human leg muscles: implications for chronic muscle pain. *Exp Physiol* 2013;98:1125–32.
- 75 Lund JP, Donga R, Widmer CG *et al.* The pain adaptation model: a discussion of the relationship between chronic musculoskeletal pain and motor activity. *Can J Physiol Pharmacol* 1991;69:683–94.
- 76 Qerama E, Fuglsang-Frederiksen A, Kasch H *et al.* A double-blind, controlled study of botulinum toxin A in chronic myofascial pain. *Neurology* 2006;67:241–5.
- 77 Unalan H, Majlesi J, Aydin FY *et al.* Comparison of high-power pain threshold ultrasound therapy with local injection in the treatment of active myofascial trigger points of the upper trapezius muscle. *Arch Phys Med Rehabil* 2011;92:657–62.
- 78 Lavelle ED, Lavelle W, Smith HS. Myofascial trigger points. *Anesthesiol Clin* 2007;25:841–51.
- 79 Cummings TM, White AR. Needling therapies in the management of myofascial trigger point pain: a systematic review. *Arch Phys Med Rehabil* 2001;82:986–92.
- 80 Tough EA, White AR, Cummings TM *et al.* Acupuncture and dry needling in the management of myofascial trigger point pain: a systematic review and meta-analysis of randomised controlled trials. *Eur J Pain* 2009;13:3–10.
- 81 Rickards LD. The effectiveness of non-invasive treatments for active myofascial trigger point pain: a systematic review of the literature. *Int J Osteopathic Med* 2006;9:120–36.
- 82 Annaswamy TM, De Luigi AJ, O'Neill BJ *et al.* Emerging concepts in the treatment of myofascial pain: a review of medications, modalities, and needle-based interventions. *PM R* 2011;3:940–61.
- 83 Ho KY, Tan KH. Botulinum toxin A for myofascial trigger point injection: a qualitative systematic review. *Eur J Pain* 2007;11:519–27.
- 84 Hartman SE. Why do ineffective treatments seem helpful? A brief review. *Chiropr Osteopat* 2009;17:10.
- 85 Cohen ML. Placebo theory. In: Hutson M, Ward A, eds. *Oxford Textbook of Musculoskeletal Medicine*. 2nd edn. Oxford University Press, 2014, in press.

- 86 Ziaefar M, Arab AM, Karimi N *et al.* The effect of dry needling on pain, pressure pain threshold and disability in patients with a myofascial trigger point in the upper trapezius muscle. *J Bodyw Mov Ther* 2013;18: 298–305.
- 87 Piche M, Arsenault M, Rainville P. Cerebral and cerebrospinal processes underlying counterirritation analgesia. *J Neurosci* 2009;29:14236–46.
- 88 Goffaux P, Redmond WJ, Rainville P *et al.* Descending analgesia—when the spine echoes what the brain expects. *Pain* 2007;130:137–43.
- 89 Willer JC, Bouhassira D, Le Bars D. Neurophysiological bases of the counterirritation phenomenon: diffuse control inhibitors induced by nociceptive stimulation. *Neurophysiol Clin* 1999;29:379–400.
- 90 Sprenger C, Bingel U, Buchel C. Treating pain with pain: supraspinal mechanisms of endogenous analgesia elicited by heterotopic noxious conditioning stimulation. *Pain* 2011;152:428–39.
- 91 Simons DG. Review of enigmatic MTRPs as a common cause of enigmatic musculoskeletal pain and dysfunction. *J Electromyogr Kinesiol* 2004;14: 95–107.
- 92 Player RP. On irritation of the spinal nerves. *Quart J Sci* 1821;12:428.
- 93 Brown T. On irritation of the spinal nerves. *Glasgow Med J* 1828;1:131–60.
- 94 Teale TP. A treatise on neuralgic diseases: dependent upon irritation of the spinal marrow and ganglia of the sympathetic nerve. Woodstock: Nahum Haskell, 1834.
- 95 Mitchell SW. Injuries of nerves and their consequences. Philadelphia: J.B. Lippincott and Company, 1872.
- 96 Gowers WR. A manual of diseases of the nervous system. Philadelphia: P. Blakiston, Son & Co., 1896.
- 97 Nothnagel H. Neuritis in relation to its diagnosis and pathology. In: Volkmann R, ed. Clinical lectures on subjects concerned with medicine, surgery, and obstetrics. London: The New Sydenham Society, 1877, 210–36.
- 98 Bove GM, Ransil BJ, Lin HC *et al.* Inflammation induces ectopic mechanical sensitivity in axons of nociceptors innervating deep tissues. *J Neurophysiol* 2003;90: 1949–55.
- 99 Dilley A, Lynn B, Pang SJ. Pressure and stretch mechanosensitivity of peripheral nerve fibres following local inflammation of the nerve trunk. *Pain* 2005;117: 462–72.
- 100 Dilley A, Bove GM. Resolution of inflammation-induced axonal mechanical sensitivity and conduction slowing in C-fiber nociceptors. *J Pain* 2008;9:185–92.
- 101 Bove GM. Focal nerve inflammation induces neuronal signs consistent with symptoms of early complex regional pain syndromes. *Exp Neurol* 2009;219:223–7.
- 102 Kellgren JH. On the distribution of pain arising from deep somatic structures with charts of segmental pain areas. *Clin Sci* 1938;4:35–46.
- 103 Kellgren JH. A preliminary account of referred pains arising from muscle. *Br Med J* 1938;12:325–7.
- 104 Kellgren JH. The anatomical source of back pain. *Rheumatol Rehabil* 1977;16:3–12.
- 105 Feinstein B, Langton JNK, Jameson RM *et al.* Experiments on pain referred from deep somatic tissues. *J Bone Joint Surg Am* 1954;36-A:981–97.
- 106 Arendt-Nielsen L, Svensson P. Referred muscle pain: basic and clinical findings. *Clin J Pain* 2001;17: 11–9.
- 107 Latremoliere A, Woolf CJ. Central sensitization: a generator of pain hypersensitivity by central neural plasticity. *J Pain* 2009;10:895–926.

I am writing to oppose the expansion of the scope of practice of Physical Therapists to include acupuncture, which they are re-naming "dry needling", within their scope of practice. I am attaching several documents and links for your consideration of their initiative.

Skye Sturgeon, DAOM, L.Ac.

Department Chair, Associate Professor, & Core Faculty, Acupuncture and East Asian Medicine Department
School of Traditional World Medicines, Bastyr University <http://bastyr.edu>, Special Projects Consultant

Dry Needling is Acupuncture: But What of Education? What of Public Safety?

By William Morris, DAOM, PhD, LAc

One of my patients told me recently, that their physical therapist used a "dry needle" and that it wasn't acupuncture. Apparently, physical therapists (PT) are taught to tell their patients that "only acupuncturists practice acupuncture." The PT told my patient dry needling is not a form of acupuncture.

To that, I say, what? They must be exposed to something besides moxibustion. Anyone who claims they are not doing acupuncture because they don't use traditional methods of thought is misleading the public, but, why would they? I will speculate.

There are teachers who profit from short training programs in the procedure of dry needling trigger point therapy. Their publications and testimony can be convincing. But, if we explore the problem more closely, the conflict of interest for these people and their profession glares like the midday sun on my watch.

"Word-tricksters" - as I like to call them - change language in order to gain personal advantage. Contrary to their assertions, acupuncture *is* intramuscular manual therapy, trigger point needling, functional dry needling, intramuscular stimulation or any other method by which a needle is inserted to effect therapeutic change. Acupuncture, is both incisive and invasive. When the words are twisted to justify unsafe training practices, it poses distinct ethical programs when viewed from the interest of the common good.

The trickster's message, "dry needling is not acupuncture" has even seeped into our mainstream sports press. Washington Wizards basketball guard, Martell Webster recently told the Post, "Dry needle is weird. It hurts. It's when they go in and actually floss your muscle with the needle. Acupuncture, they just stick it in pressure points to try to relieve some tension."¹ The "flossing" action is consistent with lifting and thrusting techniques of acupuncture. It appears that Webster's PT could use some more education. The pain of acupuncture when performed by a PT is not a necessary standard of practice.

The problem of misrepresenting acupuncture is not my personal opinion. According to the American Association of Acupuncture and Oriental Medicine (AAAOM) Blue Ribbon Panel on Inter-professional Standards, dry needling and any of its alternate designations are acupuncture. The World Health Organization shares this opinion. They and the AAAOM are not the only consensus think tanks coming to such conclusions. Further, the North Carolina Acupuncture Licensing Board (NCALB) affirms, "The insertion of an acupuncture needle into the dermis, muscular or fascia tissue with the intention of

promotion, maintenance, restoration of health and the prevention of disease is indeed the practice of acupuncture."²

There is a 92 percent correlation between trigger points and acupuncture points.^{3,4} Peng et al concluded that both, "induce similar linear propagation of needling response... both of them can treat symptoms of internal organs such as diarrhea, constipation, dysmenorrhea, etc. Therefore, they are very similar in anatomic location, clinical indications, and the linear propagation of needling response induced by acupuncture, etc."⁵ The literature points to "dry needling" as a synonym for acupuncture.⁶

As a reminder, scope of practice is procedural – and – not behavioral⁷. In other words, how I think about inserting a needle has no bearing upon whether I am performing acupuncture. I may choose to use contemporary methods such as neuroanatomical, Yamamoto scalp, auricular and trigger point needling. I may also choose to organize my thought in terms of blood vessels. Whether I use pre-modern or contemporary thought – I am practicing acupuncture.

My sense of certainty about these assertions was heightened when I performed a *PubMed* search on January 18, 2013. Using the term dry needling, I pulled down 101 citations. I then sorted for the word acupuncture, culling 54 articles that used the term acupuncture in conjunction with dry needling. Further, there were studies comparing injectables (wet needling) against dry needling. 39 of the studies used the term injection. Here are eight titles of articles that use acupuncture synonymously with dry needling. They are gathered using the search terms dry needling anywhere in the article and acupuncture in the title:

1. Acupuncture and dry needling in the management of myofascial trigger point pain: a systematic review and meta-analysis of randomised controlled trials.⁸
2. Acupuncture and dry-needling for low back pain: an updated systematic review within the framework of the cochrane collaboration.⁹
3. Acupuncture and dry-needling for low back pain.¹⁰
4. Progress of research on acupuncture at trigger point for myofascial pain syndrome.¹¹
5. Comparison of acupuncture to injection for myofascial trigger point pain.¹²
6. Comparison of mini scalpel-needle release, acupuncture needling, and stretching exercise to trigger point in myofascial pain syndrome.¹³
7. Electro-acupuncture combined with the trigger point needle-embedding for treatment of primary trigeminal neuralgia in 31 cases.¹⁴
8. Randomized trial of trigger point acupuncture compared with other acupuncture for treatment of chronic neck pain".¹⁵

Noting that acupuncture can also be wet, there are several jurisdictions that authorize qualified acupuncturists to inject substances. These include Colorado, Florida, New Mexico and Washington and China.

A Point of Clarification

I do not support closure. That is, I am not against any of the healthcare disciplines practicing acupuncture with appropriate education.¹⁶ That means they can demonstrate a reasonable process for developing competencies and assessments along with standards for qualifying the teachers and systems of education. To date, only the acupuncture profession has fulfilled these criteria. They further have a publicly determined set of statutes, which provide for governance of the procedure within a profession and thus having the capacity and will to protect the public safety.

To wit: let us pursue a collaborative process of developing inter-professional competencies. Remove biomedicine and herbal medicine courses from the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) standards. Then, take what is left over in acupuncture programs as the starting place for a dialogue for portable competencies. We can't remove professionalism and ethics

since anyone who promotes the use of an incisive and surgical procedure with as little as 10 or even 100 hours of training likely needs a refresher. To avoid conflicts of interest, no individual who stands to profit from seminars should determine competencies and educational standards, nor should they testify in legislature on behalf of the common good.

References

1. Kogod S. Martell Webster is sold on acupuncture. *Washington Post* 2013.
2. (NCALB) NCALB. Dry Needling is Intramuscular Manual Therapy is Acupuncture. Post Office Box 10686, Raleigh, NC 27605. 919.821.3008. Fax: 919.833.57432013.
3. Dorsher PT. Myofascial referred-pain data provide physiologic evidence of acupuncture meridians. *J Pain*. 2009;10(7): 723-31. Epub 2009/05/05.
4. Dorsher PT. Trigger Points And Acupuncture Points: Anatomic And Clinical Correlations. *Medical Acupuncture*. 2006;17(3).
5. Peng ZF. [Comparison between western trigger point of acupuncture and traditional acupoints]. *Zhongguo zhen jiu = Chinese acupuncture & moxibustion*. 2008;28(5): 349-52. Epub 2008/07/26.
6. Morris W. Scope and Standards for Acupuncture: Dry Needling? 2011;12(5).
7. Acupuncture in California: Study of Scope of Practice Overview of Current Status and Issues to Consider Prepared for the Milton Marks "Little Hoover" Commission on California State Government Organization and Economy: UCSF Center for the Health Professions; May, 2004.
8. Tough EA, White AR, Cummings TM, Richards SH, Campbell JL. Acupuncture and dry needling in the management of myofascial trigger point pain: a systematic review and meta-analysis of randomised controlled trials. *Eur J Pain*. 2009;13(1): 3-10. Epub 2008/04/09.
9. Furlan AD, van Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, et al. Acupuncture and dry-needling for low back pain: an updated systematic review within the framework of the cochrane collaboration. *Spine*. 2005;30(8):944-63. Epub 2005/04/19.
10. Furlan AD, van Tulder MW, Cherkin DC, Tsukayama H, Lao L, Koes BW, et al. Acupuncture and dry-needling for low back pain. *Cochrane Database Syst Rev*. 2005(1):CD001351. Epub 2005/01/28.
11. Ma Y, Bu H, Jia JR, Zhang X. [Progress of research on acupuncture at trigger point for myofascial pain syndrome]. *Zhongguo zhen jiu = Chinese acupuncture & moxibustion*. 2012;32(6):573-6. Epub 2012/06/30.
12. Gazi MC, Issy AM, Avila IP, Sakata RK. Comparison of acupuncture to injection for myofascial trigger point pain. *Pain practice : the official journal of World Institute of Pain*. 2011;11(2):132-8. Epub 2010/08/03.
13. Ma C, Wu S, Li G, Xiao X, Mai M, Yan T. Comparison of miniscalpel-needle release, acupuncture needling, and stretching exercise to trigger point in myofascial pain syndrome. *The Clinical journal of pain*. 2010;26(3):251-7. Epub 2010/02/23.
14. Zhu X. Electro-acupuncture combined with the trigger point needle-embedding for treatment of primary trigeminal neuralgia in 31 cases. *Journal of traditional Chinese medicine = Chung i tsa chih ying wen pan / sponsored by All-China Association of Traditional Chinese Medicine, Academy of Traditional Chinese Medicine*. 2008;28(1): 13-4. Epub 2008/04/18.
15. Kim SY, Park HJ, Yin CS. Comment on the "Randomised trial of trigger point acupuncture compared with other acupuncture for treatment of chronic neck pain". *Complementary therapies in medicine*. 2008;16(6): 363-4. Epub 2008/11/26.
16. Morris W. Acupuncture and Closure: Turf Wars. *Acupuncture Today*. 2013;14(1).

I am writing in opposition to the expansion of the scope of practice of Physical Therapists to include acupuncture, which they are re-naming "dry needling", within their scope of practice. I sent you documents and links for your consideration under separate cover. I consider the arguments that dry needling is different from acupuncture are specious and disingenuous, at best. Bellwether states of New York, Oregon, and California have thwarted attempts to allow physical therapists and naturopaths from appropriating acupuncture within their scope. This attempt during their sunrise review is contra to the opinion of Washington state's Attorney General, issued just last year. I regret that I did not have more time to address this issue. Please forgive the disjointed narrative that follows. If desired, I would be happy to provide expert testimony regarding this issue.

My current role is that I am the Chair of Acupuncture and East Asian Medicine in the School of Traditional Medicine at Bastyr University. As such I am responsible for four programs including a Doctorate of Acupuncture and Oriental Medicine (DAOM), which includes a specialty in Pain Management that is a collaboration with UW Medical School and Harborview Hospital Pain Clinic. I have been a licensed acupuncturist in four states and I have been president, dean, core faculty, and/or clinical supervisor at five acupuncture colleges. My doctorate is from the American College of Traditional Chinese Medicine in San Francisco and my personal specialty is in Pain Management.

Acupuncture Education

Bastyr's acupuncture programs feature an integrated approach to acupuncture education. In Fall 2017, our regionally-accredited (NWCCU) acupuncture program will lead to an entry-level doctorate comprised of more than 3800 hours of didactic, lab practicum, and clinical study. Applicants to our programs, most of whom have a Bachelor's degree or who will obtain their Bachelor's during their course of study, must have completed a minimum of general chemistry, cellular biology, physics, and psychology as prerequisites. Once admitted to our program, acupuncture students must take 286 hours of anatomy and physiology (with 88 hours of cadaver study), organic chemistry, biochemistry, microbiology, and pharmacology. They receive 132 hours of Western Pathology and 121 hours of Biomedicine Clinical Skills training, which includes physical exam, orthopedic and neurological assessment, trigger points, imaging, and laboratory testing. All of this didactic and practicum training is consolidated in our supervised clinical education of 1138 hours.

If physical therapists want to use acupuncture needles to treat patients, they should learn how to do it properly. Currently, there are medical doctors, chiropractors, naturopaths, nurse practitioners, and massage therapists matriculated in the acupuncture program at Bastyr. Their

plan on how they will use their acupuncture skill in their treatment of patients will likely differ. But these dual degree students, are seeking the ability to practice acupuncture competently and safely. It's amusing to consider that anyone would consider 54 hours of training adequate. I wonder how physical therapists would respond the suggestion that acupuncturists might offer a course in their doctorate program in physical therapy. I thinking a five quarter-course with no clinical supervision would prove adequate. Then, acupuncturists could seek to have physical therapy included in their scope. Very tempting. Another modality to bill for.

Acupuncture education has evolved to its current status due to a recognition that acupuncture is being accepted by a larger number of Americans every year. Research and popular media agree that acupuncture is good for pain. There are many ways that pain is generated and manifests in a person. Most pain complaints involve the muscular-skeletal system. There may be trauma, overuse, overstrain, on-the-job injury, lack of exercise, weakness, poor nutrition and many other etiologies when a patient complains of pain. In acupuncture medicine, a holistic approach is necessary. Simply releasing trigger points often provides temporary relief but usually changes in routine, behavior, diet, ergonomics, etc. are required. "Acupuncture" is particularly good for muscular-skeletal pain.

The language of medicine. An example.

The typical patient speaks colloquial English. A patient may come into a clinic complaining of elbow pain. I often teach students that in acupuncture medicine, we translate the patient's complaint into Chinese terminology because to create a positive outcome based on our understanding, this is required. A practitioner of biomedicine will translate the complaint into Greek/Latin. Elbow pain becomes damp bi or qi and blood stagnation when assessed by an acupuncturist and lateral epicondylitis in biomedicine terms. Which one is correct? To treat this condition, a biomedicine practitioner may palpate for and release trigger points in the wrist extensor muscles distal to the elbow joint.

In acupuncture medicine, this condition is one of the Hand Yang Ming tendino-muscular meridian (Jingjin). The tendino-muscular meridians represent dynamic kinetic systems of muscles, tendons, ligaments, and fascia. The Hand Yang Ming traverses the arm from the index finger to the shoulder (and more). Inserting needles into an acupoint named Shou San Li (LI-10) is indicated for this condition to remove the obstruction (bi) that prevents the normal smooth flow of qi and results in pain. This point is located two inches distal to the cubital crease on a line connecting the styloid process of the radius to the lateral end of the cubital crease. The needle is inserted perpendicularly to a depth of 0.8-1.2 inches (where the acupoint is actually located). Where is this point anatomically? In the belly of any of the wrist extensors. Crucially important is that the acupuncturist may insert several needles in this area—wherever pain is elicited upon palpation. What's more is that several other points on the Hand Yang Ming Meridian will be used, near the origin of the extensors at the lateral epicondyle (LI-12) along with distal points such as LI-1, LI-4, & LI-7. Treating trigger points alone will not yield as effective results.

A game of word substitution

Consider the following:

Though acupuncturists use acupuncture to treat myofascial pain, they also use acupuncture to treat restrictions in range of motion due to contractures in muscle fibers, fascial adhesions or scar tissue.

Acupuncture points are very common and have been described in numerous diagnoses: radiculopathies, joint dysfunction, disc pathology, tendonitis, craniomandibular dysfunction, migraines, tension headaches, carpal tunnel syndrome, whiplash associated disorders, spinal dysfunction, pelvic pain and urologic syndromes, post herpetic neuralgia, complex regional pain syndrome, phantom pain, among others. The acupuncture needling technique involves the insertion of solid filament needles into the skin and underlying tissue to disrupt pain sensory pathways and relax contracted fibers. Clinical research suggests that acupuncture helps reduce local and peripheral pain and sensitization, thereby speeding up the restoration of muscle function and range of motion. Acupuncture alone has been shown to be an effective treatment for neuro-musculoskeletal diseases or conditions, including arthritis, tendonitis, carpal tunnel syndromes and chronic pain.

This are demonstrably true statements. I simply took these paragraphs from the physical therapist's submission to the Sunrise Review and substituted "acupuncture" for "dry needling" and acupuncturist for physical therapist.

Congruence of "trigger points" and acupoints. A comparison of trigger point and acupoints maps shows a coincidence of 90-92%. This is not difficult to understand since there are 365 "regular" points on the 14 Meridians and at least 400 named "extra or empirical" points. On top of that, acupuncturists are trained to palpate for points sensitive to pressure, elicit discomfort, or refer pain. These are called "ah shi" points meaning "ah, yes", which is the patient's response to this palpation. The use of acupuncture techniques date and have evolved from the Han Dynasty (~250 AD) and were "first" introduced to the "West" during the Qing Dynasty (1644-1911). After the emissaries and missionaries brought some of the ideas and techniques, there main use was for muscular-skeletal pain. I have always imagined that Dr. Travell, et al. based their work on ideas that permeated from this time. To quote Birch, "...the concept of trigger points arose as a kind of adaptation of ancient Chinese ideas to a modern Western system as part of the process of acculturation of acupuncture in the West—define the culturally new concept in terms of existing accepted concepts. The Point!

In closing, renaming acupuncture needling as dry needling because it is different than Chinese medicine is to engage in sophistry. Remember that "dry" needling refers to the fact that the needles cannot inject a medicine (the "wet"). This resulted when researchers and practitioners realized that point injection therapy to treat trigger points was not as effective as a "dry" acupuncture needle. And, understand "they" were using the FDA-approved medical devise, acupuncture needles, until they repackaged the very same product and renamed them "solid filiform" needles. At best, dry needling, when meant to refer to the treatment of muscular-

skeletal pain, is a subset of acupuncture. When dry needling is used to treat other conditions, those are other subsets of acupuncture. A square is still a rectangle. Sounds different, but it's simply a special case.

Skye Sturgeon, DAOM, L.Ac.

Department Chair

Associate Professor & Core Faculty

Acupuncture & East Asian Medicine

BASTYR UNIVERSITY

I am a Doctorate of Physical Therapy student at the University of Washington and I am writing you today concerning the Sunrise Review for inclusion of dry needling into the Physical Therapy practice act.

Firstly, dry needling needs to be defined and disassociated from acupuncture. According to a 2013 paper by the American Physical Therapy Association (APTA), "[d]ry needling is a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments." This is an evidence-based practice used by well-trained, educated, and skilled physical therapists, which has the support of multiple studies in the scientific literature. While the insertion of filiform needles may be visually similar to the insertion of acupuncture needles, this is where the similarities end. Acupuncture claims to target certain points to change how "energy" or Chi flows through the body, but this unfortunately is unsupported by the scientific literature. Dry needling on the other hand, has a physiologic basis shown to directly affect myofascial trigger points and thus increase soft tissue mobility, reduce pain, and improve overall function of the person being treated.

The APTA has established clear clinical guidelines regarding dry needling regarding patient selection, indications, precautions, contraindications, and procedures in order to ensure patient safety at all times. Physical therapist go through years of extensive education and continued training in order to deliver evidence-based treatments. Physical therapists are highly qualified to perform dry needling. I have included the APTA paper for reference.

Scare stories have been circulated that physical therapist might cause a pneumothorax or an unwanted fetal miscarriage, however, these are not based in any facts. Far too often fear is used as psychological tool to manipulate people into reacting emotionally, instead of thinking critically regarding a subject.

As physical therapists, we strive to provided the highest quality care while promoting the safety of our patients. We respectfully request that you critically consider the evidence presented before you and promote the practice of evidence-based medicine within the community. Please consider the practice of dry needling as a safe and effective treatment tool in the hands of well-educated and skilled physical therapy practitioners to help our patients return to more fully functioning lives.

Jon Mark Wahlstrom, SPT, University of Washington
Doctorate of Physical Therapy program, Class of 2017
(APTA Resource Paper attached at end of comments)

Description of Dry Needling In Clinical Practice:

An Educational Resource Paper

PRODUCED BY THE APTA PUBLIC POLICY, PRACTICE, AND PROFESSIONAL AFFAIRS UNIT

FEBRUARY 2013



American Physical Therapy Association.

DESCRIPTION OF DRY NEEDLING IN CLINICAL PRACTICE

FORWARD

The American Physical Therapy Association (APTA) created this document to provide background information on the performance of dry needling in clinical practice for members and components. APTA is the national professional association representing more than 85,000 physical therapists, physical therapist assistants, and students nationwide.

DESCRIPTION OF DRY NEEDLING

Dry needling is a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments. Dry needling (DN) is a technique used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, and, diminish persistent peripheral nociceptive input, and reduce or restore impairments of body structure and function leading to improved activity and participation.

The physiological basis for DN depends upon the targeted tissue and treatment objectives. The treatment of myofascial trigger points (referred to as TrPs) has a different physiological basis than treatment of excessive muscle tension, scar tissue, fascia, and connective tissues. TrPs are hyperirritable spots within a taut band of contracted skeletal muscle fibers that produce local and/or referred pain when stimulated. TrPs are divided into active and latent TrPs dependent upon the degree of irritability. Active TrPs are spontaneously painful, while latent TrPs are only painful when stimulated, for example, with digital pressure. TrPs can be visualized by magnetic resonance imaging and sonography elastography,¹⁻⁵ which has shown that active TrPs are larger than latent TrPs and feature a reduction in circulation.² TrPs are physiological contractures,⁶ characterized by local ischemia and hypoxia,^{2,7} a significantly lowered pH (active TRPs only),⁸⁻¹⁰ a chemically altered milieu (active TRPs only),⁸⁻¹⁰ local and referred pain,¹¹⁻¹³ and altered muscle activation patterns.^{14,15} Although latent TrPs are not spontaneously painful, recent research has shown that they do contribute to nociception, therefore they need to be included in the treatment plan. TrPs are associated with dysfunctional motor endplates,^{16,17} endplate noise,¹⁸ and an increased release of acetylcholine.¹⁹⁻²³ TrPs activate muscle nociceptors and are peripheral sources of persistent nociceptive input, thus contributing to the development of peripheral and central sensitization.²⁴⁻²⁷ Stimulation of TrPs activates the periaqueductal grey and anterior cingulate cortex in the brain,²⁸⁻³⁰ and enkaphalinergic, serotonergic, and noradrenergic inhibitory systems associated with A- Δ (A delta) fibers through segmental inhibition.^{31,32}

DN can be divided into deep and superficial DN. Deep DN has been shown to inactivate TrPs by eliciting local twitch responses (LTR),^{33,34} which are modulated by the central nervous system.^{35,36}

A LTR is a spinal cord reflex that is characterized by an involuntary contraction of the contracted taut band,^{36,37} which can be elicited by a snapping palpation or penetration with a needle.³⁸⁻⁴⁰ The LTR has been shown to be associated with alleviation and mitigation of spontaneous electrical activity or motor endplate noise,^{17,18,41,42} a reduction of the concentration of numerous nociceptive, inflammatory, and immune system related chemicals,^{9,10,43} and relaxation of the taut band.⁴⁴ Deep DN of TrPs is associated with reduced local and referred pain,^{45,46} improved range of motion,^{14,15} and decreased TrP irritability both locally^{18,47} and more remotely.^{42,48} DN normalizes the chemical milieu and pH of skeletal muscle⁸⁻¹⁰ and restores the local circulation.⁴⁹ Superficial DN is thought to activate mechanoreceptors coupled to slow conducting unmyelinated C fiber afferents, and indirectly, stimulate the anterior cingulate cortex.⁵⁰ Superficial DN may also be mediated through stimulation of A- Δ fibers,⁵¹ or via stretching of fibroblasts in connective tissue.³² Superficial DN is associated with reduced local and referred pain and improved range of motion,^{52,53} but it is not known at this time whether superficial DN has any impact on normalizing the chemical environment of active TrPs or reducing motor endplate noise associated with TrPs in general.

The physiological basis for DN treatment of excessive muscle tension, scar tissue, fascia, and connective tissues is not as well described in the literature, but the available research shows that there may be several benefits. Muscle tension is determined by a combination of the basic viscoelastic properties of a muscle and its surrounding fascia, and the degree of activation of the contractile apparatus of the muscle.⁵⁴ There is some evidence that excessive muscle tension, as seen for example in spasticity, can be alleviated with DN.^{55,56} Scar tissue has been linked to myofascial pain⁵⁷ and fibroblasts.^{58,59} Fibroblasts are specialized contractile cells within the fascia that are of particular interest, as they synthesize, organize, and remodel collagen, dependent upon the tension between the extracellular matrix and the cell.^{60,61} DN, especially when used in combination with rotation of the needle, can place fibroblasts in a high tension matrix, at which point the fibroblast changes shape and assumes a lamellar shape, and increases its collagen synthesis and cell proliferation.^{62,63} DN has been shown to directly activate fibroblasts through mechanical manipulation of the needle,^{31,64,65} which in turn activates the release of cytokines and other pro-inflammatory mediators.⁶⁶⁻⁷⁰ DN can play a substantial role in the process of *mechanotransduction*, which is described as the process by which the body converts mechanical loading into cellular responses.^{20,71-76} Fibroblast activation with a solid filament has been shown to result in pain neuromodulation.^{32,66}

INDICATIONS FOR USE

DN may be incorporated into a treatment plan when myofascial TrPs are present, which may lead to impairments in body structure, pain, and functional limitations. TrPs are sources of persistent peripheral nociceptive input²⁴ and their inactivation is consistent with current pain management insights.⁷⁷ DN also is indicated with restrictions in range of motion due to contracted muscle fibers or taut bands, or other soft tissue restrictions, such as fascial adhesions or scar tissue. TrPs have been identified in numerous diagnoses, such as radiculopathies,⁷⁸ joint dysfunction,⁷⁹ disk pathology,⁸⁰ tendonitis,⁸¹ craniomandibular dysfunction,^{82,83} migraines,^{84,85} tension-type headaches,^{86,87} carpal tunnel syndrome,^{88,89} computer-related disorders,^{90,91} whiplash associated disorders,⁹²⁻⁹⁴ spinal dysfunction,⁹⁵ pelvic pain and other urologic syndromes,⁹⁶⁻⁹⁹ post-herpetic neuralgia,^{100,101} complex regional pain syndrome,^{102,103} nocturnal cramps,¹⁰⁴ phantom pain,^{105,106} and other relatively uncommon diagnoses such as Barré Liéou syndrome,¹⁰⁷ or neurogenic pruritus,¹⁰⁸ among others.¹⁰⁹

PATIENT SELECTION

Safe DN practice includes the knowledge, skills, and attributes to perform the technique, which at a minimum incorporates appropriate patient selection, creation of a safe and comfortable environment, assessment of one's own capacity to provide the treatment (eg time constraints, stress, fatigue), safe handling of needles, handling and positioning of the patient, anatomical knowledge, appropriate needle technique (direction and depth), and appropriate monitoring of the patient both during and following treatment.

Regarding patient selection, DN is appropriate for nearly all patients who present with any of the indications for DN. Physical therapists (PTs) must recognize when patients present with significant needle phobia or other anxiety about being treated with needles. PTs must decide on an individual basis whether a patient with needle phobia or significant anxiety is an appropriate candidate for DN. If DN treatment is perceived as a threatening input, it is unlikely to be therapeutic.⁷⁷ In any case, to be considered for DN, patients must be able to communicate with the PT either directly or via an interpreter and they must be able to consent to the treatment.

Caution is warranted with younger patients. Based on empirical evidence, DN is not recommended for children younger than 12 years of age. When treating children, DN should only be performed with parent and child's consent. Care should be taken assuming a child understands the procedure.

PRECAUTIONS

There are certain precautions to be considered with the use of DN:

1. Patients with a needle aversion or phobia may object to the physical therapy treatment with DN. With appropriate education, however, these patients may still consider DN.
2. Patients with significant cognitive impairment may have difficulty understanding the treatment parameters and DN intervention.
3. Patients who are unable to communicate directly or via an interpreter may not be appropriate for DN treatments.
4. Patients may not be willing to be treated with DN.
5. Patients need to be able to give consent for the treatment with DN.
6. Local skin lesions must be avoided with DN.
7. Local or systemic infections are generally considered to be contraindicated.
8. Local lymphedema (note: there is no evidence that DN would cause or contribute to increased lymphedema, ie, postmastectomy, and as such is not a contraindication).
9. Severe hyperalgesia or allodynia may interfere with the application of DN, but should not be considered an absolute contraindication.
10. Some patients may be allergic to certain metals in the needle, such as nickel or chromium. This situation can easily be remedied by using silver or gold plated needles.
11. Patients with an abnormal bleeding tendency, ie, patients on anticoagulant therapy or with thrombocytopenia, must be needled with caution. DN of deep muscles, such as the lateral pterygoid or psoas major muscle, that cannot be approached with direct pressure to create hemostasis may need to be avoided to prevent excessive bleeding.
12. Patients with a compromised immune system may be more susceptible to local or systemic infections from DN, even though there is no documented increased risk of infection with DN.¹¹⁰
13. DN during the first trimester of pregnancy, during which miscarriage is fairly common, must be approached with caution, even though there is no evidence that DN has any potential abortifacient effects.¹¹¹⁻¹¹³
14. DN should not be used in the presence of vascular disease, including varicose veins.
15. Caution is warranted with DN following surgical procedures where the joint capsule has been opened. Although septic arthritis is a concern, DN can still be performed as long as the needle is not directed toward the joint or implant.

PROCEDURE

DN techniques should be guided by randomized clinical trials, basic research, systematic reviews, and clinical expertise.¹¹⁴ Clinician education, training, and clinical experience with DN should be clearly communicated to the patient. PTs should use DN only after obtaining the knowledge, skills, and attributes associated with safe and effective DN techniques. The patient should give verbal consent prior to each treatment with DN. Some jurisdictions do require a written consent for treatments with DN.

In clinical practice, DN is performed once the physical therapy examination and evaluation are completed and clear therapeutic goals and objectives are established. The solid filament needle allows the PT to target tissues that are not manually palpable, such as the subscapularis, iliacus, and lateral pterygoid muscles.¹¹⁵

As part of the procedural guidelines for DN, physical therapists must practice consistent with the OSHA Blood Borne Pathogens standard¹¹⁶ (osha.gov), which applies to all occupational exposure to blood or other potentially infectious materials. According to the OSHA Blood Borne Pathogens Standard, “gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and non-intact skin.”¹¹⁶ As DN creates “non-intact skin” and recent research has shown that the most common adverse event of dry needling is minor bleeding,¹¹⁰ it follows that the OSHA Blood Borne Pathogens Standard applies.

An explanation of the procedure to the patient should be performed prior to the application of DN. The patient should be educated on DN rationale and theory, what to expect during and after the treatment, the type of needle used, precautions, possible side effects, and expected outcomes. Possible fear of needling and pain associated with DN must be addressed. Research has shown that by activating patients’ conditioned pain modulation system, patients are able to differentiate and even appreciate the inhibition of their pain by a second noxious stimulus, ie, the pain associated with DN.¹¹⁷ This realization can activate an endogenous pain inhibitory mechanism, which inhibits early nociceptive processing. By placing DN in this broader context, patients can usually tolerate the discomfort associated with DN without risking further sensitization or windup.¹¹⁸

When using DN techniques for the treatment of TrPs, the PT should palpate the target muscle for a taut band and identify a hyperirritable spot within the taut band confirming TrPs to be treated. DN is usually performed with a solid filiform needle in a tube. The filiform needle in its tube is fixed with the non-needling hand against the suspected area by using a pincer grip or flat palpation depending on the muscle orientation, location, and direction of needle penetration. With the needling hand, the needle is gently loosened from the tube. The top of the needle is tapped or flicked allowing the needle to penetrate the skin. With deep DN, the needle is

guided toward the TrP until resistance is felt and a LTR is elicited. The elicitation of a LTR is considered essential in obtaining a desirable therapeutic effect.^{33,34} The needle is then focused in this area or other neighboring areas by drawing the needle back toward the subcutaneous tissue without taking it out of the skin, and then redirecting the needle toward the remaining TrPs.¹¹⁹ Generally, numerous LTRs can be elicited. Cessation of a given DN procedure may occur as a result of notable decreased frequency or eradication of LTRs, decreased resistance to palpation of the underlying tissue, or patient intolerance of continued needling at that particular site. Once the needle has been withdrawn completely from the skin, pressure (hemostasis) can be applied directly to the skin over the needle insertion site to aid in the prevention of possible swelling or post needling soreness. The muscle is then palpated again to reassess for taut bands and TrPs. Further needling can be performed for the same muscle or for other clinically relevant musculature within the same treatment session. With superficial needling, the needle is just slightly into a muscle in the vicinity of a TrP, but LTRs are not elicited. The needle is kept in place for approximately 30 seconds. At that time, the needle is withdrawn to the subcutaneous tissue. The therapist assesses whether the sensitivity of the TrP has decreased. If so, the DN needling can be discontinued. If the TrP is still sensitive, the needle is guided again into the muscle in the vicinity of the TrP and left in place for approximately 2 minutes.⁵¹ The superficial DN procedure is usually repeated over several TrPs in a given region. LTRs are not elicited with superficial needling techniques. Superficial DN techniques may be used when patients do not tolerate deep DN, or when excessive cramping or stiffness of the underlying tissue occurs while needling.

DN can be combined with electrical stimulation in which the needles become the electrodes. To use electrical stimulation combined with DN, a minimum of 2 needles is required per channel, but multiple channels can be used simultaneously. The best results are reached when the needles are placed within the dermatomes corresponding to the region of dysfunction.¹¹⁹ Frequencies between 2 and 4 Hz with high intensity are commonly used in nociceptive pain conditions and may result in the release of endorphins and enkephalins. For neuropathic pain, frequencies between 80 and 100 Hz are recommended, which are thought to affect the release of dynorphin, gamma-aminobutyric acid, and galanin.¹²⁰ The needles can be placed directly in or at either side of a TrP.^{121,122}

The DN treatment of fascia and connective tissues, including scar tissue, is similar to the approach for TrPs. The PT should palpate the tissues for adhesions and movement restrictions. The needle is inserted in the same manner as for TrPs, but after insertion, the needle is directed more superficially toward the adhesion or restriction. Rotating the needle facilitates mechanotransduction and eventually will lead to tissue relaxation. The needle is left in place until tissue relaxation has been achieved, at which point the needle can easily be removed. DN of fascia usually is a superficial DN technique.

After DN, functional reassessment should be performed to determine if the established outcome has been achieved. Standardized outcome tools such as the modified Oswestry Disability Index, Disability of the Arm Shoulder Hand, Patient Specific Functional Scale or Lower extremity function scale as examples should be utilized to monitor progress. The patient is monitored during the procedure for tolerance and for possible reproduction of local or referred pain sensations. It should be made clear to the patient that the treatment would cease at any time upon his or her request or if he or she was clearly not tolerating the procedure. Tolerance to the treatment should be evaluated during every session.

Manual soft tissue mobilization, therapeutic exercise, neuromuscular re-education, and functional retraining should be used in combination with DN interventions. The patient should be educated in appropriate self-care techniques post DN treatment, which may include specific stretches of the involved muscles, thermo applications, or gentle TrP pressure.

DN is rarely a stand-alone procedure and should be part of a broader physical therapy approach.¹¹⁹ DN should result in a more efficient progression to corrective exercises to improve activity limitations and participation restrictions.

OTHER CONSIDERATIONS

Physical therapists need to be cognizant of any legal or regulatory requirements or restrictions on the performance of dry needling in their state. Information on dry needling scope of practice considerations can be found in the January 2012 APTA Education Resource Paper *Physical Therapists & the Performance of Dry Needling*, available online at www.apta.org/stateissues. In addition, PTs should check with the insurance payer to see if it has issued any specific policies regarding billing of dry needling. As with any physical therapy service, PTs are responsible for providing complete and accurate documentation; resources on documentation are available online at www.apta.org/documentation.

NOTE

APTA will revise this document as new information and data becomes available and updates occur. For questions or comments regarding this document, please contact APTA Public Policy, Practice, and Professional Affairs Unit at advocacy@apta.org.

REFERENCES

1. Ballyns JJ, Turo D, Otto P, et al. Office-based elastographic technique for quantifying mechanical properties of skeletal muscle. *J Ultrasound Med*. Aug 2012;31(8):1209-1219.
2. Ballyns JJ, Shah JP, Hammond J, Gebreab T, Gerber LH, Sikdar S. Objective sonographic measures for characterizing myofascial trigger points associated with cervical pain. *J Ultrasound Med*. Oct 2011;30(10):1331-1340.
3. Chen Q, Bensamoun S, Basford JR, Thompson JM, An KN. Identification and quantification of myofascial taut bands with magnetic resonance elastography. *Arch Phys Med Rehabil*. 2007;88(12):1658-1661.
4. Chen Q, Basford J, An KN. Ability of magnetic resonance elastography to assess taut bands. *Clin Biomech (Bristol, Avon)*. 2008;23(5):623-629.
5. Sikdar S, Shah JP, Gebreab T, et al. Novel applications of ultrasound technology to visualize and characterize myofascial trigger points and surrounding soft tissue. *Arch Phys Med Rehabil*. Nov 2009;90(11):1829-1838.
6. Mense S. Morphology of myofascial trigger points: what does a trigger point look like? In: Mense S, Gerwin R, D., eds. *Muscle pain; diagnosis and treatment*. Heidelberg: Springer; 2010:85-102.
7. Brückle W, Sückfull M, Fleckenstein W, Weiss C, Müller W. Gewebe-pO₂-Messung in der verspannten Rückenmuskulatur (m. erector spinae). *Z Rheumatol*. 1990;49:208-216.
8. Shah JP, Gilliams EA. Uncovering the biochemical milieu of myofascial trigger points using in vivo microdialysis: an application of muscle pain concepts to myofascial pain syndrome. *J Bodyw Mov Ther*. Oct 2008;12(4):371-384.
9. Shah J, Phillips T, Danoff JV, Gerber LH. A novel microanalytical technique for assaying soft tissue demonstrates significant quantitative biomechanical differences in 3 clinically distinct groups: normal, latent and active. *Arch Phys Med Rehabil*. 2003;84:A4.
10. Shah JP, Danoff JV, Desai MJ, et al. Biochemicals associated with pain and inflammation are elevated in sites near to and remote from active myofascial trigger points. *Arch Phys Med Rehabil*. Jan 2008;89(1):16-23.
11. Fernández-de-las-Peñas C, Ge HY, Alonso-Blanco C, González-Iglesias J, Arendt-Nielsen L. Referred pain areas of active myofascial trigger points in head, neck, and shoulder muscles, in chronic tension type headache. *J Bodyw Mov Ther*. Oct 2010;14(4):391-396.
12. Fernández-Carnero J, Fernández de las Peñas CF, de la Llave-Rincón AI, Ge HY, Arendt-Nielsen L. Prevalence of and referred pain from myofascial trigger points in the forearm muscles in patients with lateral epicondylalgia. *Clin J Pain*. May 2007;23(4):353-360.
13. Fernández de las Peñas C, Ge HY, Arendt-Nielsen L, Cuadrado ML, Pareja JA. The local and referred pain from myofascial trigger points in the temporalis muscle contributes to pain profile in chronic tension-type headache. *Clin J Pain*. Nov-Dec 2007;23(9):786-792.
14. Lucas KR, Rich PA, Polus BI. Muscle activation patterns in the scapular positioning muscles during loaded scapular plane elevation: the effects of latent myofascial trigger points. *Clin Biomechanics*. 2010;25(8):765-770.
15. Lucas KR, Polus BI, Rich PS. Latent myofascial trigger points: their effects on muscle activation and movement efficiency. *J Bodyw Mov Ther*. 2004;8:160-166.
16. Simons DG, Hong C-Z, Simons LS. Endplate potentials are common to midfiber myofascial trigger points. *Am J Phys Med Rehabil*. 2002;81(3):212-222.
17. Simons DG. Review of enigmatic MTrPs as a common cause of enigmatic musculoskeletal pain and dysfunction. *J Electromyogr Kinesiol*. 2004;14:95-107.
18. Kuan TS, Hsieh YL, Chen SM, Chen JT, Yen WC, Hong CZ. The myofascial trigger point region: correlation between the degree of irritability and the prevalence of endplate noise. *Am J Phys Med Rehabil*. 2007;86(3):183-189.
19. Gerwin RD, Dommerholt J, Shah JP. An expansion of Simons' integrated hypothesis of trigger point formation. *Curr Pain Headache Rep*. Dec 2004;8(6):468-475.
20. McPartland JM, Simons DG. Myofascial trigger points: translating molecular theory into manual therapy. *J Man Manip Ther*. 2006;14(4):232-239.
21. Hong CZ, Simons DG. Pathophysiologic and electrophysiologic mechanisms of myofascial trigger points. *Arch Phys Med Rehabil*. 1998;79(7):863-872.
22. Bukharaeva EA, Salakhutdinov RI, Vyskocil F, Nikolsky EE. Spontaneous quantal and non-quantal release of acetylcholine at mouse endplate during onset of hypoxia. *Physiol Res*. 2005;54(2):251-255.
23. Simons DG. New views of myofascial trigger points: etiology and diagnosis. *Arch Phys Med Rehabil*. Jan 2008;89(1):157-159.
24. Dommerholt J. Dry needling — peripheral and central considerations. *J Man Manip Ther*. 2011;19(4):223-237.
25. Mense S. How do muscle lesions such as latent and active trigger points influence central nociceptive neurons? *J Musculoskelet Pain*. 2010;18(4):348-353.
26. Fernández de las Peñas C, Cuadrado M, Arendt-Nielsen L, Simons D, Pareja J. Myofascial trigger points and sensitization: an updated pain model for tension-type headache. *Cephalalgia*. 2007;27(5):383-393.

27. Xu YM, Ge HY, Arendt-Nielsen L. Sustained nociceptive mechanical stimulation of latent myofascial trigger point induces central sensitization in healthy subjects. *J Pain*. 2010;11(12):1348-1355.
28. Niddam DM, Chan RC, Lee SH, Yeh TC, Hsieh JC. Central representation of hyperalgesia from myofascial trigger point. *Neuroimage*. Feb 1 2008;39(3):1299-1306.
29. Niddam DM, Chan RC, Lee SH, Yeh TC, Hsieh JC. Central modulation of pain evoked from myofascial trigger point. *Clin J Pain*. Jun 2007;23(5):440-448.
30. Svensson P, Minoshima S, Beydoun A, Morrow TJ, Casey KL. Cerebral processing of acute skin and muscle pain in humans. *J Neurophysiol*. Jul 1997;78(1):450-460.
31. Langevin HM, Bouffard NA, Badger GJ, Churchill DL, Howe AK. Subcutaneous tissue fibroblast cytoskeletal remodeling induced by acupuncture: Evidence for a mechanotransduction-based mechanism. *J Cell Physiol*. May 2006;207(3):767-774.
32. Langevin HM, Bouffard NA, Badger GJ, Iatridis JC, Howe AK. Dynamic fibroblast cytoskeletal response to subcutaneous tissue stretch ex vivo and in vivo. *Am J Physiol Cell Physiol*. Mar 2005;288(3):C747-756.
33. Hong CZ. Lidocaine injection versus dry needling to myofascial trigger point. The importance of the local twitch response. *Am J Phys Med Rehabil*. 1994;73(4):256-263.
34. Tekin L, Akarsu S, Durmus O, Cakar E, Dincer U, Kiralp MZ. The effect of dry needling in the treatment of myofascial pain syndrome: a randomized double-blinded placebo-controlled trial. *Clin Rheumatol*. Nov 9 2012.
35. Hong C-Z, Yu J. Spontaneous electrical activity of rabbit trigger spot after transection of spinal cord and peripheral nerve. *J Musculoskelet Pain*. 1998;6(4):45-58.
36. Hong CZ, Torigoe Y, Yu J. The localized twitch responses in responsive bands of rabbit skeletal muscle are related to the reflexes at spinal cord level. *J Musculoskelet Pain*. 1995;3:15-33.
37. Hong CZ. Persistence of local twitch response with loss of conduction to and from the spinal cord. *Arch Phys Med Rehabil*. Jan 1994;75(1):12-16.
38. Rha DW, Shin JC, Kim YK, Jung JH, Kim YU, Lee SC. Detecting local twitch responses of myofascial trigger points in the lower-back muscles using ultrasonography. *Arch Phys Med Rehabil*. Oct 2011;92(10):1576-1580 e1571.
39. Hong CZ, Kuan TS, Chen JT, Chen SM. Referred pain elicited by palpation and by needling of myofascial trigger points: a comparison. *Arch Phys Med Rehabil*. 1997;78(9):957-960.
40. Simons DG, Dexter JR. Comparison of local twitch responses elicited by palpation and needling of myofascial trigger points. *J Musculoskelet Pain*. 1995;3:49-61.
41. Ge HY, Fernandez-de-Las-Penas C, Yue SW. Myofascial trigger points: spontaneous electrical activity and its consequences for pain induction and propagation. *Chinese Medicine*. 2011;6:13.
42. Hsieh YL, Chou LW, Joe YS, Hong CZ. Spinal cord mechanism involving the remote effects of dry needling on the irritability of myofascial trigger spots in rabbit skeletal muscle. *Arch Phys Med Rehabil*. Jul 2011;92(7):1098-1105.
43. Shah JP, Phillips TM, Danoff JV, Gerber LH. An in-vivo microanalytical technique for measuring the local biochemical milieu of human skeletal muscle. *J Appl Physiol*. 2005;99:1977-1984.
44. Majlesi J, Unalan H. Effect of treatment on trigger points. *Curr Pain Headache Rep*. Oct 2010;14(5):353-360.
45. Affaitati G, Costantini R, Fabrizio A, Lapenna D, Tafuri E, Giamberardino MA. Effects of treatment of peripheral pain generators in fibromyalgia patients. *Eur J Pain*. Jan 2011;15(1):61-69.
46. Srbely JZ, Dickey JP, Lee D, Lowerison M. Dry needle stimulation of myofascial trigger points evokes segmental anti-nociceptive effects. *J Rehabil Med*. 2010;42(5):463-468.
47. Chen JT, Chung KC, Hou CR, Kuan TS, Chen SM, Hong CZ. Inhibitory effect of dry needling on the spontaneous electrical activity recorded from myofascial trigger spots of rabbit skeletal muscle. *Am J Phys Med Rehabil*. Oct 2001;30(10):729-735.
48. Tsai C-T, Hsieh L-F, Kuan T-S, Kao M-J, Chou L-W, Hong C-Z. Remote effects of dry needling on the irritability of the myofascial trigger point in the upper trapezius muscle. *Am J Phys Med Rehabil*. 2010;89(2):133-140.
49. Simons DG. Understanding effective treatments of myofascial trigger points. *J Bodyw Mov Ther*. 2002;6(2):81-88.
50. Olausson H, Lamarre Y, Backlund H, et al. Unmyelinated tactile afferents signal touch and project to insular cortex. *Nat Neurosci*. Sep 2002;5(9):900-904.
51. Baldry PE. *Acupuncture, Trigger Points and Musculoskeletal Pain*. Edinburgh: Churchill Livingstone; 2005.
52. Ceccherelli F, Rigoni MT, Gagliardi G, Ruzzante L. Comparison between superficial and deep acupuncture in the treatment of lumbar myofascial pain: a double-blind randomized controlled study. *Clin J Pain*. 2002;18:149-153.
53. Edwards J, Knowles N. Superficial dry needling and active stretching in the treatment of myofascial pain--a randomised controlled trial. *Acupunct Med*. 2003;9 2003;21(3 SU):80-86.
54. Simons DG, Mense S. Understanding and measurement of muscle tone as related to clinical muscle pain. *Pain*. 1998;75(1):1-17.
55. Whisler SL, Lang DM, Armstrong M, Vickers J, Qualls C, Feldman JS. Effects of myofascial release and other advanced myofascial therapies on children with cerebral palsy: six case reports. *Explore*. May-Jun 2012;8(3):199-205.
56. Dilorenzo L, Traballesi M, Morelli D, et al. Hemiparetic shoulder pain syndrome treated with deep dry needling during early rehabilitation: a prospective, open-label, randomized investigation. *J Musculoskelet Pain*. 2004;12(2):25-34.
57. Lewit K, Olsanska S. Clinical importance of active scars: abnormal scars as a cause of myofascial pain. *J Manipulative Physiol Ther*. 2004;27(6):399-402.
58. Iqbal SA, Sidgwick GP, Bayat A. Identification of fibrocytes from mesenchymal stem cells in keloid tissue: a potential source of abnormal fibroblasts in keloid scarring. *Arch Dermatol Res*. Oct 2012;304(8):665-671.
59. Eto H, Suga H, Aoi N, et al. Therapeutic potential of fibroblast growth factor-2 for hypertrophic scars: upregulation of MMP-1 and HGF expression. *Lab Invest*. Feb 2012;92(2):214-223.
60. Findley TW. Fascia Research from a Clinician/Scientist's Perspective. *Int J Ther Massage Bodywork*. 2011;4(4):1-6.
61. Grinnell F. Fibroblast biology in three-dimensional collagen matrices. *Trends Cell Biol*. May 2003;13(5):264-269.
62. Hicks MR, Cao TV, Campbell DH, Standley PR. Mechanical strain applied to human fibroblasts differentially regulates skeletal myoblast differentiation. *J Appl Physiol*. Aug 2012;113(3):465-472.
63. Langevin HM, Bouffard NA, Fox JR, et al. Fibroblast cytoskeletal remodeling contributes to connective tissue tension. *J Cell Physiol*. May 2011;226(5):1166-1175.
64. Fu ZH, Wang JH, Sun JH, Chen XY, Xu JG. Fu's subcutaneous needling: possible clinical evidence of the subcutaneous connective tissue in acupuncture. *J Altern Complement Med*. Jan-Feb 2007;13(1):47-51.
65. Fu ZH, Chen XY, Lu LJ, Lin J, Xu JG. Immediate effect of Fu's subcutaneous needling for low back pain. *Chin Med J (Engl)*. Jun 5 2006;119(11):953-956.
66. Chiquet M, Renedo AS, Huber F, Fluck M. How do fibroblasts translate mechanical signals into changes in extracellular matrix production? *Matrix Biol*. Mar 2003;22(1):73-80.
67. Langevin HM, Storch KN, Snapp RR, et al. Tissue stretch induces nuclear remodeling in connective tissue fibroblasts. *Histochem Cell Biol*. Apr 2010;133(4):405-415.
68. Skutek M, van Griensven M, Zeichen J, Brauer N, Bosch U. Cyclic mechanical stretching enhances secretion of Interleukin 6 in human tendon fibroblasts. *Knee Surg Sports Traumatol Arthrosc*. Sep 2001;9(5):322-326.
69. Skutek M, van Griensven M, Zeichen J, Brauer N, Bosch U. Cyclic mechanical stretching modulates secretion pattern of growth factors in human tendon fibroblasts. *Eur J Appl Physiol*. Nov 2001;86(11):48-52.
70. Adair-Kirk TL, Senior RM. Fragments of extracellular matrix as mediators of inflammation. *Int J Biochem Cell Biol*. 2008;40(6-7):1101-1110.
71. McPartland JM. Expression of the endocannabinoid system in fibroblasts and myofascial tissues. *J Bodyw Mov Ther*. Apr 2008;12(2):169-182.
72. Khan KM, Scott A. Mechanotherapy: how physical therapists' prescription of exercise promotes tissue repair. *Br J Sports Med*. Apr 2009;43(4):247-252.
73. Langevin HM, Churchill DL, Cipolla MJ. Mechanical signaling through connective tissue: a mechanism for the therapeutic effect of acupuncture. *FASEB J*. Oct 2001;15(12):2275-2282.
74. Chan MW, Hinz B, McCulloch CA. Mechanical induction of gene expression in connective tissue cells. *Methods Cell Biol*. 2010;98:178-205.
75. Hinz B, Phan SH, Thannickal VJ, et al. Recent developments in myofibroblast biology: paradigms for connective tissue remodeling. *Am J Pathol*. Apr 2012;180(4):1340-1355.
76. Hinz B. The myofibroblast: paradigm for a mechanically active cell. *J Biomech*. Jan 5 2010;43(1):146-155.
77. Moseley GL. A pain neuromatrix approach to patients with chronic pain. *Man Ther*. Sep 2003;8(3):130-140.
78. Rosomoff HL, Fishbain DA, Goldberg N, Rosomoff RS. Myofascial findings with patients with "chronic intractable benign pain: of the back and neck. *Pain Management*. 1989;3:114-118.
79. Bajaj P, Bajaj P, Graven-Nielsen T, Arendt-Nielsen L. Trigger points in patients with lower limb osteoarthritis. *J Musculoskelet Pain*. 2001;9(3):17-33.
80. Hsueh TC, Yu S, Kuan TS, Hong CZ. Association of active myofascial trigger points and cervical disc lesions. *J Formos Med Assoc*. 1998;97(3):174-180.
81. Wang C-F, Chen M, Lin M-T, Kuan T-S, Hong CZ. Teres minor tendinitis manifested with chronic myofascial pain syndrome in the scapular muscles; a case report. *J Musculoskelet Pain*. 2006;14(1):39-43.
82. Friction JR. Etiology and management of masticatory myofascial pain. *J Musculoskelet Pain*. 1999;7(1/2):143-160.
83. Teachey WS. Otolaryngic myofascial pain syndromes. *Curr Pain Headache Rep*. Dec 2004;8(6):457-462.
84. Calandre EP, Hidalgo J, Garcia-Leiva JM, Rico-Villademoros F. Trigger point evaluation in migraine patients: an indication of peripheral sensitization linked to migraine predisposition? *Eur J Neurol*. Mar 2006;13(3):244-249.
85. Giamberardino MA, Tafuri E, Savini A, et al. Contribution of myofascial trigger points to migraine symptoms. *J Pain*. Nov 2007;8(11):869-878.

86. Fernández de las Peñas CF, Cuadrado ML, Gerwin RD, Pareja JA. Referred pain from the trochlear region in tension-type headache: a myofascial trigger point from the superior oblique muscle. *Headache*. Jun 2005;45(6):731-737.
87. Fernández de las Peñas C, Alonso Blanco C, Cuadrado ML, Pareja JA. Myofascial trigger points in the suboccipital muscles in episodic tension-type headache. *Man Ther*. 2006;11:225-230.
88. Skubick DL, Clasby R, Donaldson CC, Marshall WM. Carpal tunnel syndrome as an expression of muscular dysfunction in the neck. *J Occupational Rehab*. 1993;3(1):31-43.
89. Qerama E, Kasch H, Fuglsang-Frederiksen A. Occurrence of myofascial pain in patients with possible carpal tunnel syndrome - a single-blinded study. *Eur J Pain*. Jul 2009;13(6):588-591.
90. Treaster D, Marras WS, Burr D, Sheedy JE, Hart D. Myofascial trigger point development from visual and postural stressors during computer work. *J Electromyogr Kinesiol*. Apr 2006;16(2):115-124.
91. Hoyle JA, Marras WS, Sheedy JE, Hart DE. Effects of postural and visual stressors on myofascial trigger point development and motor unit rotation during computer work. *J Electromyogr Kinesiol*. Feb 2011;21(1):41-48.
92. Freeman MD, Nystrom A, Centeno C. Chronic whiplash and central sensitization; an evaluation of the role of a myofascial trigger points in pain modulation. *J Brachial Plex Peripher Nerve Inj*. 2009;4:2.
93. Dommerholt J. Persistent myalgia following whiplash. *Curr Pain Headache Rep*. Oct 2005;9(5):326-330.
94. Ettlin T, Schuster C, Stoffel R, Bruderlin A, Kischka U. A distinct pattern of myofascial findings in patients after whiplash injury. *Arch Phys Med Rehabil*. Jul 2008;89(7):1290-1293.
95. Fruth SJ. Differential diagnosis and treatment in a patient with posterior upper thoracic pain. *Phys Ther*. Feb 2006;86(2):254-268.
96. Doggweiler-Wiygul R. Urologic myofascial pain syndromes. *Curr Pain Headache Rep*. Dec 2004;8(6):445-451.
97. Jarrell J. Myofascial dysfunction in the pelvis. *Curr Pain Headache Rep*. Dec 2004;8(6):452-456.
98. Jarrell JF, Vilos GA, Allaire C, et al. Consensus guidelines for the management of chronic pelvic pain. *J Obstet Gynaecol Can*. Sept 2005;27(9):869-887.
99. Weiss JM. Pelvic floor myofascial trigger points: manual therapy for interstitial cystitis and the urgency-frequency syndrome. *J Urol*. Dec 2001;166(6):2226-2231.
100. Weiner DK, Schmader KE. Posttherapeutic pain: more than sensory neuralgia? *Pain Med*. May-Jun 2006;7(3):243-249.
101. Chen SM, Chen JT, Kuan TS, Hong CZ. Myofascial trigger points in intercostal muscles secondary to herpes zoster infection of the intercostal nerve. *Arch Phys Med Rehabil*. 1998;79(3):336-338.
102. Dommerholt J. Complex regional pain syndrome; part 1: history, diagnostic criteria and etiology. *J Bodyw Mov Ther*. 2004;8(3):167-177.
103. Rashiq S, Galer BS. Proximal myofascial dysfunction in complex regional pain syndrome: a retrospective prevalence study. *Clin J Pain*. Jun 1999;15(2):151-153.
104. Prateepavanich P, Kupniratsaikul V, Charoensak T. The relationship between myofascial trigger points of gastrocnemius muscle and nocturnal calf cramps. *J Med Assoc Thailand*. 1999;82:451-459.
105. Kern KU, Martin C, Scheicher S, Muller H. Auslösung von Phantomschmerzen und -sensationen durch muskuläre Stumpfttriggerpunkte nach Beinamputationen [Referred pain from amputation stump trigger points into the phantom limb]. *Schmerz*. Aug 2006;20(4):300-306.
106. Kern U, Martin C, Scheicher S, Müller H. Does botulinum toxin A make prosthesis use easier for amputees? *J Rehabil Med*. Sep 2004;36(5):238-239.
107. Longbottom J. A case report of postulated 'Barré Liéou syndrome'. *Acupunct Med*. Mar 2005;23(1):34-38.
108. Stellon A. Neurogenic pruritus: an unrecognised problem? A retrospective case series of treatment by acupuncture. *Acupunct Med*. Dec 2002;20(4):186-190.
109. Dommerholt J, Stanborough RW. Muscle pain syndromes. In: Cantu RI, Grodin AJ, Stanborough RW, eds. *Myofascial Manipulation*. Austin: Pro-Ed; 2012:125-180.
110. Brady, S., McEvoy, J., Dommerholt, J., Doody, C.: Adverse events following trigger point dry needling: a prospective survey of chartered physiotherapists. submitted, 2012.
111. Betts D, Budd S. 'Forbidden points' in pregnancy: historical wisdom? *Acupunct Med*. 2011; 29:137-139.
112. Cummings M. 'Forbidden points' in pregnancy: no plausible mechanism for risk. *Acupunct Med*. 2011;29:140-142.
113. Guerreiro da Silva AV, Uchiyama Nakamura M, Guerreiro da Silva JB. 'Forbidden points' in pregnancy: do they exist? *Acupunct Med*. 2011;29:135-136.
114. Cicerone KD. Evidence-based practice and the limits of rational rehabilitation. *Arch Phys Med Rehabil*. Jun 2005;86(6):1073-1074.
115. Gerwin RD, Dommerholt J. Treatment of myofascial pain syndromes. In: Boswell MV, Cole BE, eds. *Weiner's pain management; a practical guide for clinicians*. Vol 7. Boca Raton: CRC Press; 2006:477-492.
116. United States Department of Labor OSHA. Occupational Safety and Health Standards, Z, Toxic and Hazardous Substances, 1910.1030. *Bloodborne pathogens*. Washington, DC: United States Department of Labor, Occupational Safety & Health Administration.
117. Bjorkedal E, Flaten MA. Expectations of increased and decreased pain explain the effect of conditioned pain modulation in females. *J Pain Res*. 2012;5:289-300.
118. Legrain V, Iannetti GD, Plaghki L, Mouraux A. The pain matrix reloaded: a salience detection system for the body. *Prog Neurobiol*. Jan 2011;93(1):111-124.
119. White PF, Craig WF, Vakharia AS, Ghoname E, Ahmed HE, Hamza MA. Percutaneous neuromodulation therapy: does the location of electrical stimulation effect the acute analgesic response? *Anesth Analg*. Oct 2000;91(4):949-954.
120. Lundeberg T, Lund I. Is there a role for acupuncture in endometriosis pain, or 'endometrial-gia'? *Med Acupunct*. Jun 2008;26(2):94-110.
121. Elorriaga A. The 2-Needle Technique. *Med Acupunct*. 2000;12(1):17-19.
122. Mayoral O, De Felipe JA, Martínez JM. Changes in tenderness and tissue compliance in myofascial trigger points with a new technique of electroacupuncture. Three preliminary cases report. *J Musculoskel Pain*. 2004;12(suppl):33.



American Physical Therapy Association.

1111 North Fairfax Street • Alexandria, Virginia 22314-1488 • 800/999-2782 • www.apta.org • advocacy@apta.org



Washington East Asian Medicine Association

At its fundamental level, the Sunrise Review application to add dry needling to the physical therapy scope of practice asks the Department of Health to endorse the creation of a new and separate medical procedure called “dry needling,” which in all respects is a type of acupuncture, and to agree that a separate training regime would satisfy the three criteria for expanding a profession’s scope of practice.

In the Sunrise process, the applicant bears the burden of proof to show whether the proposal meets the criteria set in law. RCW 18.120.010 requires an applicant to demonstrate that a proposed expansion will:

1. Protect the public from harm;
2. Provide assurance of professional ability to perform the increased scope of practice (such as education and training); and
3. Provide the most cost-beneficial option to protect the public.

We show that the application fails to satisfy any of the three criteria and therefore cannot be approved.

- The application fails to demonstrate protection of the public from harm.
- The proposed education and training fail to assure professional ability.
- The application does not even address whether it would be cost-beneficial.

Instead of creating a new and separate medical procedure, we observe that the academic and clinical education of East Asian Medicine Practitioners already protects the public from harm, assures professional ability, and is cost-effective. Instead of creating a new, much lower standard for needling, we recommend physical therapists meet the more appropriate standards already established in state law.

Our recommendation is neither new nor unreasonable. When chiropractors and naturopaths add needle therapy to their scope of practice, they gain licensure as EAMPs. Existing law allows one year of academic credit for their expensive training in Western medicine. The Department of Health’s recommendation should be to add physical therapists to this list, simultaneously

recognizing their Western training, while validating existing standards for safety, training, and cost-effectiveness.

American Medical Association Policy on Dry Needling H-410.949¹

Our AMA recognizes dry needling as an invasive procedure and maintains that dry needling should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed medical physicians and licensed acupuncturists.

“Dry needling is indistinguishable from acupuncture.”²

¹ “Dry Needling is an Invasive Procedure”. Official AMA Policy H-410.949

² <http://www.ama-assn.org/ama/ama-wire/post/physicians-timely-public-health-issues>

³ <http://www.apta.org/PolicyResources/PositionPapers/>

⁴ <http://www.ptwa.org/about/bylaws-policies-and-other-governance-documents>

I. Summary of WEAMA’s Position

Acupuncture and dry needling are indistinguishable from one another from a regulatory and legislative standpoint. Thus, dry needling should be governed by the established statutes that govern acupuncture. Anyone using a dry/acupuncture/filiform needle should meet benchmarks for safety before touching the human body with a needle for therapeutic purposes, which requires extensive training to perform safely.

- The American Society of Acupuncturists, American Association of Acupuncture and Oriental Medicine, the Council of Colleges of Acupuncture and Oriental Medicine, and others have taken strong positions against the expansion of physical therapy to include this procedure.
- Major medical organizations have taken strong stances against dry needling as well, such as:
 - American Medical Association (AMA)
 - American Academy of Physical Medicine and Rehabilitation (AAPMR)
 - American Academy of Medical Acupuncture (AAMA)—which represents the largest collection of medical doctors practicing acupuncture in the United States.
- By comparison, the only organizations that appear to officially support the practice of dry needling are those specifically associated with the physical therapy profession.

Organizations and Associations with Policy or Position Statement in Opposition to Dry Needling by Physical Therapists	Organizations and Associations with Policy or Position Statement in Support of Dry Needling by Physical Therapists
American Medical Association American Academy of Physical Medicine and Rehabilitation American Academy of Medical Acupuncture American Society of Acupuncturists Council of Colleges of Acupuncture & Oriental Medicine American Association of Acupuncture & Oriental Medicine Washington East Asian Medicine Association	American Academy of Orthopaedic Manual Physical Therapists <i>The American Physical Therapy Association (APTA) and the Physical Therapy Association of Washington are presumed to support this yet no official policy or position statement was found.^{3 4}</i>

- The application for scope expansion to include dry needling in the practice of physical therapy with only 54 hours of training and without clinical supervision, oversight, or third-party testing fails to meet— let alone establish—safe standards for said practice.

³ <http://www.apta.org/PolicyResources/PositionPapers/>

⁴ <http://www.ptwa.org/about/bylaws-policies-and-other-governance-documents>

- The safety of this practice has not been established,⁵ as has been demonstrated by lack of any long-term, large cohort safety studies and the concomitant lack of injury reporting.
- The training requirements of 54 hours are unsupported by the very report the physical therapists suggest endorses this number.⁶
- There is no evidence that this scope expansion will be cost-effective, while considerable evidence to the contrary exists.⁷

Safety

Dry needling has not been sufficiently proven safe when performed by physical therapists:

- The oft-cited data on the safety of dry needling is drawn from a single prospective survey, the Brady study.⁸ The study has several flaws.
 - It fails to meet its own criteria for reliability by failing to meet the parameters it set for sample size by nearly 25%.^{9 10} An inadequate sample size renders statistical data unreliable, according to EC parameters.
 - It does not disclose possible conflicts of interest, normally expected of quality, peer-reviewed research. (*See “Section 2—Safety” for a closer examination of this study.*)
 - It was specific only to the dry needling of trigger points, but the definition of dry needling set forth in the bill language of SB6374 specifies not only trigger points, but also undefined “muscular and connective tissues,” for which there are no safety data available.
- The testimony did not reveal the high percentage of adverse events sustained in dry needling, but focuses only on the less frequent, most serious ones. A recent comparative review of studies shows the incidence rate for minor adverse events among dry needlers to be more than double that among acupuncturists, (19.2%¹¹ vs 8.6%¹²).¹³
- Many significant adverse events, such as those cited by CNA, a professional liability insurance provider, were simply not reported in the original sunrise application or by the

⁵ See Section 2.1 Safety

⁶ See Section 2.2 Training

⁷ See Section 2.3 Cost Effectiveness

⁸ Brady S., McEvoy J., Dommerholt J., Doody C. “Adverse Events Following Trigger Point Dry Needling: A Prospective Survey of Chartered Physiotherapists.” *The Journal of Manual & Manipulative Therapy* 22.3 (2014): 134–140. PMC.

⁹ European Commission: Enterprise and industry directorate-general: a guideline on summary of product characteristics. [document on the Internet]. European Commission. 2005 [cited by (8) above on 2012 7 July]

¹⁰ “The study aimed to identify any rare AEs, meaning a sample size of greater than 10 000 treatments was necessary.” This study survey only 7629 treatments. Brady S., McEvoy J., Dommerholt J., Doody C. “Adverse Events Following Trigger Point Dry Needling: A Prospective Survey of Chartered Physiotherapists.” *The Journal of Manual & Manipulative Therapy* 22.3 (2014): 134–140. PMC

¹¹ *ibid.*

¹² Witt CM, Pach D, Reinhold T, Wruck K, Brinkhaus B, Mank S, et al. Treatment of the adverse effects from acupuncture and their economic impact: a prospective study in 73,406 patients with low back or neck pain. *Eur J Pain.* 2011;15:193–7.

¹³ https://www.physiotherapyalberta.ca/files/faq_dry_needling_adverse_events.pdf

FSBPT. CNA reported a 400% increase from 2011 to 2015 in liability claims related to dry needling, which they consider “an emerging area of risk.”¹⁴

Training

The requirement of 54 hours is unsubstantiated.¹⁵

- Section 2 of this report reveals that there is no data that quantifies this amount of training as sufficient for this scope expansion.
- To perform EMGs, for example, a physical therapist must complete 400 hours of education and 200 supervised studies before practicing.¹⁶
- To perform spinal manipulations, a PT in Washington must complete 800 hours of training, with no less than 250 supervised patient encounters.¹⁷
- The same PT’s wish to be allowed to perform an invasive medical procedure involving sharp metal objects penetrating the human body--a potentially dangerous medical procedure, entirely novel to their field—with only 54 hours of training and zero supervised clinical outpatient training hours.

Cost-effectiveness

An essential criterion to judge whether or not to expand a scope of practice is that the applicant demonstrate that the proposal will provide the most cost-effective option to protect the public.

- The application has no data on this point and therefore fails to meet the requirement
- The application provided:
 - No cost comparison to other modalities;
 - No mention of referral to EAMPs who regularly do trigger point needling.¹⁸
 - No mention of the fact that dry needling is not covered by insurance so all patients must pay out of pocket. (*See Section II—Cost Effectiveness*)

Dry Needling is Acupuncture

As was mentioned in testimony, the reason this Sunrise Review is happening is because physical therapists in Washington State refuse to admit the common-sense reality that dry needling is a form of acupuncture, in order to bypass established acupuncture law in this state. A recent paper published in the Journal of Alternative and Complementary Medicine concluded: "Dry Needling is the Intent to Bypass Regulation to Practice Acupuncture."¹⁹ Note that the applicants never

¹⁴ [https://www.cna.com/web/wcm/connect/2d3eaa76-aca2-4f6f-bfd8-](https://www.cna.com/web/wcm/connect/2d3eaa76-aca2-4f6f-bfd8-e7706368cdac/RC_Healt_PT_Claim_Report_Update.pdf?MOD=AJPERES&CACHEID=2d3eaa76-aca2-4f6f-bfd8-e7706368cdac)

[e7706368cdac/RC_Healt_PT_Claim_Report_Update.pdf?MOD=AJPERES&CACHEID=2d3eaa76-aca2-4f6f-bfd8-e7706368cdac](https://www.cna.com/web/wcm/connect/2d3eaa76-aca2-4f6f-bfd8-e7706368cdac/RC_Healt_PT_Claim_Report_Update.pdf?MOD=AJPERES&CACHEID=2d3eaa76-aca2-4f6f-bfd8-e7706368cdac)

¹⁵ See Section 2.2 Training

¹⁶ Washington Administrative Code 246-915-370. Physical Therapists and Physical Therapist Assistants. Electroneuromyographic examinations education and training.

¹⁷ Washington Administrative Code 246-915-380. Physical Therapists and Physical Therapist Assistants. Spinal manipulation--Endorsement.

¹⁸ Fabrey, L, Cogdill, K, Kelley, J. A National Job Analysis: Acupuncture and Oriental Medicine Profession. Olathe, Kansas: Applied Measurement Professionals, Inc.; 2003. http://www.nccaom.org/wp-content/uploads/pdf/NCCAOM_final_JA_Report_2003.pdf.

¹⁹ Fan AY, Zheng L, Yang G. Evidence that Dry Needling is the Intent to Bypass Regulation to Practice Acupuncture in the United States. J Altern Complement Med 2016; 22(8):591-593.

state that dry needling is not acupuncture, nor were they able to clearly articulate differences in oral or written testimony. (*See Section II--Training.*) This is because dry needling is a form of acupuncture.

- The procedure itself, the insertion of a monofilament needle, is the same.
- The tool is the same, namely the monofilament, or acupuncture, needle.
 - Dr Dommerholt claimed in oral testimony that: (00:14:00): “*The FDA has approved specific dry needling needles also referred to as physiotherapy needles for the use of the dry needling by the physical therapists in the United States.*”
 - Yet “Physiotherapy” is the proprietary, or *brand* name, for a new needle he has helped develop, which the FDA classifies as an acupuncture needle. (*See Picture from FDA website, Section II--Dry Needling is Acupuncture.*)
- The targets of the procedure are trigger points, which are known as *ashi* acupuncture points and are therefore the same.
- The manipulation techniques used in dry needling are the same as acupuncture techniques developed 2000 years ago.
- Even the same response to needling was described in Chinese texts 2000 years ago.
- Physical therapists failed to describe how so called “dry needling” is not acupuncture.

The Washington East Asian Medicine Association urges the Department of Health to recognize that:

- **Dry needling is a form of acupuncture.**
- **There are no independently vetted standards for dry needling education.** (*See Section II--Training*)
- **In the interest of public safety, the practice of inserting filiform needles for therapeutic purpose should meet the benchmarks for didactic education, supervised clinical hours, and third-party testing for minimum competency, as required for licensure as an East Asian Medicine Provider.**

II. Applicant's Failure to Meet Sunrise Review Criteria

RCW 18.120.010 states that a scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument.
- The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

To simplify, this translates to:

1. Protecting the public from harm (Safety);
2. Providing assurance of professional ability to perform the increased scope of practice (Training); and
3. Providing the most cost-beneficial option to protect the public (Cost-effectiveness).

By these measures, the applicants have given insufficient evidence to support this expansion.

1. SAFETY

Does the applicant provide sufficient proof that dry needling by physical therapists with 54 hours of training is safe and protects the public from harm?

Inadequate Reporting

Accurate and comprehensive reporting of data on the harm or potential for harm of the practice are required to determine the safety of a scope expansion. Yet it became clear during oral and previously written testimony that many significant adverse events were not reported in the original application, possibly because they were not reported to individual physical therapy boards. These events were cited by CNA, a professional liability insurance provider that reported several incidents that the FSBPT did not. More alarmingly, CNA reported a 400% increase from 2011 to 2015 in liability claims related to dry needling, “an emerging area of risk.”²⁰ (*See Section II--Safety*)

²⁰ https://www.cna.com/web/wcm/connect/2d3eaa76-aca2-4f6f-bfd8-e7706368cdac/RC_Healt_PT_Claim_Report_Update.pdf?MOD=AJPERES&CACHEID=2d3eaa76-aca2-4f6f-bfd8-e7706368cdac

The data on the safety of dry needling comes from a single problematic study, “Adverse Events Following Trigger Point Dry Needling,”²¹ aka, “the Brady study,” or “Brady,” which is also the only the only safety study cited in the HumRRO report on competencies.²² The Brady study falls short of meeting its own intended sample size requirements for its category of safety study²³ by nearly 25%.²⁴ “The study aimed to identify any rare AEs, meaning a sample size of greater than 10,000 treatments was necessary”²⁵ for reliability, yet the researchers failed to meet their research criteria by achieving a total number of only 7629. By comparison, as the authors of that study also note, “Witt et al.²⁶ carried out the largest prospective acupuncture study to date, citing 229,233 patients and 2.2 million acupuncture treatments.”

More importantly, this sole study is applicable to only one part of the proposed scope expansion: trigger point needling. It does not address the needling of other tissues that would be allowed as written.²⁷

Additionally, the data pool for the Brady study did not include all eligible therapists, but rather depended on volunteers who might be reluctant to self-report adverse events.

The testimony did not reveal the high percentage of adverse events sustained in dry needling, but focused only on the less frequent, most serious ones. A recent comparative review of studies shows the incidence rate for minor adverse events among dry needlers to be more than double that among acupuncturists (19.2%²⁸ vs 8.6%²⁹).³⁰

Potential Conflicts of Interest

Furthermore, the Brady study does not report any potential conflicts of interest, such as authors who also work for for-profit training organizations that might benefit from low adverse event

²¹ Brady S., McEvoy J., Dommerholt J., Doody C. “Adverse Events Following Trigger Point Dry Needling: A Prospective Survey of Chartered Physiotherapists.” *The Journal of Manual & Manipulative Therapy* 22.3 (2014): 134–140. PMC.

²² Caranagno J, et al. Analysis of Competencies for Dry Needling by Physical Therapists. July 10, 2015. https://www.fsbpt.org/Portals/0/documents/freeresources/DryNeedlingFinalReport_20150812.pdf

²³ European Commission: Enterprise and industry directorate-general: a guideline on summary of product characteristics. [document on the Internet]. European Commission. 2005 [cited by (8) above on 2012 7 July]

²⁴ “Brady S., McEvoy J., Dommerholt J., Doody C. “Adverse Events Following Trigger Point Dry Needling: A Prospective Survey of Chartered Physiotherapists.” *The Journal of Manual & Manipulative Therapy* 22.3 (2014): 134–140. PMC

²⁵ Ibid.

²⁶ Witt CM, Pach D, Reinhold T, Wruck K, Brinkhaus B, Mank S, et al. Treatment of the adverse effects from acupuncture and their economic impact: a prospective study in 73,406 patients with low back or neck pain. *Eur J Pain*. 2011;15:193–7.

²⁷ Applicant Report: Dry Needling in Physical Therapist Scope of Practice. As submitted to the Washington State Department of Health. 1 June 2016

²⁸ Brady S., McEvoy J., Dommerholt J., Doody C. “Adverse Events Following Trigger Point Dry Needling: A Prospective Survey of Chartered Physiotherapists.” *The Journal of Manual & Manipulative Therapy* 22.3 (2014): 134–140. PMC.

²⁹ Witt CM, Pach D, Reinhold T, Wruck K, Brinkhaus B, Mank S, et al. Treatment of the adverse effects from acupuncture and their economic impact: a prospective study in 73,406 patients with low back or neck pain. *Eur J Pain*. 2011;15:193–7.

³⁰ https://www.physiotherapyalberta.ca/files/faq_dry_needling_adverse_events.pdf

outcomes.³¹ Such disclosures are expected of quality, peer-reviewed research. The study, has four authors, and key applicant testifier Jan Dommerholt is one of them. Co-author McEvoy is, like Dommerholt, also an instructor for the David G Simons Academy, a dry needling education provider, from which the data pool was derived. Yet neither Dommerholt or McEvoy discloses their involvement with this organization. Dommerholt also does not disclose his position as a proprietor of a dry needling training company, Myopain Seminars. (*See Section II--Safety.*)

Procedural Safety Standards

Furthermore, Dommerholt stated that “*OSHA standards actually by far exceed the clean needle techniques of acupuncturists use in their training.*” Yet in developing the Clean Needle Technique (CNT) requirements and testing for acupuncturists, experts from OSHA and the Center for Disease Control (CDC) were consulted to ensure that the recommendations in the CNT manual meet current OSHA and CDC standards. “The safety standards contained in the [CNT] manual represent best practices applicable to any healthcare practitioner who uses a filiform needle or related techniques.”³² Physical therapists are not required to meet these superior safety standards. (*See Section II--Safety.*)

Does the applicant provide sufficient proof that dry needling by physical therapists with 54 hours of training is safe and protects the public from harm?

No.

2. TRAINING

Does the applicant provide assurance of professional ability to perform the increased scope?

The practice analysis on dry needling in physical therapy commissioned by the Federation of State Boards of Physical Therapy (FSBPT) is referred to as the “HumRRO report,” or “HumRRO,” named for the research organization that authored it. While it serves as a foundational report for conclusions meant to establish that the training proposed by the applicants is sufficient, the report neither states nor supports those conclusions.

³¹ “An obvious [conflict of interest] COI exists, if an investigator has certain relationships with a company or organization that could lead them to benefit financially or commercially from the outcome of a trial.” Ghooi, Ravindra B. “Conflict of Interest in Clinical Research.” *Perspectives in Clinical Research* 6.1 (2015): 10–14. PMC. Web. 14 Aug. 2016.

³² Belluomini, Jenny. *Clean Needle Technique: A Manual for Acupuncturists and Other Healthcare Professionals*. Brookline, Mass: Complementary Medicine Press, 2000. Print.

HumRRO

The HumRRO serves as the primary foundation for arguments provided by the applicants, yet not only does the report itself raise questions, it instead paradoxically reveals flaws and inconsistencies in the PT application.

- The HumRRO report never specifies the amount of additional hours of specialized training that are recommended. The 54-hour figure in the PT application is unfounded and not based in evidence.³³
- The HumRRO notes that, "Advanced or specialized training (e.g., dry needling course, residency program) is required for 16 of the knowledge areas needed for dry needling,"³⁴ and advises that "any practice hour metric should be theoretically or practically linked to the professional standard for safe and effective practice (AERA, APA, NCME, 2014)."³⁵ Yet, this has not been done for this scope expansion.
- No acupuncturist or medical acupuncturist, arguably needle therapy experts, was consulted in the creation of this report.
- Each member of the task force was a physical therapist without overlap into any other discipline.³⁶
- Five of the seven HumRRO task force members were affiliated with two dry needling training companies, Kinetacore and Myopain Seminars, each of which offers weekend seminars. The combined length of Kinetacore's Functional Dry Needling Levels 1 & 2 is 54 hours.^{37 38}

Importance of avoiding bias

Maintaining transparency and freedom from bias are important aspects of research. When performing data collection or research of any sort, agreed upon criteria are assessed, which factor

³³ The report claims that PTs know 86% of what they need to know in order to needle safely. If "what they need to know" = X, and we define Y as "additional hours needed" we have $14\% \times X = Y$. Nowhere in the report, testimony or any other source is X defined. You cannot definitively solve for Y without defining X. Thus, 54 hours is not based on any substantive fact.

³⁴ Caranagno J, et al. Analysis of Competencies for Dry Needling by Physical Therapists. July 10, 2015. https://www.fsbpt.org/Portals/0/documents/freeresources/DryNeedlingFinalReport_20150812.pdf

³⁵ "Although additional training is needed for the development of psychomotor skills (as well as the 16 knowledge requirements noted previously), there does not appear to be widespread agreement regarding the minimum number of practice hours necessary (Kalichman & Vulfsons, 2010). Indeed, the acquisition of knowledge and skills is dependent on more than just the number of hours of deliberate practice (Hambrick, Oswald, Altman, Meinz, Gobet, & Campitelli, 2014). The Task Force argued that variation across individuals in terms of their aptitude, education, experience, and clinical specialization results in different rates of development. Additionally, any practice hour metric should be theoretically or practically linked to the professional standard for safe and effective practice (AERA, APA, NCME, 2014)."

³⁶ Joe Donnelly, PT, DHS, OCS (*Myopain Seminars*); Sean Flannagan, PT, DPT, Cert. SMT, Cert. DN; Michelle Layton, DPT, OCS, MTC, CMTPT, FAAOMPT, CCTT (*Myopain Seminars*); Keri Maywhort, PT, DPT (*Kinetacore*); JJ Thomas, MPT, CMTPT (*Kinetacore*); Sumesh Thomas, PT, DPT; Edo Zylstra, PT, DPT, MS, OCS, IMSp (*Kinetacore*)

³⁷ *ibid*

³⁸ Functional Dry Needling® - Level 1 Training. (n.d.). Retrieved August 16, 2016, from <http://www.kinetacore.com/physical-therapy/Functional-Dry-Needling-Level-1-Training/page17.html>
Functional Dry Needling® - Level 2 Training. (n.d.). Retrieved August 16, 2016, from <http://www.kinetacore.com/physical-therapy/Trigger-Point-Dry-Needling-Level-II-Training/page18.html>

into the quality and validity of the interpretation of the results.^{39 40 41} HumRRO is no exception. While variation in criteria is expected depending on the nature of the data, elements such as clear disclosure of any conflicts of interest and bias are universally understood. The Association of American Medical Colleges defines conflicts of interest as “situations in which financial or other personal considerations may compromise, or have the appearance of compromising, an investigator’s judgment in conducting or reporting research.”⁴² Bias is defined as an error caused by systematically favoring some outcomes over others and may be introduced during sampling of the populations or in the analysis of data.⁴³ “Biases... can affect clinical decision-making by making interventions appear safer or more effective than they really are. High-profile examples where undisclosed conflicts of interest have clearly affected clinical practice may have contributed to the erosion of public trust in biomedical research and peer review processes.”⁴⁴ Given that five of the seven task force members were affiliated with for-profit seminar companies, it would seem that avoiding the appearance of bias and any conflicts of interest have not been satisfied.

Unclear Definitions of “Dry Needling”

Dry needling is not clearly defined in the report or anywhere nationally. According to the definition proffered in the HumRRO report, on which “the language of the proposed legislation (SB 6374) is based,”⁴⁵ dry needling could mean the insertion of a needle literally anywhere in the body, or the whole of the practice of acupuncture. While the proposed language of the scope expansion also claims that dry needling does not include the stimulation or treatment of acupuncture points or meridians, because this cannot be differentiated, it cannot be enforced. As such, we see physical therapists practicing unlicensed acupuncture nationwide.⁴⁶

Without a clear definition of what dry needling is or is not:

- Competencies cannot be determined.

³⁹ Boaz, A., & Ashby, D. (2003). *Fit for purpose? Assessing research quality for evidence based policy and practice*. London: ESRC UK Centre for Evidence Based Policy and Practice.

⁴⁰ Shavelson, R. J., & Towne, L. (Eds.). (2002). *Scientific research in education*. Washington, DC: National Research Council, National Academy Press.

⁴¹ Lohr, K. N. (2004). Rating the strength of scientific evidence: Relevance for quality improvement programs. *International Journal for Quality in Health Care*, 16(1), 9–18.

⁴² Association of American Medical Colleges Ad Hoc Committee on Misconduct and Conflict of Interest in Research (1990). *Guidelines for dealing with faculty conflicts of commitment and conflicts of interest in research*. *Academic Medicine*, 65(7), 487-96. doi:10.1097/00001888-199007000-00025

⁴³ Hsu, J. L., Banerjee, D., & Kuschner, W. G. (2008). Understanding and Identifying Bias and Confounding in the Medical Literature. *Southern Medical Journal*, 101(12), 1240-1245. doi:10.1097/smj.0b013e31818860c0

⁴⁴ Dunn, A. G., Coiera, E., Mandl, K. D., & Bourgeois, F. T. (2016). Conflict of interest disclosure in biomedical research: A review of current practices, biases, and the role of public registries in improving transparency. *Res Integr Peer Rev Research Integrity and Peer Review*, 1(1). doi:10.1186/s41073-016-0006-7

⁴⁵ Applicant Report: Dry Needling in Physical Therapist Scope of Practice. As submitted to the Washington State Department of Health. 1 June 2016.

⁴⁶ Goddard, A. Survey of Errors and Omissions in the Sunrise Review Application. As submitted to the Washington State Department of Health, 2016.

- Without competencies, outcome data—information collected to evaluate the capacity of a practitioner to meet certain standards—cannot be determined.
- Without outcome data, there is no basis for the establishment of certification or regulatory oversight.
- The lack of oversight is highlighted by the evidence that many significant adverse events were not reported to physical therapist boards.

The American Medical Association recently stated plainly that no dry needling standards exist, and when and if they are set, “The practice of dry needling by physical therapists and other non-physician groups should include—at a minimum—the benchmarking of training and standards to already existing standards of training, certification and continuing education that exist for the practice of acupuncture.”⁴⁷

PT Proposal Fails to Meet Recommendations of Its Own Report

The Department of Health pointed out that the original application failed to “*demonstrate the courses meet the 16 knowledge requirements that require advanced/specialized training for competency in dry needling identified in the HumRRO report (Table 2, page 12).*”⁴⁸ DOH requested that the applicants “*please provide more detail to demonstrate that the 16 recommended knowledge requirements are met through the available post-graduate/continuing education training programs.*”

As DOH observed, the applicant report suggests that 54 hrs follows from the task force [i.e. HumRRO] recommendations. They further observe that 54 hours does not follow from the HumRRO report. In other words, the very study the physical therapists rely on to suggest that 54 hours is supported, in no way supports that number, which DOH recognized. The courses offered by companies like Myopain Seminars (Dommerholt) and Kinetacore (Thomas) do not satisfy the recommendations. DOH asked for more justification yet did not receive it.

Additionally, these 16 knowledge criteria ostensibly comprise the remaining 14% of competencies needed to attain proficiency, meaning 86% of what would be required to attain proficiency has been covered in prior PT training. But this 14% figure is a fraction of items on a list, without regard to their importance. For example, one of the 86% is “expose the area being needled.” (#4 on the HumRRO report, at pg. iv.) Yet one of the 14% is “Needle insertion techniques,” (#13 of the HumRRO report, at pg. v), as if these are reasonably comparable. Although these are obviously of different value, the applicant quotes them as if they are of equal value. The DOH’s question was not sufficiently answered in the written follow-up nor was it clearly addressed in oral testimony.

⁴⁷ <http://www.ama-assn.org/ama/ama-wire/post/physicians-timely-public-health-issues>

⁴⁸ Sunrise Review – Adding Dry Needling to Physical Therapist Scope of Practice Follow-Up Questions to Applicant Report. July 19, 2016

Moreover, the learning objectives of the five courses cited vary considerably in their content, with respect to both didactic (4-40%) and experiential (60-96%) training, again highlighting the absence of standardization in current dry needling training. The proposed scope expansion offers no safeguards in determining which, if any, of these individual programs meet the 16 knowledge requirements.⁴⁹

By comparison, the WAC requires vastly more hours of training before a physical therapist may perform EMG (400 hours plus 200 studies under supervision) or spinal manipulation (800 hours). (*See Appendix IV—Training.*)

Does the applicant provide assurance of professional ability to perform the increased scope?

No. There are no existing standards by which to determine proficiency.

3. COST-EFFECTIVENESS

Does this scope expansion provide the most cost-beneficial option to protect the public?

An essential criterion to judge whether or not to expand a scope of practice is that the applicant demonstrate that the proposal will provide the most cost-effective option to protect the public. Remarkably, the application has no data on this point and therefore fails to meet the requirement.

The application has no comparison of the cost of physical therapists doing dry needling to any other modality – only statistics about societal costs of low back pain. It quotes the Bree Collaborative about physical therapy as though Bree endorses the parameters set forth in the application. But Bree recommends standard physical therapy, not dry needling.

The most cost-effective means to provide therapeutic needling is for physical therapists to refer patients to fully trained East Asian Medicine Practitioners. The marginal cost, (i.e., the additional cost to society) is zero, because licensed EAMPs already have the necessary training and licensure to practice safely and effectively.

Dry needling, termed as such, is not billable to insurance companies, unlike acupuncture by EAMPs, so patients must pay out of pocket for this service. There are no CPT (Current Procedural Terminology) codes specific to dry needling acupuncture. The APTA has advised against billing it under other codes.⁵⁰ The creation of CPT codes is under the jurisdiction of the

⁴⁹ See Appendix IV—Training

⁵⁰ http://www.iamt.org/wp-content/uploads/2014/04/APTASTatement_DryNeedling-2014.pdf

American Medical Association, which has resolved that dry needling is an invasive procedure that should only be performed by MDs and licensed acupuncturists.

Classes in dry needling cost each participant more than \$1,500⁵¹ to \$1990.⁵² Naturopathic physicians and doctors of chiropractic are given credit for their extensive training in western medicine when they add training for licensure in acupuncture. This is the standard for cost-effective preparation in Washington. Physical therapists should be expected to follow the same path of dual licensure.

Does this scope expansion provide the most cost-beneficial option to protect the public?

No. If anything, this scope expansion will increase costs to the public. Referring to needle therapy specialists, EAMPs, is the most obvious cost-beneficial option.

Dry Needling is a Form of Acupuncture

The applicant's key testifier, Jan Dommerholt of Myopain Seminars, says that dry needling is “within the scope of acupuncture.”⁵³ The scope of acupuncturists is acupuncture. Given that acupuncturists can only do what is in their scope, and dry needling is a monofilament needling therapy, it would seem clear that dry needling is a form of acupuncture. It was established during oral testimony that acupuncturists and dry needlers target the same tissue and agreed by both sides that dry needling is within the scope of acupuncture. The logical conclusion is that dry needling is a form of acupuncture.

It was also established during oral testimony that trigger points and ashi points are synonymous and that acupuncturists regularly use them in practice.⁵⁴ The Department of Health clarified during testimony that physical therapists want to claim that, because the *intent* of the procedure is different, the *procedure itself* is different.⁵⁵ This is an erroneous argument. First, modern acupuncturists commonly needle with biomedical intent,^{56 57} meaning the claim that the intent

⁵¹ From LearnIMS, led by Steven Goodman, for a 27-hour class, which would be insufficient under the terms of this bill.

<http://www.learnims.com/#/registration/cfvg> accessed July 15, 2016

⁵² <https://conf.myopainseminars.com/cgi-bin/crstart.pl?e=U2FsdGVkX18GTryV0pLC3MduvYy2mUacbx-vHhgYymxeZqNM7OdzCA>

⁵³ Dommerholt, J. J Man Manip Ther. 2011 Nov; 19(4): 223–227.

⁵⁴ Fabrey, L, Cogdill, K, Kelley, J. A National Job Analysis: Acupuncture and Oriental Medicine Profession. Olathe, Kansas: Applied Measurement Professionals, Inc.; 2003. http://www.nccaom.org/wp-content/uploads/pdf/NCCAOM_final_JA_Report_2003.pdf.

⁵⁵ Question posed by the Department of Health and affirmed during oral testimony. 2 Aug 2016. See Appendix—Scope.

⁵⁶ In fact all the WEAMA compilers of this report fall into this category and tend to needle with biomedical intent. Acupuncturists speak the language of two medical paradigms that are not mutually exclusive, but actually enhance each other, as they describe the same human phenomena at different points in time through different cultural lenses. -authors

⁵⁷ Fabrey, L, Cogdill, K, Kelley, J. A National Job Analysis: Acupuncture and Oriental Medicine Profession. Olathe, Kansas: Applied Measurement Professionals, Inc.; 2003. http://www.nccaom.org/wp-content/uploads/pdf/NCCAOM_final_JA_Report_2003.pdf.

differs is factually in error to begin with.⁵⁸ Second, the notion that the intent of a procedure somehow changes the procedure itself is also mistaken. The understanding of the procedure might differ, but the procedure itself remains the procedure. If not, this would mean that the trepanation performed by ancient peoples to rid themselves of “evil spirits” by drilling holes through the skull is somehow not a form of surgery, simply because the ostensibly direct purpose is not consistent with a biomedical paradigm.⁵⁹ Real or not, the procedure clearly involves cutting or drilling through the skull for therapeutic purpose. So, not surprisingly, trepanation is defined as form of surgery.⁶⁰ Lastly, a scope of practice relates to procedures themselves and cannot conceivably be enforced according to intent.

While Thomas, Dommerholt, and others testified that physical therapists only want to do one component of what an acupuncturist does,⁶¹ that sentiment does not reflect actual dry needling practice in the United States, and also exhibits a fundamental misunderstanding of acupuncture itself. Although some physical therapists claim they do not intend to, many physical therapists are already practicing acupuncture outright, yet call it dry needling. Many visual exhibits were provided in previously submitted written testimony.⁶² Additionally, it suggests that Dommerholt and Thomas and the rest are cognizant that dry needling is indeed acupuncture. An acupuncturist performs acupuncture. ”A small component of acupuncture,”⁶³ is still acupuncture.

Whether it is the *Dry Needling Institute* teaching acupuncture protocols in its courses and posting pictures of this freely on social media,⁶⁴ or *Systemic Dry Needling*, or *Integrative Dry Needling*, that both rely on a textbook on “biomedical acupuncture,” by acupuncturist Yun-Tao Ma,⁶⁵ physical therapists are undeniably practicing acupuncture. Both latter programs credit Ma as their original teacher.⁶⁶ ⁶⁷ Neither site, nor Ma’s LinkedIn page, lists his acupuncture credentials, though older sources clearly define him as “LAc,” licensed acupuncturist.⁶⁸

James Dunning (Dry Needling Institute) goes further, and suggests that, “physical therapy should consider broadening the definition of dry needling to encompass the stimulation of neural,

⁵⁸ See the letter from Michael Schroeder, previously submitted, which compellingly articulates EAMP training in both spheres.

⁵⁹ Nolen-Hoeksema, *Abnormal Psychology*, 6e, McGraw-Hill Education, 2014

⁶⁰ <http://www.merriam-webster.com/medical/trepanation> Def: a hole in the skull produced surgically

⁶¹ Department of Health Hearing. Approximately 02:33:00. 2 Aug 2016. See Appendix—Scope.

⁶² Goddard, A. The Problematic Language of SB6374, as noted Scope Expansion/Sunrise Application, Appendix A. As submitted to the Washington State Department of Health, 2016.

⁶³ See Appendix II—Scope

⁶⁴ Ex.: <https://twitter.com/DrDunning/status/759769985526796289>; also see source cited in previous footnote.

⁶⁵ Ma, Yun-tao. *Biomedical Acupuncture for Sports and Trauma Rehabilitation Dry Needling Techniques*. New York: Elsevier; 2010.

⁶⁶ <https://www.systemicdryneedling.com/about/team/>

⁶⁷ <https://integrativedryneedling.com/about-us/dr-yun-tao-ma/>

⁶⁸ http://www.acupuncturetoday.com/mpacms/at/columnist_previous.php?id=2891

muscular, and connective tissues, not just [trigger points].”⁶⁹ This is medical acupuncture. He also advises that, “Physical therapists should not ignore the findings of the Western or biomedical ‘acupuncture’ literature that have used the very same ‘dry needles’ to treat patients with a variety of neuromusculoskeletal conditions in numerous, large scale randomized controlled trials.”⁷⁰ Thousands of years of acupuncture practice laid a foundation for the modern research cited by Dunning. As is being recognized by such dry needling acupuncture researchers, acupuncture has measurable effects on autonomic regulation,⁷¹ neuroendocrine mechanisms,⁷² the cardiovascular system,⁷³ tissue repair,⁷⁴ and obviously the muscular system itself. What they are “discovering” in their research is none other than acupuncture.

Is there a new kind of needle?

Much was made of the common tool used in dry needling and acupuncture in oral testimony. Jan Dommerholt appeared to say that a new kind of needle had been developed for dry needling, a “physiotherapy needle,” stating that, “the FDA has approved specific dry needling needles, also referred to as “physiotherapy” needles, for the use of the dry needling by the physical therapists in the United States.”⁷⁵ What he neglected to mention is that “Physiotherapy” is actually the proprietary or *brand* name of these needles, and not the name of a new kind of needle, according to the FDA, which determines this. The FDA, another independent third party, classifies these needles as ACUPUNCTURE needles and he is named as a developer⁷⁶ of them. In other words, his new needle is another brand of acupuncture needle, according to the FDA. Please see below, taken directly from the FDA website.⁷⁷

⁶⁹ Dunning J, Butts R, Mourad F, Young I, Flannagan S, Perreault T. Dry needling: a literature review with implications for clinical practice guidelines. *Physical Therapy Reviews*. 2014;19(4):252-265

⁷⁰ *ibid*

⁷¹ Li, Qian-Qian et al. “Acupuncture Effect and Central Autonomic Regulation.” *Evidence-based Complementary and Alternative Medicine: eCAM* 2013 (2013): 267959. PMC. Web.

⁷² Liang, Fengxia, Rui Chen, and Edwin L. Cooper. “Neuroendocrine Mechanisms of Acupuncture.” *Evidence-based Complementary and Alternative Medicine: eCAM* 2012 (2012): 792793.

⁷³ Ballegaard S1, Muteki T, Harada H, Ueda N, Tsuda H, Tayama F, Ohishi K. Modulatory effect of acupuncture on the cardiovascular system: a cross-over study. *Acupunct Electrother Res*. 1993 Apr-Jun;18(2):103-15.

⁷⁴ Yu, Zhan-ge et al. “Effects of Zusanli and Ashi Acupoint Electroacupuncture on Repair of Skeletal Muscle and Neuromuscular Junction in a Rabbit Gastrocnemius Contusion Model.” *Evidence-based Complementary and Alternative Medicine: eCAM* 2016 (2016): 7074563. PMC. Web. 24 July 2016.

⁷⁵ Sunrise Review Hearing. [00:14:00] Washington State Department of Health. 2 August 2016

⁷⁶ <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfRL/rl.cfm> Search query: Owner/Operator Name: “Agupunt.”

⁷⁷ *Ibid*.

New Search		Back To Search Results
Proprietary Name:	Physiotherapy Needles	
Classification Name:	NEEDLE, ACUPUNCTURE, SINGLE USE	
Product Code:	<u>MQX</u>	
Device Class:	2	
Regulation Number:	<u>880.5580</u>	
Medical Specialty:	General Hospital	
Registered Establishment Name:	<u>AGUPUNT S.L.</u>	
Registered Establishment Number:	3011541120	
Owner/Operator:	<u>AGUPUNT S.L.</u>	
Owner/Operator Number:	10048785	
Establishment Operations:	Contract Manufacturer	

As specified and cited in previous written testimony, attempts to create a new “dry needle” category with the FDA have been unsuccessful.⁷⁸ In July, 2016, producers of Myotech needles were also ordered not to “sell, deliver, mail, furnish, or otherwise distribute in any way needles regulated as Class II medical device by the FDA, including but not limited to Myotech Dry Needles, within the State of California without appropriate licensure under California’s Pharmacy Law.”⁷⁹

These “physiotherapy needles” remain acupuncture needles. According to Oregon attorney Scott Jerger, "The purchase and receipt of acupuncture needles by individuals who are not qualified to practice acupuncture or for intended uses other than acupuncture make such needles legally "adulterated" and/or "misbranded" under the FDCA and is in direct violation of the FDCA and FDA's implementing regulations." (*This letter was submitted in previous written testimony.*)

Is there a new kind of needle, specific to dry needling that has been approved by the FDA?

No. Dommerholt has helped develop another brand of acupuncture needle, according to the FDA

Neither a rebranded acupuncture needle, nor a renamed form of acupuncture can make dry needling new or different. Because dry needling is indistinguishable from acupuncture, regulating bodies cannot determine when a physical therapist is practicing dry needling or when they are practicing acupuncture. This renders the change to the RCW unenforceable.^{80 81}

⁷⁸ https://www.accessdata.fda.gov/cdrh_docs/pdf15/K150903.pdf

⁷⁹ International Center for Integrative Medicine vs Kinetacore, US Dry Needling and Physio Products LLC, IDryNeedle, Medbridge, Inc., Red Coral Acupuncture Supplies Pts Ltd.; Paul Killoren; Edo Zylstra; Austin Woods. US District Court for the Central District of CA. Case NO. 8:16-cv-00736-JLS-GJS

⁸⁰ Goddard, A. Survey of Errors and Omissions in the Sunrise Review Application. As submitted to the Washington State Department of Health, 2016.

A note on dry needling legislation and regulation.

Seeing that the physical therapists have failed to meet any of the three primary criteria, one might wonder why other states have allowed dry needling when it is clearly unwarranted. “Dry needling has gained popularity rapidly since 2000,”⁸² ahead of proper legislation and regulation. As awareness of the practice of dry needling has grown, more organizations are defining positions against it. AMA Board Member, Russell W.H. Kridel, observes: “Lax regulation and nonexistent standards surround this invasive practice. For patients’ safety, practitioners should meet standards required for acupuncturists and physicians.”⁸³

In many states, dry needling was simply declared to be a form of “manual therapy,” a claim which was rejected in Washington State.^{84 85 86} The greater medical community was slow to respond nationwide, but states where acupuncture is well-represented in the medical system have tended toward the same conclusion WEAMA has: that dry needling is acupuncture and should be regulated as such. Scope of practice varies widely from state to state in many professions. What is accepted in one state doesn’t make it acceptable in another. We determine our scope on a state level, according to the needs of our populace.

⁸¹ See Appendix II—Scope

⁸² Heming Zhu, PhD, CMD, MD, MAcu, LicAcu, and Heidi Most, MAcu, LicAcu. Dry Needling Is One Type of Acupuncture. *Journal of Medical Acupuncture*. Volume 28, Number 4, 2016.

⁸³ <http://www.ama-assn.org/ama/ama-wire/post/physicians-timely-public-health-issues>

⁸⁴ South Sound Acupuncture Association vs. Kinetacore, et al. October 2014.

⁸⁵ SB6374 dies in committee. 4 Feb 2016. <http://app.leg.wa.gov/billinfo/summary.aspx?bill=6374&year=2015#documents>

⁸⁶ Goddard, A. The Problematic Language of SB6374, as noted Scope Expansion/Sunrise Application, Appendix A. As submitted to the Washington State Department of Health, 2016.

Washington Attorney General Ruling. 15 April 2016. <http://www.atg.wa.gov/ago-opinions/scope-practice-physical-therapy>

CONCLUSION

The applicant bears the burden of proof to demonstrate that their proposal meets the criteria set in law. RCW 18.120.010 requires the applicant show that a proposed expansion will:

1. Protect the public from harm;
2. Provide assurance of professional ability to perform the increased scope of practice (such as education and training); and
3. Provide the most cost-beneficial option to protect the public.

In the foregoing, we have demonstrated that the application failed to satisfy any of the three criteria and therefore should not be approved.

- The application fails to demonstrate protection of the public from harm
- The proposed education and training fail to assure professional ability
- The application does not even address whether it would be cost-beneficial.

Rather than create a new and separate medical procedure, the training of East Asian Medicine Practitioners already protects the public from harm, assures professional ability, and is cost-effective. Instead of creating a new, lower standard for needling, physical therapists should meet the standards already established in state law.

Our position is the established precedent for Washington State. When chiropractors and naturopaths add needle therapy to their scope of practice, they gain licensure as EAMPs. They receive one year of academic credit for their expensive prior biomedical training. DOH's recommendation should be to add physical therapists to this list, simultaneously recognizing their biomedical training and validating existing standards for safety, training, and cost-effectiveness.

Therefore , the Washington East Asian Medicine Association urges the Department of Health Sunrise Review Committee to recognize that:

- **Dry needling is a form of acupuncture.**
- **There are no standards for dry needling education, training, and oversight.**
- **In the interest of public safety, the practice of inserting filiform needles for therapeutic purpose should meet the benchmarks for didactic education, supervised clinical hours, and third-party testing for minimum competency, as required for licensure as an East Asian Medicine Provider.**
- **The PT application failed to satisfy any of the three Sunrise criteria and therefore cannot be approved.**

- **Acupuncture from EAMP's, who already have the necessary training to practice therapeutic needling safely and effectively, is the safest and most cost-effective way for the public to receive the benefits of this valuable procedure.**

The Washington East Asian Medicine Association further urges the Department of Health Sunrise Review Committee to reject the physical therapy scope expansion application.

Appendices—supporting information and commentary on:

- I. Dry needling v. acupuncture
- II. Scope
- III. Safety
- IV. Training
- V. Cost-Effectiveness

Due to the nature of a Sunrise Review hearing, opponents have limited time in which to comment and are thus unable to address concerns or questions that arise in that process. This section will clarify or rebut misleading statements given in oral testimony, in support of our position that anyone using a dry/acupuncture/filiform needle should meet benchmarks for safety before touching the human body with a needle for therapeutic purposes, which requires extensive training to perform safely.

These misleading statements will, where appropriate, be categorized according to general area of concern, and also the criteria that scope expansion proposals are intended to meet, labeled herein as Safety, Training, and Cost-Effectiveness.

I. Dry needling v. acupuncture

A. Studies

DOH: *So I have a question on page let's see 19 of your report. It says, results from acupuncture studies cannot be applied to dry needling as it is different in both location and depth of needle from acupuncture. Can you explain how it is different than acupuncture? I don't feel like I have a clear understanding of how dry needling is not acupuncture, what the differences are? (WEAMA emphasis)*

Dommerholt: *That's a very good question. That's not a question to which I have an easy answer because you can argue any side of that discussion and when we talk about acupuncture, I think we have to realize that there are many different kinds of school of acupuncture. I live in the State of Maryland. The schools in Maryland has a very different training program than the school in New York City for example. In China alone, they have over 80 different schools of acupuncture along variations of a theme. The schools within the United States are all slightly different. So when you talk about acupuncture, the question is, what kind of acupuncture are you referring to? Traditional Chinese, Japanese, Vietnamese, French Vietnamese, Maryland et cetera, et cetera. There are so many variabilities. It's almost like asking me what kind of car do I drive without or you guessing what kind of car I drive without me telling you.*

WEAMA: Yes, there are many different kinds of acupuncture. Yet every one of those many different styles describes itself as acupuncture. And none would claim that the others weren't acupuncture. Just like with so many varieties of "car," they are all cars. It does not depend on which of the many forms of acupuncture one considers, as they are all acupuncture and that is the point. Dry needling acupuncture is a name for one of the many types of acupuncture, also called trigger point needling or *ashi* needling. It is still acupuncture.

Dommerholt: *So the arguments will be made by acupuncturists that dry needling has already been practiced for thousands of years. By needling ashi points by doing thrusting lift and thrusting techniques which is true. There is no question about it that acupuncturists can do this and it's in their scope.*

The issue is not whether it's exclusive to acupuncturists or whether overlapping scope is actually necessary. At the same time, in my teaching program, we always have acupuncturists in every single course. I just taught a course the last two weekends and we have four acupuncturists in those courses. Every acupuncturist since 1997 that has courses attending our courses always says, there is this entirely different if anything I've ever learnt in acupuncture school. So are they the same? There is overlap but the biggest difference I would emphasize to you that acupuncture is a discipline, dry needling is a technique that yes belongs within the field of acupuncture but I am also teaching course for veterinary medicine or doctors. We use dry needling to treat horses, we did dry needling to the dogs and cats and even zoo animals. So dry needling is a technique – dry needling is not a discipline.

WEAMA: Dry needling is not a "technique," as it is sometimes presented. It is a procedure, as the AMA states in their recent resolution.

WEAMA: Additionally, the notion that "Results from acupuncture studies cannot be applied to dry needling as it differs in both location and depth of needle from acupuncture," is incorrect. The claim comes from the Brady study co-authored by Dommerholt.⁸⁷ By contrast, other dry needling researchers have seen the value in looking to acupuncture studies for understanding and insight into the mechanisms and benefits of therapeutic needling. A dry needling literature review notes in a section titled, "*Physical Therapists Should Not Ignore the Findings of Western Acupuncture Trials*," "the vast majority of the 'acupuncture' trials are not

⁸⁷ Brady, Sarah et al. "Adverse Events Following Trigger Point Dry Needling: A Prospective Survey of Chartered Physiotherapists." *The Journal of Manual & Manipulative Therapy* 22.3 (2014): 134–140. PMC.

claiming to move *qi* along meridians or channels.”⁸⁸ Thousands of years of acupuncture practice laid a foundation for modern research. The public should not be misled to believe that a re-named needling style is new, better or even remotely as well-studied.

Dommerholt also fails to establish the differences between acupuncture and dry needling. While he calls physical therapy a discipline and acupuncture a discipline, he does not also acknowledge that acupuncture is a procedure. Dry needling is procedurally indistinguishable from acupuncture.

B. *Trigger points vs ashi points*

Trigger point needling (aka dry needling) is new only by name. Modern acupuncturists use trigger, motor points, and modern anatomy and physiology in their practices. In addition to the default understanding that most of the classical points are in fact trigger points, and that by extension, acupuncturists can be said to be needling trigger points on a daily basis, the majority of acupuncturists incorporate the understanding and treating of trigger and motor points, as trigger and motor points, into their practices. In 2003, the national certifying body for acupuncture standards, the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), which administers board exams and board certification, surveyed then-current use of trigger and motor points among acupuncturists. Fully 82% of those acupuncturists surveyed reported the use of trigger points in the treatment of pain.”⁸⁹

Additionally, the application attempts to cast doubt that trigger points were *ashi* points. Although previously submitted in written testimony, the following is worth repeating:

- Ronald Melzack, Ph.D., world-renowned pioneer in the field of pain research, reported that, “trigger points and acupuncture points for pain [i.e. *ashi* points], though discovered independently, and labeled differently, represent the same phenomenon and can be explained in terms of the same neural mechanisms.”⁹⁰
- In describing needling trigger points, L. Kalichman, a physical therapist, and S. Vulfsons, a medical doctor, state that a “very similar method was developed in 7th century by Chinese physician Sun Su-Mo [Sun Simiao],

⁸⁸ Dunning J, Butts R, Mourad F, Young I, Flannagan S, Perreault T. Dry needling: a literature review with implications for clinical practice guidelines. *Physical Therapy Reviews*. 2014;19(4):252-265

⁸⁹ Fabrey, L, Cogdill, K, Kelley, J. A National Job Analysis: Acupuncture and Oriental Medicine Profession. Olathe, Kansas: Applied Measurement Professionals, Inc.; 2003. http://www.nccaom.org/wp-content/uploads/pdf/NCCAOM_final_JA_Report_2003.pdf.

⁹⁰ Melzack, R, Stillwell, DM, Fox, EJ. Trigger Points and Acupuncture Points for Pain: Correlations and Implications. *Pain*. 1977;3(1):3–23.

who inserted needles at points of pain, which he called Ah-Shi [ashi] points. From the description of these points, it is clear that they are what are currently referred to as MTrPs [Myofascial Trigger points]."⁹¹

- In 2008, two medical doctors, Dorsher and Fleckenstein, demonstrated that 93.3% of the “common trigger points” in Travell’s *Trigger Point Manual* corresponded anatomically to established classical, channel-based acupuncture points.⁹²
- Citing further pain and somatovisceral evidence, they conclude that trigger points and acupuncture points are likely the same physiologic phenomenon.⁹³
- The World Health Organization defines trigger points as a subset of acupuncture points.⁹⁴

The applicant submission on this point, however, badly misrepresents the issue.

- It cites only an editorial by Stephen Birch, but not the quantitative research by Drs. Dorsher and Fleckenstein. (*See PT Application, Appendix*).
- It also fails to mention Dorsher’s rebuttal of Birch’s piece, describing it as Birch’s “conceptual opinions.”⁹⁵
- Finally, applicants fail to include Dorsher’s revisiting Birch’s analysis and finding that the clinical correspondence of trigger points and acupuncture points for pain is likely 95% or higher.⁹⁶

II. Scope

The applicant's key testifier, Jan Dommerholt of Myopain Seminars, agrees that dry needling is “within the scope of acupuncture.”⁹⁷ The scope of acupuncturists is acupuncture. Given that acupuncturists can only do what is in their scope, and dry needling is a needling therapy, dry needling must be a form of acupuncture, else it could not be within the acupuncture scope. It was established during the hearing that acupuncturists and dry needlers target the same tissue and it was agreed by both sides that

⁹¹ Kalichman L, Vulfsons S. Musculoskeletal Pain, *Journal of the American Board of Family Medicine* 2010; 23(5): 640-646.

⁹² Dorsher PT, Fleckenstein J. Trigger Points and Classical Acupuncture Points, Part 1: Qualitative and Quantitative Anatomic Correspondences. *German Journal of Acupuncture and Related Techniques* 2008;51(3): 15-24.

⁹³ Ibid.

⁹⁴ Hoyt, J. “Acupuncture, Dry Needling and Intramuscular Manual Therapy: Understanding Acupuncture’s Therapeutic Role in America.” *Coalition for Safe Acupuncture Practice. Abstract.* (2012): 15. CCAM Research Partners Press

⁹⁵ On the Probability of Trigger Point–Acupuncture Point Correspondences: An Evidence-Based Rebuttal of Stephen Birch’s Commentary. *J Altern Complement Med*, Vol 14, No. 10, 2008, p. 1183

⁹⁶ Can classical acupuncture points and trigger points be compared in the treatment of pain disorders? Birch’s analysis revisited. *J Altern Complement Med.* 2008 May;14(4):353-9

⁹⁷ “There is no question about it that acupuncturists can do this and it’s in the scope.” Dommerholt. (00:41:45) Sunrise Review Hearing. Washington Department of Health. 2 August 2016

dry needling is within the scope of acupuncture. The logical conclusion is that dry needling is a form of acupuncture.

Because dry needling *is indistinguishable from* acupuncture, regulating bodies would be unable to determine when a physical therapist begins to work beyond their scope. Here the DoH asks Thomas to clarify that it is only the intention that separates dry needling from acupuncture:

[2:33:28] DOH: *I have one clarifying question. So the first comment that you made about intent of practice, I am just trying to make sure that I have this clear. So when we first started the testimony, I asked about the definitions of trigger points which I am assuming that from what I read and what we've heard today are the aim of dry needling, of the dry needling technique for physical therapists. So if there is a common definition of what a trigger point is and common needles being used by both. The same needles in some cases by physical therapists and acupuncturists, you are stating that the intent of practice is what differentiates the two practices.*

JJ Thomas: *That's not the only thing...*

WEAMA: As argued in previously submitted testimony and earlier in this paper, physical therapists claim that because the intent of the invasive procedure is different, the procedure itself is different, a fallacious argument.⁹⁸ And on top of the problematic argument itself, how would a scope of practice be enforced according to intent? The impossibility of determining when a physical therapist is practicing dry needling acupuncture or when they are practicing non-dry needling acupuncture renders the change to the RCW unenforceable.⁹⁹

JJ Thomas: *That's not the only thing but I think what might answer your question is recognizing that yes, they may be treating components within their acupuncture technique that address the neuromuscular skeletal system. However, that small component would be the only part that would be classified under our scope of practice. So to follow that up, for us to go and get do a licensure, then that would require us, now we would be taking additional hours that take us outside our current scope of practice. So we would be able to do these other skill sets that currently are not but we don't have an interest in that.*

⁹⁸ McIntyre, A. Dry Needling Is Acupuncture. As submitted to the Washington State Department of Health, 2016.

⁹⁹ Goddard, A. Survey of Errors and Omissions in the Sunrise Review Application. As submitted to the Washington State Department of Health, 2016.

WEAMA: While this is further evidence that dry needling is indeed acupuncture, Ms. Thomas may only speak for herself and cannot be assumed to speak for all of the programs mentioned in the original applicant report or follow-up answers. As exhibited in prior testimony,¹⁰⁰ physical therapists are using acupuncture points and protocols all over the country but call it dry needling. Physical therapists are also treating conditions beyond their training such as hormonal imbalances¹⁰¹ which would be out of scope in Washington, yet because dry needling *is indistinguishable from* acupuncture from a regulatory and legislative standpoint, regulating bodies would have difficulty determining such. This situation is a testament to the need for those who insert a filiform needle into the body for therapeutic benefit to be fully licensed as acupuncturists.

Acupuncture is a skilled procedure. The applicant exhibits a fundamental misunderstanding of acupuncture. Considering dry needling acupuncture as “just one component” of what acupuncturists do is naive.¹⁰² A needle inserted into the body does not occur in a physiological vacuum. The therapeutic insertion of needles into the body is a procedure that has measurable effects on autonomic regulation,¹⁰³ neuroendocrine mechanisms,¹⁰⁴ the cardiovascular system,¹⁰⁵ tissue repair,¹⁰⁶ and obviously the muscular system itself. It should follow that the insertion of needles should be performed by someone trained to understand how the procedure affects the body as a whole, such as modern acupuncturists, who receive both biomedical and East Asian medical education, in addition to standards, testing, and oversight. Physical therapists who do not receive comprehensive training in needling therapies, as EAMPs do, don’t know that they don’t know the underlying physiological effects of needling.

Claiming to only do one component of an acupuncturist’s scope is akin to saying, “We just want to learn brain surgery. We don’t want to learn thoracic surgery, as we don’t do that.” The problem is that surgery is surgery, the basics of which require time and supervised practice to master, sharing common competencies involving the basic procedure of surgery itself, namely cutting into the body for therapeutic purpose. Because acupuncture is a form of minimally invasive surgery, the analogy is appropriate.

¹⁰⁰ Goddard, A. Survey of Errors and Omissions in the Sunrise Review Application. As submitted to the Washington State Department of Health, 2016.

¹⁰¹ See Appendix II—Scope

¹⁰² See Appendices—Scope

¹⁰³ Li, Qian-Qian et al. “Acupuncture Effect and Central Autonomic Regulation.” Evidence-based Complementary and Alternative Medicine: eCAM 2013 (2013): 267959. PMC. Web.

¹⁰⁴ Liang, Fengxia, Rui Chen, and Edwin L. Cooper. “Neuroendocrine Mechanisms of Acupuncture.” Evidence-based Complementary and Alternative Medicine: eCAM 2012 (2012): 792793.

¹⁰⁵ Ballegaard S1, Muteki T, Harada H, Ueda N, Tsuda H, Tayama F, Ohishi K. Modulatory effect of acupuncture on the cardiovascular system: a cross-over study. *Acupunct Electrother Res.* 1993 Apr-Jun;18(2):103-15.

¹⁰⁶ Yu, Zhan-ge et al. “Effects of Zusanli and Ashi Acupoint Electroacupuncture on Repair of Skeletal Muscle and Neuromuscular Junction in a Rabbit Gastrocnemius Contusion Model.” Evidence-based Complementary and Alternative Medicine: eCAM 2016 (2016): 7074563. PMC. Web. 24 July 2016.

Dommerholt (00:14:00) *Suggesting that a needle is a tool and it is reserved to one particular discipline only is like saying that only a cardiologist will be allowed to use a stethoscope. Do we really want a healthcare system where one profession claims exclusive rights over the tool. When I use the stethoscope in my physical therapy practice, I do not suggest that I am a cardiologist.*

WEAMA: No "discipline" is claiming exclusive rights to the tool. The FDA has determined their exclusivity, as is their purview, and has determined the category of this tool, namely Acupuncture Needle. The more appropriate analogy is a scalpel. The "discipline" in this case is surgery, which obviously includes specific contexts for use of the tool. Otherwise, it's just a knife. Anyone cutting the skin open for therapeutic purpose is performing surgery, by definition, regardless of how much or little training they have had. [eg. Def from Merriam Webster: "medical treatment in which a doctor cuts into someone's body in order to repair or remove damaged or diseased parts (Chiefly US)" ¹⁰⁷] The same applies here: anyone using an acupuncture needle penetrating the skin for therapeutic purpose is, by definition, performing acupuncture. This conclusion is inescapable. Lastly, a stethoscope is a diagnostic, not therapeutic tool. The analogy is not entirely appropriate.

Next we have an example of how physical therapists appear to be practicing acupuncture:

"I am a student of Integrative Dry Needling, which addresses imbalances on both sides of the body and not just symptomatic trigger points. What motivated me to learn dry needling was my own chronic pain and frequent headaches and migraines. Despite radical changes in my diet, muscle pain continued to rob me of quality time with my family and friends, and I still experienced cyclical migraines that lasted 2 to 3 days just before my menstrual cycle would start. My migraines now occur very infrequently and my cyclical headaches have been mostly abated if I receive a dry needling treatment BEFORE my cycle begins and if I am needled into deeper tissues to produce a twitch. It is not enough to have dry needling to my neck and shoulders, but to deeper structures in my hips, where I can have a bigger effect on inflammation throughout my body." ¹⁰⁸

WEAMA: The writer of this blog noticed that acupuncture (here called dry needling) has systemic effects. An acupuncturist understands these effects already, is trained to treat them, capable of understanding them, as well as recognizing any red flags. Treating hormonal imbalances is not within the scope of physical therapy, so the question arises, what if it happens unintentionally? That might or might not be good for the patient, but

¹⁰⁷ <http://www.merriam-webster.com/dictionary/surgery>

¹⁰⁸ <http://www.healthycorewellness.com/#!/Reduce-Inflammation-and-Pain-With-Integrative-Dry-Needling/c2su/562b84e80cf258da0e9171e0>

the lack of training and understanding make this problematic if physical therapists try to duplicate the results, with inadequate training. They would be out of scope, yet because dry needling is indistinguishable from acupuncture, regulating bodies could not determine this.

In addition to many images provided in previous testimony, below is a supposed image of “dry needling.”¹⁰⁹ Note that written on the body are acupuncture points, including KI1, KI2, KI6, SP3 and SP4. (KI=Kidney meridian; SP=Spleen meridian)

Physical Therapists Performing Electro-Acupuncture



SMI James Dunning @DrDunning · Jul 31

8-point semi-standardized electrical **#dryneedling** for plantar fasciitis at DN-2 down in the **#bayou #cajun** country



In writing about the history of dry needling, David Legge observes that, “without the interest in acupuncture in the mid-1970s and the introduction of acupuncture needles into contemporary practice, it is likely that dry needling would never have become an established modality.”¹¹⁰ To discount acupuncture by claiming that it only works to “restore energy flow” is an example of physical therapists “not knowing what they don’t know,” also known as the Dunning-Kruger Effect.¹¹¹

¹⁰⁹ <https://twitter.com/DrDunning/status/759769985526796289>

¹¹⁰ Legge, D. A History of Dry Needling. *Journal of Musculoskeletal Pain* 22(3) May 2014

¹¹¹ “Those with limited knowledge in a domain suffer a dual burden: Not only do they reach mistaken conclusions and make regrettable errors, but their incompetence robs them of the ability to realize it.” Kruger, J., Dunning, D. *Unskilled and Unaware of It*:

III. Safety

Dommerholt: *“The Federation of State Boards of Physical Therapy maintains a disciplinary database of all actions taken by all physical therapy state boards in the country and the database does not contain a single citation describing harm or injury from dry needling by a physical therapist.”*

WEAMA: While this is technically true, the answer is misleading because it represents only one source of available data. As presented in the oral testimony of John Moore, EAMP and representative of the the National Center for Acupuncture Safety and Integrity (NCASI), numerous injuries have occurred that were not reported by the FSBPT.

The initial report, follow-up questions and oral testimony, failed to reveal the following from 2016 report by CNA¹¹², a professional liability insurance provider:

- three pneumothoraces,
- damage to a nerve,
- one broken needle requiring surgical removal.

Instead of including readily available information, the applicants supplied only a letter from CNA that is four years old.

Dommerholt: *“...all physical therapists are trained to meet [Occupational Safety and Health Administration] OSHA standards as part of the physical therapy training. OSHA standards actually by far exceed the clean needle techniques of acupuncturists use in their training. Several things in the clean needle technique that acupuncture is used. You may argue that it’s inconsistent with OSHA as far as not wearing gloves for example, the skin being penetrated.”*

WEAMA: In developing the Clean Needle Technique (CNT) requirements and testing for acupuncturists, experts from OSHA and the Center for Disease Control (CDC) were consulted to ensure that the recommendations in the CNT manual meet current OSHA and CDC standards. “The safety standards contained in the [CNT] manual represent best practices applicable to any healthcare practitioner who uses a filiform needle or related techniques.”¹¹³ By contrast, learning OSHA standards in physical therapy school does not guarantee that a physical therapist will, by extension, somehow have an innate understanding of safe acupuncture needle handling.

How Difficulties in Recognizing One's Own Incompetence Lead to Inflated Self-Assessments. *Journal of Personality and Social Psychology*. 1999, Vol. 77, No.6. 1121-1134

¹¹²[https://www.cna.com/web/wcm/connect/2d3eaa76-aca2-4f6f-bfd8-](https://www.cna.com/web/wcm/connect/2d3eaa76-aca2-4f6f-bfd8-e7706368cdac/RC_Healt_PT_Claim_Report_Update.pdf?MOD=AJPERES&CACHEID=2d3eaa76-aca2-4f6f-bfd8-e7706368cdac)

[e7706368cdac/RC_Healt_PT_Claim_Report_Update.pdf?MOD=AJPERES&CACHEID=2d3eaa76-aca2-4f6f-bfd8-e7706368cdac](https://www.cna.com/web/wcm/connect/2d3eaa76-aca2-4f6f-bfd8-e7706368cdac/RC_Healt_PT_Claim_Report_Update.pdf?MOD=AJPERES&CACHEID=2d3eaa76-aca2-4f6f-bfd8-e7706368cdac)

¹¹³ Belluomini, Jenny. *Clean Needle Technique: A Manual for Acupuncturists and Other Healthcare Professionals*. Brookline, Mass: Complementary Medicine Press, 2000. Print.

Dommerholt: “In 2014, I was one of the authors of an Adverse Events study of dry needling by physical therapists. It prospectively evaluated, nearly 8000 physical therapy treatments with dry needling and we found there is a risk of a significant adverse events – that is really talking about the Pneumothorax or collapsed lung – was less than 0.04%. The risk of internal bleeding you are taking ibuprofen is 14% just for comparison.”

WEAMA: This article has four authors, and Dommerholt is one of them. As authors, neither Dommerholt or McEvoy discloses their positions as instructors for the education provider, the David G Simons Academy, from which the data pool was derived. Dommerholt also does not disclose his position as a proprietor of a DN course, Myopain Seminars. There is no statement of conflicts of interest, which are typical in peer-reviewed research. See the screen shot below, where Dommerholt lists his affiliation with a university, as does McEvoy.

Journal List > J Man Manip Ther > v.22(3); 2014 Aug > PMC4101552



J Man Manip Ther. 2014 Aug; 22(3): 134–140. PMCID: PMC4101552
doi: [10.1179/2042618613Y.0000000044](https://doi.org/10.1179/2042618613Y.0000000044)

Adverse events following trigger point dry needling: a prospective survey of chartered physiotherapists

[Sarah Brady](#),¹ [Johnson McEvoy](#),² [Jan Dommerholt](#),³ and [Catherine Doody](#)¹

¹School of Public Health, Physiotherapy and Population Science, University College Dublin, Belfield, Ireland
²University of Limerick, Ireland
³Shenandoah University, Winchester, VA, USA

Correspondence to: Sarah Brady, Care of: School of Public Health, Physiotherapy and Population Science, University College Dublin, Belfield, Dublin 4. Email: sarah.brady24@gmail.com

[Author information](#) [Copyright and License information](#)

Finally, the data pool did not even include all eligible therapists. It depended on volunteers out of the 183 therapists trained through David G Simons Academy. Only 39 participants actually completed the questionnaire. N=39 is not an adequate number for a prospective safety study. They calculate their response rate as 76% because they got 39 responses from 51 volunteers. The real response rate, however, is 21%, calculated from 39/183 eligible. The sample size is made of volunteers (who may have a vested interest in not reporting adverse events).

DOH: *I have one really quick question about informed consent when you are working with the patient if you are going to be using the dry needling technique or one of the other endorsements, is there a separate informed consent for that specific technique when you are working on a patient or do they just give the general informed consent for the therapy that they are being given?*

JJ Thomas: *So you can correct me if I am wrong but I believe it varies state to state. Some states specifically address this and some do not. In Delaware, they specifically do require an informed consent and it's a separate consent and we are obviously – we review the risks and precautions ahead of time.*

WEAMA: This does not answer the question of whether a specific informed consent pertaining to dry needling will be required within Washington State.

IV. Training

The practice analysis on dry needling in physical therapy commissioned by the Federation of State Boards of Physical Therapy (FSBPT) is referred to as the HumRRO, named for the research organization that authored it. The HumRRO serves as the primary foundation for arguments provided by the applicants yet it appears biased and fails in the following ways:

- The HumRRO calls for additional clinical supervision after an (unspecified) amount of additional hours of specialized training required. No course offers this, nor would the scope expansion in Washington require it.
- The HumRRO report never specifies the amount of additional hours of specialized training that are recommended. The 54-hour course is completely arbitrary and not based in fact.¹¹⁴
- That 54 hours happens to match up exactly with the curriculum of Myopain Seminars and others.
- Not a single expert with training in and knowledge of using filiform needles for a therapeutic purpose (i.e. an acupuncturist or even a medical acupuncturist) was consulted in the creation of this report.
- Every person on the task force was a physical therapist without overlap into any other discipline.
- Five of the seven task force members are affiliated with for-profit dry needling training companies.

¹¹⁴ The report claims that PTs know 86% of what they need to know in order to needle safely. If “what they need to know” = X, and we define Y as “additional hours needed” we have $14\% \times X = Y$. Nowhere in the report, testimony or any other source is X defined. You cannot definitively solve for Y without defining X. Thus, 54 hours is not based on any substantive fact.

According to the report,¹¹⁵ “The Task Force defined specialized training as a full course on a particular topic or set of topics—short (e.g., half-day) workshops do not fulfill this requirement”—and recommended that “opportunities to practice actual needling should be incorporated into and provided immediately after the training to reinforce learning.” Also, “the Task Force observed that the majority of these skills and abilities are acquired through entry-level training and education. However, because dry needling is not included in most entry-level physical therapy programs (Adrian, 2013), the psychomotor skills needed to handle needles and palpate tissues require specialized training.”

Not only was the recommendation of follow-up opportunities to practice needling ignored, but no recommendation regarding the number of hours of additional “specialized” training required was given.

The report continues: “Although additional training is needed for the development of psychomotor skills (as well as the 16 knowledge requirements noted previously), there does not appear to be widespread agreement regarding the minimum number of practice hours necessary (Kalichman & Vulfsons, 2010).”

The report claims that physical therapists know 86% of what they need to know in order to needle safely. “What they need to know” = X. They then suggest that the report somehow connects logically to the figure of 54 hours. Yet nowhere in the report, testimony, or any other source is this X defined. How can an equation like this be solved in the absence of the total hours variable? The fact that it can’t demonstrate that 54 hours is arbitrary--or at least not connected to the report the physical therapists seem keen to connect it to. Additionally, that number would need to be supported by actual data, but it is not. X remains unknown.

Dunning et al propose that, “those with limited knowledge in a domain suffer a dual burden: Not only do they reach mistaken conclusions and make regrettable errors, but their incompetence robs them of the ability to realize it.”¹¹⁶ In fact, “what they don’t know” is the precisely the undefined “X” mentioned on the previous page.

Simply put: the 54 hour recommendation is seemingly arbitrary and unsupported by the report that ostensibly supports it.

In a follow-up to the applicant, the Department of Health requested additional clarification, stating:

¹¹⁵ Caranagno J, et al. Analysis of Competencies for Dry Needling by Physical Therapists. July 10, 2015. https://www.fsbpt.org/Portals/0/documents/freeresources/DryNeedlingFinalReport_20150812.pdf

¹¹⁶ Kruger, J., Dunning, D. Unskilled and Unaware of It: How Difficulties in Recognizing One's Own Incompetence Lead to Inflated Self-Assessments. *Journal of Personality and Social Psychology*. 1999, Vol. 77, No.6. 1121-1134

Q4. *The applicant report lists objectives of available continuing education courses on dry needling, stating that the average length of these courses is 54 hours and satisfies the task force’s recommendations, however:*

The objectives listed for the above do not demonstrate the courses meet the 16 knowledge requirements that require advanced/specialized training for competency in dry needling identified in the HumRRO report (Table 2, page 12);

Please provide more detail to demonstrate that the 16 recommended knowledge requirements are met through the available post-graduate/continuing education training programs

This question was not sufficiently answered in the written follow-up nor was it clearly defined in the oral testimony. The learning objectives of the five courses cited vary considerably, highlighting the lack of standardization in dry needling training, yet there are no safeguards established in determining which, if any, of these individual programs meet the 16 knowledge requirements.

The same could be said for the following question:

Q5. *How much of the specialized training is didactic and how much experiential?*

This was not addressed in oral testimony, and the table used to indicate an answer by the applicant showed a wide variance from 4-40% didactic vs 60-96% experiential, again highlighting the absence of standardization in current dry needling training.

Jan Dommerholt: *“Only about 20% of the 300-hour program [for MDs to practice medical acupuncture] is within the scope of physical therapy practice and where it pertains to musculoskeletal and chronic pain conditions. The rest of the physician training of acupuncturists and I think that most acupuncture training in general does not apply to the scope of physical therapy and therefore it didn’t seem so relevant.”*

JJ Thomas: *“...the calls by our opponents for 300 plus hours are just simply unfounded.”*

WEAMA: Both witnesses turn the argument on its head. The rules for Sunrise call for the applicant to bear the burden of proof to show 54 hours is sufficient for technical competence and safety. They do not.

Three hundred hours is an arbitrary amount of training that is pulled from the number of hours required for fully licensed medical doctors to practice acupuncture. In addition to the fact that many MDs routinely use needles in their practice, they have gone through extensive training and residencies in the use of needles and other minor and major surgical procedures, as opposed to PTs, who have not. Thus the training floor should be considerably higher. Nowhere in the application, oral, or published written testimony is it shown that the 54 hours of training—offered by a wide variety of programs that vary widely in their curriculum—is justified. See *Section 2—Training* above.

Dan Anton: *“I am here to talk to you about entry level Doctor of Physical Therapy Education and how it pertains to dry needling.”*

WEAMA: Most of the education referenced throughout the application and oral testimony refers to entry level Doctor of Physical Therapy Education, however, dry needling courses are not restricted to DPTs; any physical therapist may attend.

Dan Anton: *“It’s during the first year that students begin to learn important concepts regardless of dry needling joint mobilization or physical examination techniques are conducted. Specific to dry needling, students learn the anatomy of the vascular system to avoid puncturing major blood vessels or otherwise impeding their flow. Students also learn and dissect all internal organs. For example, they learn the depth of the kidneys and lungs to avoid puncturing these organs with needles.”*

WEAMA: If dry needling is an advanced procedure available only to physical therapists who have been practicing for more than one year, it is hard to imagine they are learning anatomy specific to safe needle insertion in the first year. We could not find a reference to such first-year training.

Dan Anton: *“We do not consider dry needling an entry level technique similar to electrodiagnostic testing (EDX) such as Fine Wire Electromyography. In Washington, graduates who wish to practice electrodiagnostic testing must complete the requisite continuing medical education and apply for an endorsement to their license.”*

According to the Washington Administrative Code (WAC) 246-915-370¹¹⁷:

¹¹⁷ Washington Administrative Code 246-915-370. Physical Therapists and Physical Therapist Assistants. Electroneuromyographic examinations education and training.

Electroneuromyographic examinations education and training.

A physical therapist may perform electroneuromyographic (EMG) examinations, which may include needle EMG and nerve conduction studies, to test neuromuscular function only if the physical therapist has received a referral from an authorized health care practitioner identified in RCW **18.74.010**(7) and only upon demonstrating education and training in EMG examinations. The board will accept the following as evidence of education and training:

- (1) A minimum of **four hundred hours of instruction** in electroneuromyographic examinations including at least **two hundred needle EMG studies under direct supervision from a qualified provider**.

WEAMA: By contrast, the scope expansion to include—*for the first time*—an advanced, surgical, incisive therapeutic procedure, says only 54 hours and zero supervised studies/patient encounters are required. Additionally, in EMG testing (a diagnostic test, not therapeutic procedure) the needle is inserted to a depth and left at that depth for the duration of the test. In dry needling acupuncture, not only is the needle manipulated vigorously, sometimes traveling inches per thrust, it is one of the more aggressive forms of acupuncture, requiring deft skill and sensitivity. This level of proficiency is not attainable in 54 hours total training.

Dan Anton: *“I can comment about the spinal manipulation endorsement. So spinal manipulation endorsement, students learn that technique in physical therapy school. Then, they have a year of their internships where they practice that and we have students going to internships all the time where they are using the techniques as well as dry needling. They are actually using the techniques in Montana, Utah, Oregon pretty much all of the areas surrounding Washington. As far as training after if the person wants to practice in Washington, then they have to get an endorsement. So they work under someone who has an endorsement already or can sign off on their hours at a clinical specialist and that person works with the new graduate for a certain amount of time to cover their hours and then they can apply for the endorsement post-grad. Does that answer your question?”*

WEAMA: Anton states that spinal manipulation is a technique that students learn in physical therapy school, yet in order to receive an endorsement to practice this technique in Washington state, a physical therapist must meet requirements of 800 hundred additional hours of training, as specified in WAC 246-915-380:

(1) A physical therapist may perform spinal manipulation only after being issued a spinal manipulation endorsement by the secretary. The secretary, upon approval by the board, shall issue an endorsement to a physical therapist who has at least one year of full-time, orthopedic, postgraduate practice experience that consists of direct patient care, averaging at least thirty-six hours a week, and who provides evidence in a manner acceptable to the board of all of the following additional requirements:

(a) Training in differential diagnosis of no less than one hundred hours outlined within a course curriculum;

(b) Didactic and practical training related to the delivery of spinal manipulative procedures of no less than two hundred fifty hours clearly delineated and outlined in a course curriculum;

(c) Specific training in spinal diagnostic imaging of no less than one hundred fifty hours outlined in a course curriculum; and

(d) At least three hundred hours of supervised clinical practical experience in spinal manipulative procedures.

(i) Be supervised by a clinical supervisor who:

(A) Holds a spinal manipulation endorsement under this section; or

(B) Is a licensed chiropractor or osteopathic physician and surgeon;

(ii) Be under the close supervision of the clinical supervisor for a minimum of the first one hundred fifty hours of the supervised clinical practical experience, after which the supervised clinical practical experience must be under the direct supervision of the clinical supervisor.

(iii) Be completed within eighteen months of completing the educational requirements in (a) through (c) of this subsection, unless the physical therapist has completed the educational requirements in (a) through (c) of this subsection prior to July 1, 2015, in which case the supervised clinical practical experience must be completed by January 1, 2017.

(2) A physical therapist holding a spinal manipulation endorsement under subsection (1) of this section shall consult with a health care practitioner, other than a physical therapist, authorized to perform spinal manipulation if spinal manipulative procedures are required beyond six treatments.

WEAMA: The hours of training and supervision required total 800 hours. And that is *with* prior doctoral program education, as Anton indicated is the case. By contrast, this scope expansion proposal declares 54 hours of training to be sufficient for a physical therapist to learn an entirely new invasive procedure. Physical therapy scope expansion with so little training is unprecedented.

The recent resolution by the American Medical Association plainly states that standards need to be set and that currently, there simply are none. The FSBPT lacks the specificity required to create these standards, and the applicants do not explain how every dry needling certification program meets these criteria and, if any fail to meet certain ambiguous criteria, how they will be excluded from the list of approved programs.

DOH: *How many hours was your certification course that you went through for the military and did it include a clinical internship?*

John Schroeder: *Sort of. There was a home study that was about 3 - 4 hours. The certification course was 27 hours for 3 days. When I returned back to base of JBLM, the department that I work out of, it is dedicated just to the Green Berets. However it is under the credentialing wing of Madigan Army Medical Center. So I was required to be observed, supervised by another credentialed provider. That took probably 3 months or so. That's called (FPPE) Focused Provider Proficiency Evaluation. But after I went through that then Madigan agreed to credential myself to be a practitioner of that technique.*

WEAMA: While it was established during the course of testimony that within the military, dry needling is allowed after certification via a civilian dry needling program plus some number or hours of supervised patient encounters, that figure was never revealed. Bear in mind that a "military physician does not have to be concerned with medical malpractice insurance, and is at no immediate personal risk for liability judgments in malpractice cases,"¹¹⁸ so is not necessarily a comparable measure for safety because dry needling in the military requires clinical supervision, nor cost-effectiveness, as the cost to the military in terms of expense to the patient or the cost of malpractice litigation is non-existent.

V. Cost-Effectiveness

As discussed previously, it is incumbent upon the applicant to demonstrate the cost-effectiveness of a proposed expansion of scope as one of the three primary criteria it must fulfill. The applicant must demonstrate that the proposal will provide the most cost-effective option to protect the public. Yet, the application has no data on this point and therefore fails entirely to meet this fundamental requirement.

¹¹⁸ <https://www.acep.org/clinical---practice-management/understanding-medical-liability-in-military-medicine/>

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
2050 Worth Road
Fort Sam Houston, Texas 78234-6000

MEDCOM Regulation
No. 40-60

4 June 2012

Medical Services
PHYSICAL THERAPISTS AND THE PERFORMANCE OF DRY NEEDLING

Supplementation of this regulation and establishment of forms other than U.S. Army Medical Command (MEDCOM) forms are prohibited without prior approval from Headquarters, MEDCOM, ATTN: MCHO-CL-C.

- 1. History.** This issue publishes a new regulation.
- 2. Purpose.** This regulation provides policy guidance to physical therapists (PTs) preparing to request dry needling clinical privileges. It provides further guidance to military treatment facility (MTF) commanders, credentials coordinators, physical therapy clinic chiefs or supervisors, and designated preceptors regarding the training requirements and oversight of PTs not yet fully privileged to perform dry needling.
- 3. References.** References are listed in appendix A.
- 4. Explanation of abbreviations and terms.** Abbreviations and terms are explained in the glossary.
- 5. Applicability.** This regulation applies to PTs in MEDCOM facilities who are requesting regular privileges to perform dry needling procedures, and those personnel precepting PTs who are performing dry needling.
- 6. Responsibilities**
 - a.* MTF commanders will establish the mission for physical therapy management of pain conditions and neuromuscular injuries utilizing the most current techniques to include dry needling.
 - b.* Physical therapy clinic chiefs will designate qualified preceptors to oversee the PT until fully privileged to perform dry needling.

c. Physical therapy preceptors will be a provider privileged to perform dry needling and capable of conducting the enhanced supervision of the clinician's performance and validating clinical proficiency. *Note:* Enhanced supervision is referred to as "focused professional performance evaluation" in The Joint Commission current standards.

d. In accordance with AR 40-68, chapter 9, the MTF credentials committee will conduct the appropriate credentials review and recommend to the MTF commander approval or disapproval of the requested regular dry needling privileges.

7. Background

a. The American Academy of Orthopaedic Manual Physical Therapy (AAOMPT) supports the use of dry needling as a treatment tool within the scope of physical therapy practice (<https://www.aaompt.org/about/statements.cfm>). From the AAOMPT position statement: "Dry needling is a neurophysiological evidence-based treatment technique that requires effective manual assessment of the neuromuscular system. Physical therapists are well trained to utilize dry needling in conjunction with manual physical therapy interventions. Research supports that dry needling improves pain control, reduces muscle tension, normalizes biochemical and electrical dysfunction of motor endplates, and facilitates an accelerated return to active rehabilitation."

b. The American Physical Therapy Association (APTA) considers dry needling within the scope of practice for PTs and will include this technique in the next revision of the APTA's *Guide to Physical Therapy Practice*.

c. The U.S. Army Medical Department position is to allow the performance of dry needling by qualified healthcare providers, particularly by PTs.

8. Policy

a. Only those PTs who meet the following training, experience, and supervisory criteria will be granted regular privileges to perform dry needling:

(1) Training requirement.

(a) Completion of formal clinical and practical dry needling training provided as part of an entry-level or post-graduate professional physical therapy education program. The academic training program course catalogue or curriculum will be provided as proof of dry needling content; or,

(b) Completion of a State-approved certificate producing continuing medical education program; or,

(c) Completion of an alternative training program approved by the Physical Therapy Consultant to The Surgeon General. PTs must receive prior approval from the Consultant before engaging in an alternate training program.

(d) At such time that the APTA mandates additional or alternate training requirements, Department of Defense PTs will be required to adhere to those guidelines.

(2) Clinical experience and supervision.

(a) Experience consistent with achieving Category I physical therapy privileges as set forth in AR 40-68, paragraph 7-17.

(b) The enhanced supervision (referenced in para 6c) will be in accordance with AR 40-68, paragraph 9-4e. The requirement for supervision will be annotated by the privileging authority on DA Form 5440A (Approval of Clinical Privileges/Staff Appointment), item 6e.

(c) A written plan for supervision developed by the Chief, Physical Therapy (comparable title) will be maintained in the PT's provider activity file with copy provided to the PT and the designated preceptor.

(d) A qualified provider privileged to perform dry needling within the regional medical command (RMC) or area of operations (AO), if in theater, will serve as preceptor. If such a preceptor is not available within the RMC or AO, the therapist will coordinate with a qualified preceptor from another RMC or AO. The preceptor will provide oversight in the form of direct and/or indirect supervision, as deemed appropriate, based on the individual needs of the PT under supervision. The supervisory requirements will be specified in the written plan for supervision.

(e) The designated preceptor will perform a formal review of the 25 separate dry needling patient cases (multiple encounters with the same patient will be counted as one patient case) managed by the PT to assess the therapist's clinical reasoning and application of dry needling principles and techniques. *Note:* During the period that the PT is completing these 25 cases, he/she is granted dry needling privileges *with supervision*. Privileges *with supervision* is termed enhanced supervision. (See AR 40-68, para 9-4e, for guidance on enhanced supervision.)

(f) Upon completion of the 25 supervised cases, the preceptor will confirm the student has demonstrated proficiency in performing dry needling and no longer requires enhanced supervision. The therapist's competency to safely and effectively perform dry needling will be addressed by the preceptor in a memorandum to the credentials committee.

(g) The provider is then eligible to request regular privileges to perform dry needling.

b. A PT requesting regular dry needling privileges will—

(1) Complete the request for privileges using DA Form 5440-21 (Delineation of Clinical Privileges-Physical Therapy) or by following appropriate prompts in the electronic Centralized Credentials Quality Assurance System.

(2) Present the following documentation to the credentials committee:

(a) Summary of professional education and evidence of completion of training.

(b) Formal memorandum by the preceptor confirming proficiency of the candidate.

c. DA Form 5441-21 (Evaluation of Clinical Privileges-Physical Therapy) and DA Form 5374 (Performance Assessment) will be used to evaluate and document the PT provider's dry needling competence and skill in accordance with AR 40-68.

Appendix A References

Section I Required Publications

This section contains no entries.

Section II Related Publications

AR 40-68

Clinical Quality Management

Section III Prescribed Forms

This section contains no entries.

Section IV Referenced Forms

DA Form 5374

Performance Assessment

DA Form 5440A

Approval of Clinical Privileges/Staff Appointment

DA Form 5440-21

Delineation of Clinical Privileges-Physical Therapy

DA Form 5441-21

Evaluation of Clinical Privileges-Physical Therapy

Glossary

Section I Abbreviations

AAOMPT

American Academy of Orthopaedic Manual Physical Therapy

AO

area of operation

APTA

American Physical Therapy Association

MEDCOM

United States Army Medical Command

MTF

military treatment facility

PT

physical therapist

RMC

regional medical command

Section II Terms

Dry needling (or intramuscular manual therapy)

An invasive procedure in which a solid filament needle is inserted into the skin and muscle, directly at a myofascial trigger point to diagnose and treat neuromuscular pain and functional movement impairments. Myofascial trigger points consist of palpable hypersensitive taut bands, nodules, or knots within myofascial tissue that are related to the production and maintenance of the pain cycle. Dry needling is based upon Western medical concepts and includes a neuromusculoskeletal examination, assessment, identification of a neuroanatomical basis for needle site selection, and neurophysiologic rationale for treatment effects. Dry needling does not rely on traditional Chinese or Eastern medicine theories, the stimulation of auricular or meridian-based acupuncture points and terminology, or the restoration of energy flow within the body. At no time does dry needling include the use or injection of any medication or substance into the body.

Supervision

The process of reviewing, monitoring, observing, and accepting responsibility for assigned personnel. The three types of supervision are—

Indirect. The supervisor performs retrospective review of selected records. Criteria used for review relate to quality of care, quality of documentation, and the authorized scope of privileges/practice of the individual in question. Reviews may also include countersignature or authentication of medical entries, reports, or orders prescribed by another.

Direct. The supervisor is involved in the decision-making process. This may be further subdivided as follows: (1) *Verbal*—the supervisor is contacted by telephone or informal consultation before implementing or changing a regimen of care; and (2) *Physically present*—the supervisor is present physically through all or a portion of care.

The proponent of this publication is the Office of the Assistant Chief of Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-C, 2748 Worth Road, Fort Sam Houston, Texas 78234-6000.

FOR THE COMMANDER:



HERBERT A. COLEY
Chief of Staff

GARY A. WHEELER
Colonel, MS
Assistant Chief of Staff for
Information Management

DISTRIBUTION:

This publication is available in electronic media only. Copies can be obtained from Army Knowledge Online (AKO).

SPECIAL DISTRIBUTION:

MCIM (Editor) (2 cy)
MCIT-ISM-O (Forms Mgr) (1 cy)



DEPARTMENT OF THE NAVY

BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-7300

IN REPLY REFER TO

6000
27 Jan 09

MEMORANDUM FOR COMMANDER, NAVY MEDICINE EAST
COMMANDER, NAVY MEDICINE WEST
COMMANDER, NAVY MEDICINE NATIONAL CAPITAL AREA
COMMANDER, NAVY MEDICINE SUPPORT COMMAND
COMMAND SURGEON, FLEET FORCES COMMAND
THE MEDICAL OFFICER OF THE MARINE CORPS

SUBJECT: Policy on Focused Professional Practice Evaluation (FPPE); and Ongoing Professional Practice Evaluation (OPPE)

Ref: (a) The Joint Commission Accreditation Manual for Hospitals (current edition)
(b) BUMEDINST 6320.66E, Credentials Review and Privileging Program
(c) BUMEDINST 6010.17B, Navy Medical Staff Bylaws

Encl: (1) FPPE Overview
(2) FPPE Template Letter
(3) OPPE Template Form, documenting six (6) core competencies

The purpose of this memorandum is to establish a system to evaluate and document the professional current competency of all practitioners in order to assure the highest quality of patient care is provided by the organization. The Joint Commission (TJC) per reference (a) requires all practitioners upon arrival at their current duty assignment to have an initial competency assessment via a Focused Professional Practice Evaluation (FPPE). The length and level of the focused review takes into account the education, training, board certification and years of professional practice experience as a Licensed Independent Practitioner (LIP). Privileges are still granted if LIP is eligible, but the initial performance at the command will be monitored. Enclosure (1) provides a more detailed overview of the FPPE process. Enclosure (2) is included as a potential template for use at the discretion of the individual Privileging Authority (PA).

TJC further requires competency assessment be an ongoing process that promotes performance improvement activities, new developments in health care management, science and technology, and ultimately enhances the delivery of patient care. This competency is documented via enclosure (3). Ongoing Professional Practice Evaluation (OPPE) monitoring requires the collection and review of performance improvement (PI)/quality management (QM) patient care outcomes/indicators for all practitioners. OPPE information is used to prepare the individual Performance Appraisal Report (PAR) which in turn is used by the PA to grant staff appointments and clinical privileges. This requirement also applies to deployed providers; however PAs will use their best judgment in determining when to use an FPPE or OPPE.

As there is a single credentialing standard that all Navy Medical Department providers must meet, this applies to Active and Reserve Component military and all civilian health care practitioners, as defined by reference (b), who are assigned to, employed by, contracted to,

NAVMED POLICY 09-002

SUBJECT: Policy on Focused Professional Practice Evaluation (FPPE); and Ongoing Professional Practice Evaluation (OPPE)

volunteer at, or are under partnership agreement with a military treatment facility. It also applies to all providers assigned to the Fleet Marine Forces and Fleet Forces Command.

In order to comply with the requirements of reference (a), all PAs are directed, if they have not already done so, to initiate FPPEs on all practitioners upon arrival at a new command. Further, all PAs are directed to establish in writing the monthly intervals at which they will perform the OPPE (minimum of every nine months). PAs will work with Regional Commanders (RCs), the Medical Officer of the Marine Corps (TMO) and Command Surgeon Fleet Forces Command (CUSFFC) as appropriate, to ensure appropriate competency and oversight of FPPE/OPPE where sole practitioner or practitioners with limited professional practice experience as LIPs are assigned. Used appropriately, the OPPE will ensure that practitioners are fully evaluated prior to transfer to operational billets or as sole practitioners.

This policy is effective the date of this letter and remains in effect until incorporated as a change into reference (b) and (c). My points of contact for this matter are Ms. Carmen C. Birk at (202) 762-3081 or Carmen.Birk@med.navy.mil or CAPT Joseph McBreen at (202) 762-3014 or Joseph.McBreen@med.navy.mil.



A. M. ROBINSON, JR.

Focused Professional Practice Evaluation (FPPE) Policy OVERVIEW

Purpose:

Focused Professional Practice Evaluation (FPPE) provides each Privileging Authority (PA) an opportunity to evaluate the privilege specific competency of a practitioner who does not have documented evidence of competently performing the requested privilege(s) at the privileging organization. FPPE is time-limited and takes into account the practitioner's education, training, board certification and years of professional practice experience as a Licensed Independent Practitioner (LIP).

Medical Staff Oversight:

The Medical Staff is responsible for this process. The Credentials Committee, or the Executive Committee of the Medical Staff if there is no Credentials Committee, is charged with the responsibility of monitoring compliance with this policy and procedures. It receives regular status reports from each Department Head, or equivalent, related to the progress of all practitioners on the FPPE, or any problems.

Scope of Monitoring Program:

a) FPPE will occur under the following circumstances:

- When the practitioner has not previously demonstrated clinical competency at the privileging organization.
- When requesting new/additional privilege(s) where the practitioner does not have documented evidence of competently performing the requested privilege at the privileging organization.
- Whenever a question/concern arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care

b) FPPE Focus: Ensure there is sufficient information available to confirm the current competence of practitioners requesting privileges at the privileging organization.

Duration of Monitoring Period:

- Each department within the privileging organization shall define the appropriate monitoring method, number of cases, and duration of proctoring period, to determine what constitutes a practitioner's current competency.
- Monitoring may be performed using prospective, concurrent, or retrospective approaches, as determined to be the most appropriate given the practitioner's education, training, board certification and years of professional practice experience as a Licensed Independent Practitioner (LIP).
- The Department Head, or his/her designee, will determine changes to improve performance based on results of FPPEs, including proctoring, and implementation of practitioner-specific performance improvement plans, as appropriate, for practitioners who complete the FPPE.
- At a minimum, a retrospective review of five cases over the first six months will be the standard for practitioners requesting privileges which they have never previously been granted.
- The monitoring period may be extended if initial concerns are raised that require further evaluation or there is insufficient activity during the initial period.

Responsibilities of Monitors:

- The monitor's role is that of an evaluator, to review and observe cases, not of a supervisor or consultant.
- Monitors must be members in good standing of the medical staff and must have unrestricted privileges to perform any procedure(s) to be concurrently monitored.

Enclosure 1

- Monitors will monitor those portions of the medical care rendered by the practitioner that are sufficient to be able to judge the quality of care provided in relationship to the privilege(s) requested.
- In addition to specialty and privilege specific issues, monitoring also will address the general competencies.

Providers full name, Rank/Title and last 4 of SSN

DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
(Name, Address of command)

6320
(Date)

From: (Department Head; Command Name)
To: (Practitioner full name rank/suffix)
Via: (1) (Monitor if different from Department Head)
(2) (Per your command's chain of command)

Subj: FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Ref: (a) BUMEDINST 6320.66E
(b) BUMED POLICY LETTER (*****)

Encl: (1) Specialty Privilege List for (specify, e.g. General Surgery)
(2) Log Record for FPPE (not required, optional)

1. Per references (a) and (b) (please choose one of the following)
 - a. ___ First Navy Medical Staff appointment with clinical privileges
 - b. ___ Recent training program graduate from a Navy/civilian training facility
 - c. ___ Reporting from another Navy facility where you previously held the same privileges being requested.
 - d. ___ Requesting a new privilege for the first time; therefore, not possessing sufficient documented evidence of current competency.
 - e. ___ Previous FPIPE or OFPE has indicated a practice problem that requires additional monitoring. Specify problem: _____

2. The duration of this FPPE lasts until there is sufficient documented evidence of current competency. During the FPPE your current competency will be evaluated by your Monitor who is designated in writing as well as your Department Head or next level supervisor. You will be notified by your Department Head/next level supervisor at the completion of this FPPE

a. Primary Monitor: (enter name and position/title)

3. Monitoring and evaluation of your performance may include (please select one or more of the following criteria to determine the appropriate type of monitoring):

- a. ___ Direct observation
- b. ___ Periodic chart review
- c. ___ Monitoring of diagnostic and treatment techniques
- d. ___ Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing, and administrative personnel.

NOTE: Items in this template that are *Italicized and in (parenthesis)* are examples or suggestions you can use to complete the letter if you so choose.

Enclosure 2

Providers full name, Rank/Title and last 4 of SSN

4. Your monitor will review the following data to evaluate your care: Personal interactions with you; detailed medical record reviews; interviews with your team members or other staff; surveys of patients or staff interacting with you; and/or chart audits by non-medical personnel based on medical staff-defined criteria for initial appointees.

5. Your privileges are in (specify, e.g. General Surgeon); therefore, the methods used to evaluate your care are the following (methods must be appropriate to type of provider, provider's previously documented competency and in accordance with facility specific limitations): (Example below (a) through (e) is for General Surgery

a. All high risk procedures (as determined by facility) will be directly observed at least once.

b. Difficult surgical/procedural cases on ASA 4/5 will be discussed prior to actual surgical case. You will discuss your surgical approach, post-op care, and treatment plan.

c. For the first week, a 90% review of all surgical and outpatient cases will be reviewed. After the first week, the cases reviewed will decrease 50% each week if no concerns are noted, with the emphasis being on the high risk, or difficult case/patient procedures.

d. All adverse events requiring an Incident Report will be immediately discussed.

e. Every Friday at 1500, a conference is scheduled with the proctor to discuss the week's surgical and/or outpatient events.

6. If a specific problem or other deficiency is noted during this FPPE, but you are considered to be currently competent on all other factors, you will be placed under another Focused Professional Performance Evaluation (FPPE) for that specific problem, or deficiency until it is resolved.

7. The requirement for you to practice under this FPPE is not and should not be construed, as adverse in nature.

Department Head Name (Print or type) : _____

Signature: _____ Date: _____

Monitor (if different from Department head) Name: (Print or type): _____

Signature: _____ Date: _____

Individual Practitioner's Name (Print or type): _____

Signature: _____ Date: _____

NOTE: Items in this template that are *Italicized and in (parenthesis)* are examples or suggestions you can use to complete the letter if you so choose.

Enclosure 2

Providers full name, Rank/Title and last 4 of SSN

Copy to:
Practitioner
Department Head
Monitor (if different from Department Head)
Chair: Credentials Committee (If none)
ECOMS Chair

NOTE: Items in this template that are *Italicized and in (parenthesis)* are examples or suggestions you can use to complete the letter if you so choose.

Enclosure 2

ONGOING PROFESSIONAL PERFORMANCE EVALUATION

Evidenced Based Criteria

COMMAND NAME:

Date:

Practitioner's Name:

Privileges Granted:

Elements of Measurement and Suggested Evaluation Criteria

Patient Care: Compassion, appropriate and effective for the promotion of health, prevention of illness, end of life treatment as evidenced by:

1. Provide effective patient care that consistently meets or exceeds the operational setting standards of care as defined by comparative outcome data, medical literature and results of peer review activities.
2. Plan and provide appropriate, e.g., do the right thing, patient management based on patient information, patient preferences, current indications, available scientific evidence and sound clinical judgment.
3. Assure each patient is evaluated by a licensed independent practitioner as defined in the bylaws, rules and regulations and document findings in the medical record at that time.
4. Demonstrate caring and respectful behaviors when interacting with patients and their families.
5. Provide for patient comfort by managing acute and chronic patient according to medically appropriate standards.
6. Counsel and educate patients and their families.
7. Cooperate with hospital efforts to implement methods to systematically enhance disease prevention.
8. If applicable, supervise residents, students, Independent Duty Corpsmen (IDC), Certified Athletic Trainers (ATC), etc., to assure patients receive the highest quality of care.

Met: _____ **Not Met:** _____ **Not Observed:** _____ **Comments:**

Medical Clinical Knowledge: Demonstrates knowledge of established and evolving biomedical, clinical and social sciences, and application of knowledge to patient care as evidenced by:

1. Use evidence-based guidelines when available, consistent with DoD policy and Service guidelines, to include as recommended by the appropriate specialty, in selecting the most effective and appropriate diagnosis and treatment
2. Maintain ongoing medical education and board certification as appropriate for each specialty.
3. Demonstrate appropriate technical skills and medical knowledge by the use of appropriate and available methods

Met: _____ **Not Met:** _____ **Not Observed:** _____ **Comments:**

Interpersonal and Communication Skills: Demonstrates interpersonal and communication skills enabling establishment and maintenance of professional relationships with patients, families, and other members of health care teams as evidenced by:

1. Communicate effectively with health care providers, patients and families to ensure accurate transfer of information through appropriate oral, written, and electronic methods according to command and Service policies.
2. Request consultations by providing adequate communication with the consultant including a clear reason for consultation and direct provider to provider contact for urgent or emergent requests.
3. Maintain medical records, written or contained with hospital electronic systems, consistent with the medical staff bylaws, rules, regulations and policies.
4. Work effectively with others as a member or leader of a health care team as defined by comparative data methods.
5. Maintain patient satisfaction with provider care.

Met: _____ **Not Met:** _____ **Not Observed:** _____ **Comments:**

Professionalism: Demonstrates behaviors reflecting a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity and sexual orientation, and a responsible attitude to patients, profession, and society as evidenced by:

1. Act in a professional, respectful manner at all times and adhere to the Medical Staff Code of Conduct.
2. Respond promptly to requests for patient care needs.
3. Address inter-professional disagreements in a constructive, respectful manner away from patients and non-involved caregivers.
4. Participate in emergency call as required by the bylaws, rules and regulations.
5. Follow ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and discussion of unanticipated adverse outcomes.
6. Utilize sensitivity and responsiveness to culture, age, race, gender, mental/physical abilities, sexual orientation for patients and staff.

Enclosure 3

ONGOING PROFESSIONAL PERFORMANCE EVALUATION

Evidenced Based Criteria

COMMAND NAME:

Date:

Practitioner's Name:

Privileges Granted:

Elements of Measurement	
<p>Practice-Based Learning and Improvement: Demonstrates ability to use scientific evidence and methods to investigate, evaluate, and improve patient care practices as evidenced by:</p> <ol style="list-style-type: none"> 1. Regularly review your individual and specialty data for all general competencies and use the data for self improvement of patient care. 2. Respond in the spirit of continuous improvement when contacted regarding concerns about patient care. 3. Use available information and access medical information appropriate to operational setting. <p>Facilitate the learning of colleagues, students, trainees, and other health care professionals</p>	
<p>Met: _____ Not Met: _____ Not Observed: _____ Comments: _____</p>	
<p>Systems-Based Practice: Demonstrates an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize care as evidenced by:</p> <ol style="list-style-type: none"> 1. Comply with hospital efforts and policies to maintain a patient safety culture, reduce medical errors, meet national patient safety goals and improve quality. 2. Ensure timely and continuous care of patients by clear identification of covering providers and by availability through appropriate and timely electronic communication system. 3. Provide quality patient care that is cost effective by cooperating with efforts to appropriately manage the use of valuable patient care resources. 4. Advocate for quality patient care and assist patients in dealing with system complexity. 5. Actively participate in medical staff activities when requested to participate in these activities to promote improvement of overall patient care outcomes. 	
<p>Met: _____ Not Met: _____ Not Observed: _____ Comments: _____</p>	

1. Comment on any areas of concern _____

2. Please include additional comments of the applicant's medical knowledge, competence, demonstrated skill, or abilities enabling the Medical Staff in evaluating the practitioner. _____

Evaluator's Signature/Date: _____ **Title** _____

Print Evaluator's Name _____ **Telephone:** _____

Provider's Signature/Date: _____ **Title** _____

Print Provider's Name _____ **Telephone:** _____



DEPARTMENT OF THE AIR FORCE
AIR FORCE ELEMENT DOD MEDICAL SUPPORT (ELM)
ANDREWS AIR FORCE BASE, MD

MEMORANDUM FOR MTF/SGH

18 Jun 13

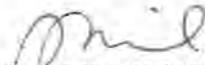
FROM: Lt Col Shari Silverman, Acting Associate Corps Chief BSC for Physical Therapy

SUBJECT: Physical Therapist Dry Needling Supplemental Privileging Process

1. Trigger Point Dry Needling (TDN) is a supplemental privilege for Physical Therapists (PT) practicing in USAF medical treatment facilities. Due to the invasive nature of this procedure, only those PTs who meet the following training, experience, and supervisory criteria will be granted regular privileges to perform TDN.
 - a. Training Requirement
 - i. Completion of a formal clinical and practical TDN training program as part of an entry-level or post-graduate professional physical therapy education program. The academic training program course catalogue or curriculum will be provided as proof of needling content; or,
 - ii. Completion of a State-approved continuing medical education program; or,
 - iii. Completion of an alternative training program approved by the USAF PT Consultant to the Surgeon General. PTs must receive prior approval from the consultant before engaging in an alternate training program. TDN content in the U.S. Air Force Advanced Physical Therapy "OZO" and the U.S. Army Advanced Clinical Operations Course "ACOP" are considered pre-approved. Additionally, TDN courses taught to USAF PTs by USAF PTs under the SME CME program are considered pre-approved.
 - iv. At such time that the American PT Association mandates additional or alternate training requirements, USAF PTs will be required to adhere to these guidelines.
 - b. Clinical experience and supervision
 - i. Scope of practice for PTs is outlined in AFI 44-119, para 7.15.3.
 - ii. A PT who has completed a training course for TDN as described in para 1.a. is required to complete 25 peer-reviewed cases before being awarded TDN supplemental privileges.
 - (1) Upon completion of the appropriate course in para 1.a. of this memorandum, the PT will submit a request for upgraded credentials to their credentials manager. This request will be for "Supervised" privileges and will include the statement that 25 peer-reviewed cases are required before awarding of full privileges.
 - (2) The PT will recommend to the Credentials Function a TDN-qualified PT to serve as preceptor for the 25 peer-reviewed cases. If such a preceptor is not available at the same MTF, the therapist will coordinate with another preceptor at another MTF for indirect supervision through electronic peer-review and case discussion. A Supervision Plan which outlines the requirements and completion status is available on the AFMS Kx Physical Therapy site (atch 1). TDN peer review will utilize the focused review form (atch 2) available on the AFMS Kx Physical Therapy site.
 - (3) Once the request for peer-reviewed performance has been approved by the Credentials Function, the therapist will be granted TDN privileges with

supervision. The PT will then perform at least 25 separate dry-needling cases (multiple encounters for the same patient will only count as one patient case), all requiring peer-review by the preceptor.

- (a) A therapist may require more than 25 cases to develop adequate competence. Therefore, the 25 cases are solely the minimal amount for supervision.
 - (b) The therapist may only treat muscles on which they were trained during their approved course.
 - (c) As the therapist is granted credentials with supervision, care must be made when the preceptor is at a facility separate from the therapist seeking supervision. In this case, the SGH may recommend a time window (i.e. 4-6 mos) to ensure the transition from supervised to full privileges while reducing the liability of prolonged privileges with supervision at geographically separate facilities.
 - (4) Upon safe and appropriate completion of 25 patient cases, the preceptor will document such attainment as an indorsement on the Supervision Plan and return to the facility SGH.
 - (5) Once the SGH has received the indorsed Supervisory Plan, the PT may apply for full TDN clinical privileges.
 - (6) A therapist who has been through this process will not have to repeat this process if they take subsequent approved courses to expand their scope of TDN practice.
2. Those therapists who are currently credentialed for TDN as of the date of this memorandum will be allowed to continue full application of their current TDN privileges.
 3. My POC for this is process is Lt Col Brian Young, 210-808-9451 or brian.a.young16.mil@mail.mil.



SHARI F. SILVERMAN, Lt Col, USAF, BSC
Acting Associate Corps Chief BSC for Physical Therapy
Physical Therapy Consultant to AF/SG

2 Attachments:

1. Peer Review Form USAF Physical Therapy Trigger Point Dry Needling, ver Jun 13
2. AF Physical Therapy Trigger Point Dry Needling Supervision Plan Template, 17 Jun 13

July 24, 2016

To Whom It May Concern:

I have had chronic back/neck issues for almost 15 years. I have tried many therapies including Pilates, various providers/types of physical therapy, personal training, orthopedists, Feldenkrais, massage, Rolfing, acupuncture, and more. They are all different. They can all be helpful. Personally for me, a varying regimen of dry needling, physical therapy, Feldenkrais, and massage have much improved my situation. I see value in all the therapies depending on personal needs and the capabilities of the provider. There are many talented providers bringing relief to different people with different needs.

In this context, the “debate” on dry needling seems strange and artificial. It is clearly not acupuncture. It has brought me (and others) enormous benefit. Saying that it is equivalent to acupuncture is like saying a composer using a pencil to write a symphony is the same as an architect using a pencil to draft a house. Yes, they both use pencils. But no, they are doing very different things. I do not view my employment of dry needling therapy as mutually exclusive or substitutable for acupuncture.

It should of course be regulated and performed safely by well-trained and certified providers, but denying the people of Washington access to this therapy doesn't serve anyone's interest.

Sincerely,

Brian Schultz
Seattle, WA

The DN Project - Keep dry needling within the scope of physical therapist practice

About this petition

Dry Needling or Triggerpoint Dry Needling (TDN) is an intramuscular soft tissue technique utilized by physical therapists, chiropractors and physicians within the constructs of a neuromusculoskeletal evaluation, diagnosis and treatment plan. Combining the educational backgrounds and specialized training for DN, this technique is safe and effective for many neuromusculoskeletal diagnoses.

Recent efforts by groups and individuals within the acupuncture community accuse DN professionals to be illegally practicing acupuncture or that the procedure is unsafe to the public. These allegations are not only false, but a disservice to a significant population of patients who have benefitted from DN. They claim to be concerned for the safety of the public or that dry needling is acupuncture. Research and empirical data finds that the risk of adverse events from dry needling are <.04%, which is significantly less than the risk of chronic NSAID use or spinal manipulation. Both of which are deemed safe for the public.

It is also untrue that acupuncture and dry needling performed by PTs are the same. Acupuncture is an Eastern or Oriental medicine technique with evaluation, technique execution, intended response and practitioner education all very different from TDN. Triggerpoint Dry Needling is a treatment modality utilized within the context of a neuromusculoskeletal evaluation and treatment plan by qualified and licensed PTs, chiropractors and physicians. Advanced training is required for TDN, but the educational background of physical therapists allows this intramuscular technique to be performed safely and effectively.

In October 2014, a county court ruling in the State of Washington ruled that Kinetacore (a Colorado-based dry needling education organization) and Salmon Bay Physical Therapy could no longer teach or perform the service of dry-needling as a part of physical therapy care in the State of Washington. If you are a clinician who utilizes DN or an individual who has benefitted from this technique, please help us keep dry needling within the scope of physical therapy practice.

UPDATE - As of June 2016, PTWA has requested a Department of Health Sunrise Review to determine whether dry needling is within the scope of PT practice. This petition will be filed as part of written testimony in SUPPORT of dry needling by physical therapists in WA, but please feel free to submit written testimony directly to sunrise@wa.doh.gov.

By signing this petition, I am stating that I am a member of the public who feels strongly that dry needling should be within the scope of physical therapist practice based on safety and efficacy.

I'd like to share just a sampling of words of wisdom found posted on social media. This sampling demonstrates the responsible, mature view regarding the efforts toward monopolizing the use of a thin, filiform needle to one profession. These are healthcare providers I would be honored to associate with in the battle against pain and suffering!

In my state of Illinois, I believe our association thought they won a victory over dry-needling. Nevertheless, I see a continuing increase in patients who have received DN, including three in just the last week. What I can conclude from this is, 1) the effort to stop dry-needling by PT is ineffectual, 2) receiving DN from a PT does not stop patients from seeking out acupuncture. In the patients mind, acupuncture is something different. Qualitatively, visiting the acupuncturist is a different experience than going for PT. In other words, there are still aspects of healing that people don't get from PT and seek out elsewhere. The paradox of the acupuncture profession is that as much as some of us would like to be part of the mainstream health care system, a large part of our draw is the fact that we are outside of that system. Personally, my own practice has never been busier. Granted, that is just my experience and there is no way to prove DN as a whole is helping or hurting our profession, but my conjecture is that it isn't, and it actually could be used in a positive way to help build it.

I used to use dry needling (as they call it here) on trigger points using protocols developed and taught by Mark Seem.

do you remember him coming to our office for a tutorial? The technique really requires a kind of feel that some practitioners will have, some won't. I kind of ended up specializing in myofascial pain, probably was 50% of my practice, and used this technique a LOT. Breaking up the trigger point patterns can be done any number of ways - ischemic pressure, spray and stretch, needling, etc. What still makes the most difference IMO is the skill of the practitioner in locating and extinguishing the patterns. Mark's techniques also incorporated the 8 Extra Meridians, again something that became a big part of my practice for all my patients. So some PTs will become good at this, most won't, and none will achieve the effects of combining meridian/yin-yang therapy with the TP tx. I wouldn't worry too much about the Texas ruling as long as acupuncturists can clearly explain the difference in what they are doing from what the PTs are doing.

Like · Reply ·  1 · May 11 at 1:47am

I do remember! I noticed that when this issue first became a big deal for LAc's, many of those ranting about it seemed to have little to no knowledge of the technique itself despite insisting they were the most qualified to use it.

I also recall that Mark Seem seemed quite okay with the overlap with PT. He's changed his tune since then.

The folks on the North Carolina Acupuncture Licensing Board are surprised that the judge dismissed their action against dry needling. The president of Daoist Traditions hopes the NCALB appeals. (Isn't she on the the NCALB?) In any case, since the judge indicated there were administrative procedures to go through before returning to court, fingers crossed that the NCALB pays attention to the judges words (and actions). Let's learn from the experience, rather than just vowing to fight.

Supply and demand

Just because you have a supply (a skill, an inventory, a location) that doesn't necessarily mean you are entitled to demand. The market decides what it wants. You can do your best to influence that choice, but it's never (alas)...

Who is protecting the public? Who is protecting their business?

Turf war over eye care erupts in the Legislature -- and on the radio

A decades-old battle inside Alaska's eye care industry has flared up again in Juneau, in a nasty, tongue-twisting turf war between the state's optometrists and...

ADN.COM

This seems appropriate to recent posts about the PT's "intent" regarding dry needling. Yes, I know many LAc's firmly believe that PT's use the term to bypass regulations pertaining to acupuncture. An official looking article stating that belief is not the same as proving it's true.

[« The lottery winners \(a secret of unhappiness\) | Main](#)

Don't argue about belief, argue about arguments

The essence of a belief is that we own it, regardless of what's happening around us. If you can be easily swayed by data, then it's not much of a belief.

On the other hand, the key to making a rational argument is that your assertions must be falsifiable.

"I believe A because of B and C." If someone can show you that "C" isn't actually true, then it's not okay to persist in arguing "A".

The statement, "All swans are white" is falsifiable, because if I can find even one black swan, we're done.

On the other hand, "The martians are about to take over our city with 2,000 flying saucers," is not, because there's nothing I can do or demonstrate that would satisfy the person who might respond, "well, they're just very well hidden, and they're waiting us out."

If belief in "A" is important to someone's story, people usually pile up a large number of arguments that are either not testable, or matters of opinion and taste. There's nothing wrong with believing "A", but it's counterproductive to engage with someone in a discussion about whether you're right or not. It's a belief, or an opinion, both of which are fine things to have, but it's not a logical conclusion or a coherent argument, because those require asserting something we can actually test.

The key question is, "is there something I can prove or demonstrate that would make you stop believing in 'A'?" If the honest answer is 'no', then we're not having an argument, are we?

Before we waste a lot of time arguing about something that appears to be a rational, logical conclusion, let's be sure we are both having the same sort of discussion.

Posted by [Seth Godin](#) on August 16, 2016

 Tweet  G+1  18  Like 632

I hope some of these clips will highlight the ability for healthcare providers to come together to help patients, instead of using our valuable energy, money, time on arguing who's stealing who's treatment tool. Not all EAMPs/Acupuncturists are against the idea of PTs performing Dry Needling. The below excerpt is written from a highly experienced acupuncturist - who "gets it" - its about the patient, not ourselves.

We say the PT's:

- are stealing our medicine! (But we don't own it.)
- are illegally expanding their scope. (The majority of states have ruled it is in the PT scope. Modifications to scope are common in health care.)
- are using Regulation to do what should be done Legislatively. (Scope clarification is often done via Regulation, which gives the public and other professionals the opportunity to weigh in and is preferable to politically driven legislative action. The public is protected through regulation. The PT's have been successful in passing Legislation allowing dry needling.)
- are pursuing this because their own techniques don't work. (Even if true, 1) why does that matter, and 2) does the argument apply to us when we add techniques lasers, essential oils, e-stim, herbs – to our scope?)
- can't possibly know enough to do this technique safely. (Many clearly do.)
- can't possibly be providing good treatments. (Their patients disagree.)
- wrongly say that dry needling isn't acupuncture. (Is it better if they say it is? Is there a legal reason our definition should prevail?)
- make the public fear acupuncture. (Insisting this technique is acupuncture will contribute to the problem. Don't we have the same problem when we use the technique?)
- should use hypodermic needles. (Does that show concern for public safety?)

excerpt taking from:

<http://theacupunctureobserver.com/tag/dry-needling/>



This petition has collected
566 signatures
using the online tools at iPetitions.com

Printed on 2016-08-15

Please accept the attached online petition for your consideration of dry needling in Washington PT scope of practice. The petition signees are a mixture of clinicians and patients wishing to have dry needling by physical therapists as a treatment option in Washington State.

Paul Killoren PT, DPT, CSCS

Appendix E

Other States

Dry Needling by Physical Therapists
As of August 30, 2016

State	Allowed	Allowed by Statute	Allowed by AG or Board Opinion	Allowed by Administrative Rule	Additional Training Required	Notes
Alaska	Yes		Board of Physical Therapy determination - Minutes of 3/28-30/2012 After mass mailing, reiterated 2012 position (2014)			“Board stands that they will not determine what can or cannot be practiced. The professional must be accountable to their education and if trained and or certified in something, those are the credentials which show you are qualified to perform the task.”
Arizona	Yes	A.R.S. 32-2001(4). SB 1154 added it in 2014.			Yes – A.A.C. R4-24-313 requires approval of program by one of a list of PT organizations. Specific course content listed, and must be 24 hours.	
Arkansas	Yes		Board of Physical Therapy determination – Minutes of 5/28/2009. After new request for determination, reiterated 2009 position. (2014)			When asked by a PT for a determination of whether dry needling is in their scope of practice, the board “determined dry needling is within the scope of practice.”
California	No					Orange County Superior Court granted a temporary restraining order against several out-of-state companies who intended to insert acupuncture needles and

State	Allowed	Allowed by Statute	Allowed by AG or Board Opinion	Allowed by Administrative Rule	Additional Training Required	Notes
						distribute acupuncture needle samples at a PT conference in Anaheim. The defendants lacked state licensure as acupuncturists or medical doctors.
Colorado	Yes			Administrative rule: 4 CCR 732-1-211. Statute is silent: C.R.S. 12-41	Yes – detailed requirements including: 46 hours of in-person training after practicing for two years	
Delaware	Yes	24 Delaware Code, Section 2602(6)(10))			Rule defines training to include 2 years in practice and specialized training to include 54 hour program	Defines dry needling in statute.
Georgia	Yes	Georgia Code 43-33-3(7)(D)			Does not appear to require.	Dry needling is included in definition of physical therapy.
Illinois	Unresolved		Conflicting legal opinions – unresolved at this time.			Informal opinion in 2010 that dry needling was within scope. After acupuncturists lobbied the Illinois PT board in 2013, they reconsidered the issue. New attorney issued opposite opinion in 2014. Illinois PT association submitted draft rules for department to consider proposing in late 2015.
Iowa	Yes		Board of Physical & Occupational Therapy Ruling on Petition for Declaratory Order		Does not appear so	“Is dry needling within the scope of practice of physical therapy as defined in Iowa Code section 148A.1(1)(b)? Response was Yes.
Kansas	Unresolved		Unresolved			Board deferred issue on whether dry needling is within PT scope to the legislature. SB 490

State	Allowed	Allowed by Statute	Allowed by AG or Board Opinion	Allowed by Administrative Rule	Additional Training Required	Notes
						“Adding dry needling to the physical therapy scope of practice” died 6/1/2016.
Kentucky	Yes		AG Opinion OAG 13-010 (9/23/2013)		AG opinion encouraged board to set requirements but there are none on their website. FAQs on website state “There is nothing in KRS chapter 327 to prohibit a credential holder from performing dry needling so long as he or she has the requisite training, expertise, and experience to perform this function.	PT board opinion upheld by AG opinion which stated they agree with the board of physical therapy “that the definition in KRS 327.010(1) is broad enough to include “dry needling” by a physical therapist with adequate training and skill to perform the procedure competently...this procedure is not currently considered an entry-level skill for physical therapists but an advanced skill...” Opinion encouraged the board to fix education and safety standards for dry needling.
Louisiana	Yes		AG Opinion OPINION 14-0216 and Administrative rule		Yes – no less than 2 years of experience in PT and 50 hours face-to-face training in dry needling. Courses also have requirements for approval.	AG opinion concluded that dry needling is within the scope of practice of physical therapy.
Maryland	Yes – if rules are adopted with educational requirements		2010 AG opinion		Yes – proposed rules require 80 hours of instruction, including 40 hours in specific dry needling-specific content, and 40 hours of practical hands-on instruction in the application and technique of dry needling, under supervision of a licensed practitioner competent in dry	2010 AG opinion “the physical therapy board may determine that dry needling is within the scope of practice of physical therapy if it conducts rulemaking... and adopts a regulation that relates dry needling to the statutory definition of the practice of physical therapy. Any such

State	Allowed	Allowed by Statute	Allowed by AG or Board Opinion	Allowed by Administrative Rule	Additional Training Required	Notes
					<p>needling who has completed these requirements and been practicing for 5 years.</p> <p>(proposed in 2013 but do not appear to have been adopted)</p>	<p>process should consider standards for education and training that presumably would be at least as strict as those set by the legislature for physicians who use acupuncture needles for similar therapeutic purposes.”</p>
Massachusetts	Unresolved		None			<p>Legislation proposed in 2015-2016 session (House Bill 2006) to add “use of needles on trigger points, Ashi points, soft indurations, motor points and/or for intramuscular needling for the treatment of myofascial pain will be considered the practice of acupuncture.” Did not pass</p>
Mississippi	Yes		<p>AG Opinion- 2012</p> <p>Administrative rules for definition and training– 3101(1.3)(6)(c)</p>		<p>Yes – 3 years of practice followed by a minimum of 50 hours of face-to-face IMS/dry needling course.</p>	<p>AG opinion stated “...the Physical Therapy Board acted within the scope of its authority when promulgating the proposed rule including the use of needles for therapeutic treatment as a technique within the scope of the statutory definition of the practice of physical therapy... we affirm our prior opinion in MS AG Op. Moore (September 10, 2012).</p>
Montana	Yes			<p>Administrative rules (proposed 5/14/2015)</p>	<p>Proposed rules state PTs must be able to demonstrate they have enough training in dry needling that meets the standards of continuing education as set forth by the</p>	<p>Proposed rules state the statutory scope is broad enough to include dry needling under “mechanical devices.</p>

State	Allowed	Allowed by Statute	Allowed by AG or Board Opinion	Allowed by Administrative Rule	Additional Training Required	Notes
					board's continuing education rules (not specific to dry needling)	
Nebraska	Yes		AG Opinion July 2016			AG opinion states "a reasonable legal argument can be made that dry needling is a "mechanical modality" or a physical agent or modality" and, therefore, falls within the statutory definition of physical therapy.
Nevada	Yes		Board opinion (2012)			Board opinion states this board "will now consider the practice of DN (as defined above) to fall within the scope of practice of physical therapy in the state of Nevada."
New Hampshire	Yes		Board interpretation (at 10/19/2011 board meeting)		States they must have "the proper certification" but there is no guidance on what that means.	FAQs on board of PTs web page: "Can a physical therapist do "dry needling?" Response: "A physical therapist can insert needles for the purpose of treating pain "dry needling" provided they have the proper certification to do so."
New Mexico	Yes (not prohibited)		PT Board decision in 2000			Board stated the Act does not prohibit dry needling
North Carolina	Yes		AG Opinion (2011)		Notice of proposed rules, 1/16/2015 stated board believes PTs can continue to perform dry needling if they possess the requisite education and training required by N.C.G.S. 90-270.24(4) "but there are no regulations to set the specific	AG Opinion is that dry needling is within PT scope of practice. No rules appear to have been adopted.

State	Allowed	Allowed by Statute	Allowed by AG or Board Opinion	Allowed by Administrative Rule	Additional Training Required	Notes
					requirements for engaging in dry needling... and physical therapists must therefore comply with 21 NCAC 48C.0101(a) which states “Physical therapy is presumed to include any acts, tests, procedures, modalities, treatments, or interventions that are routinely taught in educational programs or in continuing education programs for physical therapists and are routinely performed in practice settings.”	
North Dakota	Yes		Board statement & minutes from 5/13/2013		No	FAQs on webpage states “Yes, the North Dakota State Board of Physical Therapy has stated that dry needling is within the scope of physical therapy practice.”
Ohio	Yes		Board position 5/12/2011 meeting minutes		No	“Nothing in the Ohio Physical Therapy Practice Act prohibits a physical therapist from performing dry needling techniques. As with any specialized procedure, the physical therapist must have training and demonstrate competency in the modality. The manner in which the training is obtained and competency demonstrated are not addressed in the Practice Act.”
Oregon	No		Oregon PT Board			Licensing board states dry

State	Allowed	Allowed by Statute	Allowed by AG or Board Opinion	Allowed by Administrative Rule	Additional Training Required	Notes
			is monitoring national trends			needling of trigger points is likely within the PT scope of practice and is an advanced intervention requiring post-graduate training and education. However, "In the interest of public safety, until a measure of evidence based training and education can be determined, the board strongly advises its licensees to not perform dry needling of trigger points." They continue to monitor trends.
Rhode Island	Yes		Board position 2/14/2012 meeting minutes		No	Board members commented dry needling is within their scope of practice provided the licensed professional is comfortable trained and has appropriate background knowledge.
Tennessee	Yes	House Bill No. 25 signed into law April 9, 2015			Yes – 50 hours in content areas of musculoskeletal and neuromuscular systems; anatomical basis of pain mechanisms, chronic pain, & referred pain; trigger points; and universal precautions. 24 hours of dry needling specific instruction. (Approved by the board)	AG opinion in 2014 that legislation would be necessary to add dry needling. Legislation followed in 2015 Rules adopted 6/29/2016 adding specific required training.
Texas	Yes		AG Opinion		No	AG Opinion stated that trigger point dry needling would likely fall within the legislature's broad definition of physical therapy. Also said a court would likely conclude that the board has

State	Allowed	Allowed by Statute	Allowed by AG or Board Opinion	Allowed by Administrative Rule	Additional Training Required	Notes
						authority to determine that trigger point dry needling is within the PT scope of practice.
Utah	Yes	Utah Code 58-24b-102(14)			Yes – 2 years active practice as a PT and course in trigger point dry needling that is approved by the division; and includes at least 300 total course hours including 54 in-person instruction and 250 supervised patient treatment sessions.	Defines trigger point dry needling in statute and required training.
Virginia	Yes		Board determination 2010		Yes – Board Guidance Documents: 54 hours of post professional training including providing evidence of meeting expected competencies that include demonstration of cognitive and psychomotor knowledge and skills. The PT bears the burden of proof of sufficient education and training. Requires a referral and direction because it is an invasive procedure.	Task Force on Dry Needling made recommendation to the board on guidance for dry needling. The board voted that it is in the scope of practice of PTs but should only be practiced under certain conditions. (APTA document states regulations are in progress but board’s web page states there are no rules in progress)
Washington D.C.	Yes			Administrative rule	Yes – Must be a board approved training program (in-person) and graduate or higher level coursework that included intramuscular manual therapy in the curriculum and requires trainee to demonstrate cognitive and psychomotor	

State	Allowed	Allowed by Statute	Allowed by AG or Board Opinion	Allowed by Administrative Rule	Additional Training Required	Notes
					knowledge and skill; or graduate or higher level coursework in a CAPTE-approved educational program that included intramuscular manual therapy in the curriculum.	
West Virginia	Yes		Board opinion		No	“Dry needling is within the scope of practice of “physical therapy” as defined by West Virginia Code 30-20-9.”
Wisconsin	Yes		Board determination		No (states they must be properly trained but does not define the training)	“The board considers trigger point dry needling as within the scope of practice of physical therapy provided that the licensed physical therapist is properly educated and trained.”
Wyoming	Yes			Administrative rules	Yes – Course shall include 27 hours of in-person instruction, must be approved by state boards of physical therapy, American Physical Therapy Association or individual chapters of the American Physical Therapy Association, Federation of State Boards of Physical Therapy, or International Association for Continuing Education Training.	

Appendix F

Rebuttals to Draft Report

Rebuttals to Draft Report
October 12, 2016

Applicant Rebuttal

On behalf of the Physical Therapy Association of Washington (PTWA), I want to thank the Department of Health (Department) for its work during this sunrise review process. PTWA has serious concerns with the report and the recommendations derived from the report.

Instead of focusing on the physical therapy profession, and the merits of adding dry needling to the physical therapy scope of practice, it seems clear that the underlying premise of the Department's report is that dry needling is the same as acupuncture. However, this is not the question to be answered in this report; the question to be answered is whether physical therapists can safely and effectively practice dry needling under the endorsement required in SB 6374. Any analysis should be performed within this context.

While the sunrise criteria set forth in 18.120 RCW generally apply more to regulating a new profession rather than increasing the scope of practice of an existing, regulated profession, it is generally accepted that the applicant must show that sufficient education and training exist for the profession to adequately practice the increased scope safely. The analysis should be conducted on this question alone, and the analysis should focus on data and research, not anecdotal evidence.

To that end, PTWA has shown that:

- Medical malpractice insurers and peer reviewed literature show that dry needling does not pose an increased risk when performed by physical therapists.
- The curriculum of entry-level education of physical therapists, coupled with the curriculum of continuing education in dry needling is sufficient.
- The majority of states and the United States military define dry needling as separate from acupuncture.

We acknowledge some of the concerns of the Department and ask that the final report be written in a way to suggest future bill language that ensures a pathway to an endorsement for physical therapists to perform dry needling, based on best available evidence. Please consider the following in your recommendations:

- We ask that the Department consider adding language that suggests an appropriate, evidence-based, number of hours that would allow physical therapists to perform this technique. We would appreciate further direction as to what methods should be used to “analyze what adequate training standards should include.”
- To address concerns regarding supervision, we suggest that the Department propose a supervision requirement be included in future bill language. See suggestions from other states later in this document.
- We request that the sentence “physical therapist training does not include invasive techniques” be removed from the recommendations as physical therapist training includes needle electromyography and sharp wound debridement.
- If the Department has concerns about doctoral level training being required, we request that the Department recommend either a doctoral level of education or a certain number of years of post-entry level practice as part of the requirement for the endorsement.
- We request that the Department not limit its recommendation for collaborations to EAMPs but also suggest other needle experts such as physicians, ARNPs and naturopaths.
- We request that the sentence regarding the definition of dry needling suggest that SB 6374 utilize an alternative, already existing, definition of dry needling, such as that suggested by APTA, which does not mention acupuncture (see below).

Safety

The Department's report advises that dry needling should not be added to the physical therapy scope of practice because it is “an invasive procedure with potential serious risks of injury.” While PTWA agrees that risk of serious

injury is present, the applicant report cited evidence to show that dry needling is predominantly safe when performed by physical therapists.

- The major malpractice insurers of PTs have issued multiple statements that dry needling does not pose any increased risk when performed by physical therapists.
- A study of adverse events showed that the risk of a significant adverse event was less than 0.04% (Brady, S, McEvoy, J, Dommerholt, J & Doody, C, 2014. Adverse events following dry needling: A prospective survey of Chartered Physiotherapists. *J Manual Manipul Ther*, 22, 134-140.)
- The presence of rare cases of adverse events does not indicate a trend. Several published case reports describe pneumothorax as a result of acupuncture treatment in the United States:
 - R. J. Chaufe and A. L. Duskin, “Pneumothorax secondary to acupuncture therapy,” *Southern Medical Journal*. 2006; 99(11): 1297–1299. This article describes a pneumothorax in a 27-year-old patient receiving acupuncture treatment for right levator scapular muscle spasms, leading to hospitalization with a chest tube.
 - W. B. Von Riedenauer, M. K. Baker, and R. J. Brewer, “Video assisted thoroscopic removal of migratory acupuncture needle causing pneumothorax,” *Chest*. 2007; 131(3): 899–901. This case report describes the surgical removal of an acupuncture needle that migrated into the thoracic cage and caused a pneumothorax.
 - These individual cases, while concerning, cannot be generalized to demonstrate an overarching level of harm to the public.
- There was no legitimate evidence submitted, aside from individual cases, to show that there is a trend of increased risk from PTs performing dry needling. Many of the individual cases cited are self-reported, with no evidence that any disciplinary action was initiated, nor any findings against a physical therapist. In fact, the case cited in the report related to a leg infection (and discussed during the public hearing) was found to be due to “failure to supervisor or monitor” when the patient put their leg in a whirlpool, against medical advice, after the physical therapist had left the room. Citing this case as evidence of physical therapy negligence in technique is misleading. We request this case be removed from the report.

Education and Training

To address the Department’s concerns about the standards of courses and supervision the Department could suggest using the model language of other states:

- Arizona law requires a written and practical examination that includes sterile needle procedure, anatomical review, blood borne pathogens and contraindications.
- Colorado requires standards be met for the course instructor.
- Delaware requires a written and practical examination, as well as program curriculum requirements such as clean needle technique and emergency response, as well as requirements for the experience level of the course instructor.
- Louisiana requires experience level of the course instructor.
- Tennessee requires certain prerequisites to be met in entry level education, as well as post-graduate requirements of technique, adverse event management, practical competency, and OSHA standards.
- Utah requires 250 supervised treatment sessions.
- Wyoming requires the course be approved by the state board of PT, the APTA or state chapter, the Federation of State Boards of PT, or the International Association for Continuing Education Training.

The Department’s report states since there is no supervised clinical experience requirement, dry needling should not be added to the scope of practice. However, it is important to note that physical therapist education does include other invasive techniques such as wound debridement and needle electromyographic/nerve conduction studies. The education also includes complete cadaver dissection. According to Eastern Washington University DPT Program Chair Dan Anton, the 160 hours of DPT anatomy coursework exceeds the 120 hours of anatomy coursework completed by UW medical students. Furthermore:

- Physical therapists are supervised throughout the 54 hours of continuing education coursework and must pass an individual practical examination after each course in which they demonstrate competency.
- If the Department determines that supervision during the course and competency testing at the end of the course has not been adequate to prevent harm to the public we ask that the suggestion of supervised practice, possibly following the military model or Utah legislation, be included as a reasonable alternative.

The Department's report states that because not all physical therapists practicing in Washington have completed doctoral-level training and a doctorate is not required for licensure, dry needling should not be added to the scope of practice. It is important to note that:

- While current physical therapy education requires doctoral-level training, there has been little change in the foundational science education in anatomy, physiology and biomechanics. According to Mark Guthrie, former chair of the University of Washington Doctor of Physical Therapy Program, "the core/baseline sciences (anatomy, neurology, neuroanatomy, pathology) are pretty much the same now as 20 years ago. We have added things like pharmacology, differential diagnosis, and a much greater emphasis on evidence based practice to the DPT curriculum, but that basic content is the same. I teach our anatomy and kinesiology courses, and have for nearly 30 years, and can say for sure that the content is basically the same."
- Furthermore, the FSBPT competency paper does not specifically discuss "DPT" education but rather references "entry level" practice, a standard that PTs holding a bachelor's or master's presumably far surpass. Clinicians who do not have DPT education have, for the most part, been practicing for at least 10 years and have further refined their clinical knowledge through examination, palpation, and overall management of patients with musculoskeletal conditions.
- The draft document states that licensure requirements and scopes of practice differ from state-to-state, however physical therapy educational standards are set on a national level by the Commission on the Accreditation of Physical Therapy Education (CAPTE). Entry level knowledge and skills do not differ greatly from state-to-state, however individual scopes of practice may. Washington state does not have any different educational standards for entry level practice than the rest of the country.
- Furthermore, the Department makes the statement that the HumRRO report, "Did not include representation from medical acupuncturists or others experienced in using needles in medical practice. It also did not include EAMPs, *who have the most training and experience in filiform needle insertion techniques, needle manipulation techniques, physiological responses, and contraindications.*" This statement is not accurate considering the number of professions that also use needles and considering that the vast majority of western medical literature regarding physiological responses, safety/contraindications, and treatment efficacy regarding dry needling and medical acupuncture are published by physical therapists, MDs, DOs, and PhDs. We ask that this statement be removed or modified to include "did not include other medical professionals who commonly use needles, such as MDs, RNs, and EAMPs."

The Department's report states that PTWA "did not demonstrate that 54 hours of training is sufficient to ensure professional ability of physical therapists to perform dry needling. The required training proposed in the bill was not based on the HumRRO practice analysis cited in the applicant report." However, it is important to understand that the purpose of the HumRRO study was not to demonstrate how many hours of training are required, but rather what the content of continuing training should be. They studied physical therapist education and physical therapist integration of the technique. EAMPs and medical acupuncturists do not have knowledge of physical therapist education or practice and would not be able to comment on this. Therefore, it was not appropriate to include other health care professionals in this analysis.

In addition:

- PTWA and experts in dry needling suggest that the absence of common adverse events, despite widespread practice by physical therapists of dry needling throughout the United States and Canada, with 54 hours or less of needling education, in fact demonstrates that this amount of training is adequate.
- There has been no evidence cited that states that 54 hours is inadequate or that there are fewer adverse events with more hours of training.

- A study by White, et al, surveyed physical therapists and physicians performing “acupuncture” in the UK. Serious adverse event reported as 0 for 95% CI of 0-1.2 per 10000 or 0-0.012% risk rate. *Six percent of practitioners in the study had less than 24 hours of training, 37% had 25-100 hours, and 57% had more than 100 hours of training.* Serious adverse event reported as 0 for 95% CI of 0-1.2 per 10000 or 0- 0.012% risk rate. There was no evidence of any association between this rate and the duration of acupuncture training or clinical experience... (or) the profession of the practitioner.” (White A, Hayhoe S, Ernst E, Hart A. Survey of adverse events following acupuncture (SAFA): a prospective study of 32,000 consultations. *Acupuncture In Medicine.* 2001; 19(2):84-92.)
- A study by MacPherson et al sought to compare the results of the White study with a similar sample size of professional acupuncturists (members of the British Acupuncture Council (BAcC)). *The BAcC sets and maintains education standards based on three-year full-time accredited courses.* Serious adverse event rate reported as 0 for 95% CI of 0 to 1.1 per 10000 consultations or 0-0.012% risk rate. (MacPherson H, Thomas K, Walters S, Fitter M. A prospective survey of adverse events and treatment reactions following 34,000 consultations with professional acupuncturists. *Acupuncture In Medicine* 2001;19(2) 93- 102.)
- Currently, White 2001 and MacPherson 2001 are the only prospective studies on the safety of needle penetration techniques directly comparing physical therapists trained at the standard proposed in the applicant report, with a standard comparable to Traditional Chinese or East Asian Medicine Practitioners in the state of Washington. With the exception of minor adverse events, which are comparatively lower in the SAFA study, the results are almost identical regarding patient safety. We respectively suggest, the Department consider the outcomes of these prospective trials demonstrating that physical therapists are able to perform needle techniques with significantly fewer hours of additional training.
- Thousands of physical therapists throughout the United States and the world have integrated dry needling into their practice after taking courses such as those cited in the applicant report. Considering that most dry needling course programs feature approximately 54 hours of education, and that malpractice insurers have concluded that there has been no increased risk, it can be concluded that 54 hours is sufficient. To reiterate CNA, “CNA does not foresee the practice of dry needling by a licensed physical therapist as having any immediate claim rate or impact.” This is the current opinion of CNA, as confirmed by Michael Loughran, CNA President, Healthcare, on October 6, 2016.
- The number of hours of supervised clinical practice in EAMP entry-level education should not be used as a standard to measure physical therapy post-graduate education in dry needling. These hours presumably also include other aspects of EAMP practice outside of needle handling, as defined in Washington state law, including electrical, mechanical or magnetic devices, moxibustion, acupressure, cupping, dermal friction, Infrared, ultrasound, laser, point injection therapy, recommendation and formulation of herbs, vitamins, mineral, dietary and nutritional supplements, exercise, relaxation techniques, breathing, relaxation, and East Asian exercise techniques; Qi gong, East Asian massage, Tui na, and superficial heat and cold therapies.
- No evidence has been cited that adverse event rates are *less* in EAMP practice when compared to physical therapists performing dry needling, nor that the number of hours required for EAMP training would lead to reduced incidence of adverse events. In fact, the report cites no safety data for EAMPs, which is being held as the standard. If safety of treatment by EAMPs is being used as a standard then safety data for treatment by EAMPs, which does exist and shows similar levels of adverse events, should be included too.
- Neither WEAMA, nor the Department, have evidence for, nor have suggested, an alternative number of hours that is based on scientific evidence or claims data.

Dry needling and acupuncture

The Department’s report discusses the opposing viewpoints about whether dry needling is or is not acupuncture. Clearly, the physical therapy profession views dry needling as separate and apart from acupuncture, and we detailed that analysis in our applicant report. This is reflected in the fact that the majority of states and the United States military define dry needling as NOT being acupuncture. As the regulator of health professions, the Department should acknowledge and give weight to how other states regulate the practice of dry needling.

The Department’s report stated that, “the definition of dry needling is problematic because it states that dry needling does not include the stimulation or treatment of acupuncture points and meridians... Any future proposed

bills to add dry needling to the physical therapy scope of practice should clearly limit the definition to treatment of trigger points within the practice of physical therapy.” We disagree. We included that language in the definition specifically to differentiate dry needling from acupuncture, as the majority of states and the United States military have done. Furthermore:

- We would appreciate the suggestion from the Department in the final report that we use an alternative definition of dry needling such as the one offered in the *APTA Resource Paper: Description of Dry Needling in Clinical Practice*: “Dry needling is a skilled intervention that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments.”
- PTWA, APTA, AAOMPT, and many others do not accept that dry needling is the practice of acupuncture. We have concerns about including the term acupuncture in the PT scope of practice, even in a limited authority.

Admittedly, the applicant report did not attempt to describe the full practice of East Asian Medicine. The report was meant to describe physical therapy practice and this was not meant as an oversimplification of the profession of EAM. That being said, we do not believe that the following statement bears relevance to the goals of the Department sunrise review and ask that it be removed: “The applicant over-simplifies the practice of acupuncture in its arguments on why dry needling is not acupuncture, arguing that acupuncture is only based on the ancient rules of channels and meridians and movement of qi (energy flow).”

- The Department report states that some physical therapists state that acupuncture nomenclature is sometimes used in dry needling training. This point was refuted in public comments by dry needling educators who stated that they allow acupuncturists in dry needling education courses and use this terminology to assist in their understanding of the technique.
- East Asian Medicine profession has a long history of describing Ashi points in Traditional Chinese Medicine (TCM) texts and literature. However, the first use of Ashi point in scientific literature by TCM practitioners was Xu RD and Li H (2005). The authors state: “This article tries to clarify the origin and definition of Ashi points through textual research of traditional literature.” “Ashi points are not the same as tender points, Budiing point, or Tianying point... But are special responding points that present when the organism is ill.”
 - Xu RD, Li H. Conception of ashi points. *Zhongguo Zhen Jiu* (2005) 25(4):281-3
 - Ramey D and Buell PD. A true history of acupuncture. *Focus on Alternative and Complementary Therapies* (2004) 9:269-273
 - White A and Ernst E. A brief history of acupuncture. *Rheumatology* (2004) 43:662-663
- Although we do not dispute that the conceptual framework for ashi or trigger point acupuncture therapy may have been present for thousands of years, the actual practice of direct needling of ashi or tender points for musculoskeletal conditions, according to the literature, appears to have gained popularity among TCM and EAMPs in the last 10-15 years. Thus statements by EAMPs that for centuries they have been treating Ashi or myofascial trigger points for neuro-musculoskeletal conditions from a theoretical, clinical reasoning, and technique perspective that is indistinguishable from physical therapists performing dry needling is a gross misrepresentation of the scientific literature.
- We acknowledge that some trigger points overlap with acupuncture points. Additional acupuncture points (both on and off channel) have been added with time and the total number of points has increased to at least 2000 (Huai, L, Broffman, M, Pei, S. *A Comprehensive Textbook. China Acupuncture and Moxibustion Supplies, Taiwan 1976*). The presence and precise location of acupuncture points and meridians continues to be disputed among the various disciplines under the East Asian Medicine practice umbrella. Considering the potential of 2000 acupuncture points throughout the body it would be nearly impossible for there to be no overlap between trigger points and acupuncture points.
- Knowledge of acupuncture, acupuncture points, or ashi points, by physical therapists, is not necessary for the practice of dry needling. Nurses use needles to inject immunizations, perform TB tests, insert IVs, and perform wound debridement without knowledge of acupuncture theory or points, without adverse event. Physicians use needles to perform needle EMGs, saline injections, facet injections, epidural injections, all

without knowledge of acupuncture theory or points, without adverse event. Medical assistants and phlebotomists use needles to inject or withdraw blood, without knowledge of acupuncture theory or points, without adverse event. Physical therapists perform needle EMG and sharp debridement without knowledge of acupuncture theory or points, without adverse event. Physical therapists may, likewise, perform dry needling, potentially to an acupuncture point, without likelihood of related adverse event by not understanding acupuncture theory or practice. If there were a risk of harm from lack of understanding of acupuncture it would be prolific throughout the medical professions.

The Department's report states, "Some physical therapists contradict the applicant report, stating that there are studies that show using traditional acupuncture points is more accurate than palpation for identifying where to needle trigger points." However, unless there are specific references supporting this assertion we request that it be removed.

The following statements pertain to the practice of acupuncture and are not related to the practice of physical therapy nor questions set forth by the Department's criteria for sunrise review. We request that they be removed:

- The applicant over-simplifies the practice of acupuncture in its arguments on why dry needling is not acupuncture, arguing that acupuncture is only based on the ancient rules of channels and meridians and movement of qi (energy flow).
- Physical therapists refer to acupuncture needles as tools, just as a stethoscope is a tool. However, acupuncture needles are, and have always been, one of the main tools used by EAMPs.
- EAMP training includes use of needles and needling techniques throughout their curriculum and supervised clinical experience.

The Department's report goes on to recommend "collaboration with needling experts, such as EAMPs and medical acupuncturists... to identify core training and supervised clinical oversight for physical therapists to safely perform this procedure." However, other endorsements on the physical therapy license, such as the endorsement for a physical therapist to perform spinal manipulation, allow for experienced physical therapists to supervise the training of physical therapists pursuing endorsement. Furthermore:

- PTWA met with the Washington East Asian Medicine Association (WEAMA) on October 1st, 2015, in an attempt to discuss options for possible bill language. WEAMA did not respond to a request for suggestions for number of hours or requirements to practice.
- We collaborated with noted physiatrist and dry needling educator, Dr. Steven Goodman, regarding the requirements and attempted to collaborate with WEAMA. WEAMA leadership were unwilling to discuss options other than dual licensing.
- PTWA intends to continue to work with WEAMA and other interested parties in coming to reasonable requirements in order for physical therapists to practice dry needling in Washington state.
- Including only EAMPs and medical acupuncturists as clinical supervisors would be problematic in knowledge of integration of needling into physical therapy practice as well as willingness to collaborate.

PTWA would appreciate the consideration of additional healthcare providers, such as physical therapists with proficiency in dry needling technique (former military, endorsement from other states) to provide supervision, if required.

The use of needles

The Department's report discusses the differing legal opinions regarding the use of acupuncture needles, citing the APTA's legal analysis and the NCASI's legal analysis. Again, we reiterate our comments from the applicant report:

"NCASI alleged that dry needling by physical therapists is inconsistent with the requirements for acupuncture needles under federal law. In response, the APTA commissioned a legal analysis from the

law firm of Hogan Lovells US LLP to investigate whether NCASI's allegation against physical therapists and the physical therapy licensing boards has merit. Based on the legal analysis, APTA concluded that the allegations were without merit and provided the following rationale: "FDA regulates acupuncture needles as class II medical devices. When the FDA down-classified acupuncture needles and promulgated 21 C.F.R. § 880.5580, the FDA stated that acupuncture needles are for use by qualified practitioners as determined by the states. We believe that the FDA, in doing this, was clearly signaling that it would not involve itself in determining who is a qualified practitioner to use acupuncture needles, leaving it to the states to decide. The regulations require that acupuncture needles comply with the following special controls: (1) "labeling for single use only and conformance to the requirements for prescription devices set out in 21 C.F.R. § 801.109" ("prescription device regulation"), (2) "material biocompatibility," and (3) "sterility." Id. § 880.5580(b). This regulation does not designate acupuncture needles as restricted devices but rather categorizes them as prescription devices requiring compliance with 21 C.F.R. § 801.109."

The Department's report contains a paragraph citing the supply company AcuDepot's message that only licensed acupuncturists may purchase needles from them. We feel it is inappropriate to include this reference, as it is simply one company's practice and not a legal precedent. Also, this message would seem to eliminate physiatrists and naturopaths from being able to purchase needles from AcuDepot and both practitioners may legally perform dry needling in Washington state. We request that this reference be removed from the report.

Conclusion

The Department's report continually references the practice of acupuncture and training of East Asian Medicine Practitioners rather than focusing on the practice of dry needling and physical therapy. It is concerning that the only standard for needle usage reference throughout the report is EAMP or medical acupuncture without any reference to safety data for those professions. A plethora of other professions (MDs, DOs, RNs, MAs) use needles in daily practice with significantly fewer hours of education specific to needle handling.

PTWA has provided extensive controlled trial, case study, and malpractice data regarding the safety of physical therapists performing needle penetration techniques for neuro-musculoskeletal conditions with a standard of training equivalent to what is being proposed in SB 6374.

The inference in the DEPARTMENT sunrise review draft report that physical therapists trained in dry needling would pose an inherent public health risk without citing additional clinical trial, case study data, or supplying data that training received by EAMPs is definitively safer, is erroneous and misleading. The foundation of the EAMP testimony is opinion and theory and lacks evidence. The Department has not demonstrated that dry needling has a scientifically based concern of risk to public health, nor that 54 hours of training has led to public harm beyond a few individual cases. We acknowledge that there is inherent risk in needling but no trend of harm has been demonstrated despite practice by physical therapists throughout the US, the military, Canada and much of the world.

We believe we have submitted adequate data to prove public safety and would appreciate guidance from this report on framing a bill that would elevate the educational standards, such as criteria for coursework and supervision.

Erik Moen, PT, President
PTWA

I must admit the findings and recommendations made by the Department of Health (DoH) regarding Dry Needling (DN) by Physical Therapists (PT) baffles me to no end.

I am writing this submission from the Olympic Training Center in Colorado Springs. I am here for a para-sport classification summit. It was attended by various healthcare providers from around the country. In conversations yesterday with a Physical Medicine & Rehabilitation (PM&R) physician from Greenville SC,

I posed the question, “Is DN acupuncture or a technique?” His answer was, “It is a technique. It is not acupuncture.” He went on to describe his hospital setting where they have PT’s performing DN and acupuncturist (trained in China) performing acupuncture. He described that these practices work together and work separately to achieve varying outcomes. He described scenarios where clients have beliefs in one approach and/or the other. His PM&R MDs utilize both professionals to successfully achieve various outcomes.

I then went on to describe the current situation in Washington. He was a bit dumbfounded. He did not understand the acupuncturists stance. He perceived that the acupuncturists were fearful of losing business. The acupuncturists primarily state safety and training concerns for PT’s to perform DN. Is it truly safety they are worried about, does this argument have merit? Comparisons of safety data of the two groups demonstrate that PT’s have better safety rates when looking at DN (already provided data). When you analyze acupuncturists safety records (already provided data), they are generally higher risk,..but that is comparing the full practice of acupuncture/Chinese medicine to the DN technique of PT’s. A cupuncturists perform higher risk, deeper needle maneuvers with their practice of acupuncture then PT’s who only manipulate muscular trigger points with the technique of DN.

KOMO 4 news was recently tipped by an unidentified party as to the current deliberations for PT’s to DN in the state of Washington. The story featured both sides of the story, PT and licensed acupuncturist (LAc). I was amused to see a LAc demonstrating the practice of acupuncture without the use of medical gloves, bare-handed. The PT who demonstrated the technique of DN used medical gloves. I am not sure the LAc’s can complain of safety concerns against PTs when their leaders can’t even demonstrate common sense safety precautions with the use of gloves. How can safety be a credible claim from the acupuncturists when one of their leaders does not seem to use safe techniques in the media?

Dry needling is a technique that is safely performed by Physical Therapists/Physiotherapists worldwide. This includes PTs in our branches of military. Maine just passed legislation this last week to allow PT’s to perform the technique of DN. Dry needling has been practiced by PTs in the USA since 1978. The treatment technique of DN is accepted and referred to by Physicians worldwide. I witness this regularly with my international travels as an international official for paracycling.

Dry needling when performed by healthcare providers is not the practice of acupuncture or medical acupuncture. These are truly two completely different approaches. The premise of the DN technique is not based on the practice of Chinese medicine/acupuncture. Dry needling is soft tissue manipulation as broadly defined in the PT’s model practice act. The practice of acupuncture is not widely reimbursed by third party payers. The tradition and practice of acupuncture is considered alternative care. The full practice is not well supported by evidence based medicine.

The DoH report states concerns of training for the Physical Therapist to perform the techniques of DN. Fifty-four (54) hours of post-DPT training is the standard in the majority of states that allow DN in the USA. These hours include technique, theory, and safety. PT’s have extensive knowledge in human anatomy/function. This is excellent and extensive base knowledge for the performance of the DN technique. The PT anatomical/function training far exceeds that of the acupuncturists. A survey of Bastyr’s acupuncture curriculum suggests musculoskeletal treatment coursework is equivalent to three-quarter credits (about 30 student hours) at most. This is nowhere near what PTs receive in their training. The technique of DN demands excellent evaluation and identification of anatomical structures that would be appropriate for such an intervention. Physical Therapists are the best prepared for the inclusion of the DN technique to their practice. To reiterate, PTs are not asking to perform the practice and tradition of Chinese medicine/acupuncture. The technique of DN is not the same as the practice and tradition of Chinese medicine/acupuncture.

Physical Therapists have been safely using needles in the state of Washington for the performance of evaluative electromyograms (emg). This practice is allowed with an additional endorsement to the existing PT license. There have been no safety/health complaints from PTs using needles for the purposes of needle emg since its inclusion in 2005. Needle emg and recently spinal manipulation are examples of recent, successful practice definitions. This work required tireless and successful collaboration with other parties in the state of Washington. We have tried to collaborate with WEAMA. They refused to meet and discuss issues in October 2015. I don't believe safety and training are their primary concerns. I am not sure of what they truly so fearful of with the PTs performing the technique of DN. If they are confident in their practice,..won't their outcomes and public acceptance allow them to successfully practice? Why are they trying to exclude PTs from using the technique of DN? They don't own this technique. This technique would be used with our existing PT client base. PTs don't pretend that this technique is the practice of acupuncture. This exclusion attitude has been challenging to me. I remember my first incidental hallway meeting with the WEAMA lobbyist at a bill signing day in Olympia. She was quick and emphatic that acupuncturists refer to PT all the time. I remember thinking that I have never seen a referral to my various orthopedic practices in over 24 years of practice in the state of Washington. I remember then that there were some flawed assumptions with the WEAMA agenda.

PTWA has gone to great extents to provide data regarding the technique of DN by the PT. I strongly believe that the premise of the DoH report is flawed by the assumption that DN is tradition/practice of Chinese medicine/acupuncture. I too, strongly contend that the technique of DN by PTs and other healthcare providers is not the tradition/practice of Chinese medicine/acupuncture. I would strongly encourage you to reconsider the DoH draft recommendations regarding DN and the PT. The hours and specifics of training PTs for the safe, appropriate and effective performance of DN have been established worldwide and can be incorporated into rule making process in the eventual adoption of legislative language.

Please reconsider your draft recommendations to allow PTs in Washington to join their worldwide peers in using the technique of DN for the cost effective and safe management of their clients/patients.

Erik Moen, PT

There has been much debate about the differences of dry needling (DN) by physical therapists and acupuncture by acupuncturists. I completely understand how it could be confusing to people who have never had either treatment or DN by a PT. I also believe it's hard to grasp how special DN is if you've never felt the immense relief of chronic, intolerable muscle pain after just one session of DN from a PT.

I've had 9 surgeries for shoulder, thumb, and hip injuries in sports. The first surgery was in 2001 which led to recurrent, awful muscle pain/knots/trigger points in my back. Since 2001, I continued participating in sports and regularly (weekly/monthly) sought out relief of muscle pain from chiropractors, acupuncturists, massage therapists, sports med doctors, physical therapists, "body workers", books, "the next best thing", yoga, pilates, foam rollers, every self massage tool you can imagine. The list goes on and on, as well as the cost, for almost 5 years, until I had DN from a physio in Canada for the first time. I couldn't believe the instant relief I felt. No massage therapist could ever go deep enough without leaving bruising, which just led to more pain. Acupuncturists never quite hit the spot, and treatments with them were 50/50 chance of any relief at best, often leaving me disappointed I wasted my money since they usually didn't accept insurance.

I've continued to go through the expensive battle of finding the next best thing since PTs in WA are not allowed to perform DN, and there just isn't anything else similar except seeing a spine specialist MD for DN. The Seattle MD wanted to charge me \$450 for one session of DN. Physical therapists on average I've spent \$60 for a cash based session. The needles probably cost \$.50.

Here are the differences:

Acupuncture: Very quick conversation about what's bothering you, lie on a table and they insert multiple needles all over your body. Sometimes they put them right in the spot that hurts and sometimes they don't. They would put needles in my hand, and when I asked why, they said my pain pathway was there. **Acupuncture is very relaxing, you lay there with the needles in the same spot, resting, for up to an hour.** The acupuncturist will leave the room, sometimes coming back once or twice to touch the needle very gently pushing it deeper in or twisting it a little, sometimes you can't even feel it. After the time passes, they take them out. I've had it where they smoked herbs over the needles or attached e-stim to it (vibration). I've been offered to purchase topical rubs after. They have never once looked at my range of motion or asked me questions about my function related to my injuries. I've seen at least 20-30 different acupuncturists around the USA (WA, OR, CA, CO, UT), Austria, and Canada, and never experienced acupuncturists do anything like what I experienced when I was told by a PT or MD they were doing DN. I have also never, ever heard an acupuncturist use the term dry needling, ashi point, or trigger point until the legislative battles started a few years ago.

Dry Needling: PTs perform an hour visit initial evaluation where they look at your strength, range of motion, ask you many questions about how you're doing things at home, function, participation in work/sports, and use their hands to find tender spots on your body and see what is contributing to your pain/problem. They establish a long term treatment plan to address what is causing the dysfunction, and they use multiple exercises, manual therapy techniques, and modalities to help you reach established goals (usually to eliminate pain). When my back pain was limiting my ability to do my exercises, and massage wasn't helping the pain, I was introduced to DN. **The PT palpated my back until she found a "knot/trigger point". It was the exact spot of my pain. She inserted the needle in that exact spot in the muscle, and maneuvered it around up and down and shifted the direction of the needle. She was always holding the needle, and moved the needle back and forth in a single area for ~ 20-60 seconds. It is intense, just like it sounds like it would be!** It's not for people that don't like needles, 100%. The muscle in my back started to spasm, twitch, and then sort of flutter and then relaxed. I was a little sore after the treatment, for an hour or so, but the nagging awful pain was gone, and the following day I had 90% relief of my pain, and I was able to do my exercises. It took 2-3 sessions and my pain wasn't even there after years of daily pain.

Watching the KOMO news report, I felt it was extremely biased to acupuncture. Millions of PT therapy sessions happen annually, and over the course of 5-7 years there were minimal complaints against PTs. I would like to see the comparison of numbers of claims against other healthcare providers. I also saw the tape of the techniques by the acupuncturist and the PT. After my experience and relief of pain from DN, I went back to school, starting as a Freshman and spent the last 8 years working to become a PT, so I could help bring DN to WA state and the patients here that would benefit from it. I have never had that (demonstration of DN) treatment from an acupuncturist in the last decade, even when I told them how it was done to me in Canada by a PT. It is my belief that modern American acupuncturists have started to adapt the DN technique from physical therapists/MDs, especially as the research showing the effectiveness and legislative debates have increased awareness of DN.

Many acupuncture programs do not incorporate cadaver labs, while all PT programs in WA state do. I have assisted acupuncture students in the past to acquire passes to the UW to examine cadavers, so they could assess the depths of tissue and lung relationship. PT programs spend 3 years studying solely the body, and use our hands daily palpating people to develop exceptional skills at distinguishing different structures in the body.

Both professions have amazing things to offer WA state residents, but what they offer are different. Patients that seek treatments from each know they are expecting different experiences, and different treatment approaches. Physical therapists have extensive training working with patients and the body, and are more than qualified to safely use needles on human tissue. The DN training is for how to physically use the needle, the technique, and for safety. **I agree their should be established supervision before certification, but please incorporate these recommendations into a Sunrise Review that SUPPORTS adding dry needling to the physical therapy scope of practice.**

Let WA stay on the forefront of patient care and allow the tools that help chronic pain reach patients, at lower cost, faster outcomes, and less dependence on pain meds that have poor side effects and often don't even help.

Thank you for taking the time to read this email and relying on the research about safety to make your decision.

Jacqui Berg, DPT

The recommendation of not adding dry needling to the Physical Therapy Scope of practice by the board is shocking and ill founded. As a person who read all the testimony and was present at the Sunrise Review hearing, I'm stunned and dismayed that the board came to this conclusion– it calls into question their impartiality or preconceived notions around the technique, or their failure to truly understand the differences between dry needling and acupuncture. It is reprehensible that the board failed to read the literature and weigh the evidence – had they done this they may have better understood how different dry needling is than acupuncture. In concluding that dry needling and acupuncture are the same, it is evident that this board never read the literature nor did their due diligence to understand the distinctions between them. One can only surmise from this outcome that the board was swayed more by politics and unfounded fears than facts and evidence.

The board was tasked with the question of whether dry needling should be in the physical therapy scope of practice, which should have been a query about the skills of physical therapists, the amount of training needed to do this technique and how to best protect the public. But instead, the board's central concern seems to center on whether or not the technique is or is not acupuncture, and the board took it upon themselves to define what dry needling is. Had they read the literature and understood that dry needling is not just about the needle but is about how it is used in the context of retraining muscle performance, they may have begun to understand the distinctions between these techniques. Despite the very clear definitions and distinctions made by the panel of experts and literature, the board accepted the false conflation of the two practices. The board found that *“The definition of dry needling is problematic because it states that dry needling does not include the stimulation or treatment of acupuncture points and meridians. Since many trigger points correspond with acupuncture points and meridians (and many argue they are acupuncture ashi points), this is a confusing definition and would be difficult to enforce”*. This is circular logic and fails to appreciate that the deliberate intention of dry needling is not to stimulate acupuncture points, regardless of whether or not they correspond to an acupuncture point. It would be like saying that no one should have their blood drawn because the needle correlates to an acupuncture point. It makes no sense. So whether or not the trigger point corresponds to an acupuncture point, the point of the treatment is based on a musculoskeletal affect.

The board stated that the *“applicant group should acknowledge the overlap between dry needling and acupuncture. Proposed legislation should clearly include authority for physical therapists to perform acupuncture in the limited practice of dry needling ...”*. This again fails to see that the applicant did indeed acknowledge the possible overlap of ashi points and trigger points; however, had the board reviewed the literature, they would see that there is weak evidence for correlation between acupuncture points and trigger points. The applicant group did indeed try to sit down with the acupuncturists, but instead of having a conversation, the acupuncture group wanted the names of any PTs practicing dry needling in order to file complaints and lawsuits. Acupuncturists are waging a war (not my words, go to their website and see their “line in the sand” they’ve drawn with physical therapists doing dry needling). What’s behind their fight is economic, not safety. They are trying to co-opt the term dry needling, despite the fact that they have not contributed to any of the evidence-based literature on the subject. The fact of the matter is that acupuncturists do not do dry needling and your not allowing PTs to do this robs the public of a very effective and safe technique.

What frightens me personally is the board's statement that dry needling is within the acupuncturist scope of practice. It is not. Acupuncture is. If an acupuncturist wants to do dry needling they need to take a

course. And even this scares me. I took a course on dry needling in Colorado where my partner was an acupuncturist. She clearly had no idea how to palpate specific anatomical structures – whereas every PT in the course saw this as review. I had to vigilantly show her each and every structure in order to keep myself safe. So saying that they do dry needling is frightening. Again, dry needling is used to affect muscle performance to affect specific changes in functional movement. Do acupuncturists assess whether a synergistic chain of muscles need to be inhibited or activated, do they know what the affect of reducing tension in a muscle will have on the patients functional movement pattern? No, this is not their wheelhouse, so they do NOT do dry needling. This statement needs to be stricken from your review.

The rationale provided by the board is flawed and inconsistent in multiple ways.

1. The statement that “the applicant did not demonstrate that 54 hours is sufficient based on the report by HumRRO”, etc is a distortion of the report and an implicit contradiction by the board. Later in the report, the board completely dismisses the HumRRO report – if that is the case then they should not marry the request of 54 hours with the report. On the other hand, if the board does accept the report, then they did not listen to the expert who clearly stated that the hours needed were to acquire a motor skill to insert a needle. The board really can’t have it both ways here. Either they accept the report as valid and therefore the 54 hours is insufficient or the report is invalid. This is failed “if, then” logic. It has already been determined by including needle EMG and sharps debridement in our scope of practice, that PTs can safely insert needles with additional training. The salient point that this board failed to grasp is that PTs have the knowledge and manual skills needed to perform dry needling effectively. The 54 hours is to learn the motor skill of inserting a needle. Compare that to the 8 hours needed for a high school graduate to learn how to take your blood.

The statement that the AMA does not support PTs doing dry needling needs to be understood in context. That statement was a unilateral decision by one person on their board who is both a physician and an acupuncturist, so therefore has inherent bias toward acupuncture. Therefore this statement should not hold weight since it is based on politics, not facts.

The board states that the report is based on the doctoral level of education but points out that not all PTs in this state have this level nor are “required” to have this level. This is a stunning rationale to refuse our use of the technique and does not appreciate the history of increased training for physical therapy. Is the board trying to say that our education as PTs is insufficient? All PT programs in this state became the doctoral level in 2004. Prior to that, PTs in this state were at the Masters level since the early 1990’s. To become a PT, whether or not the PT graduated from a WA state program, they had to come from an accredited program. Nationwide, only doctoral programs currently exist. What the board seems to be tacitly saying is that if you were educated prior to the early to mid 2000s in physical therapy, then all the work and continuing education and real life education means nothing. This is a terribly flawed analysis on the board’s part.

The board completely dismissed the HumRRO report because acupuncturists and medical acupuncturists , who are “experts in needling” were not consulted in the writing of this report. Again, the board fails to understand that these professionals were not consulted because it is not the same. A better argument would have been that the report did not consult physiatrists and other physicians who practice dry needling. Nevertheless, the board in on fell sweep of one statement dismissed a very detailed, impartial analysis of what dry needling is. Again this points to the bias the board is clearly demonstrating. They did not practice impartiality and really understand this report.

In this time of opiod addiction and chronic pain, this board is complicit in keeping a very valuable service away from the public, who have the most to lose from this ill found analysis.

I believe this sunrise review needs to be revoked as written because it’s central premise is flawed.

Susanne Michaud, DPT, OCS

Thank you for the opportunity to rebut the initial draft of the Sunrise Review concerning the addition of dry needling to the physical therapist scope of practice. Being involved with initial testimony submission, presence at the hearing, and follow-up testimony; it is disappointing to read the initial draft summary. Disappointing not simply because of my personal beliefs and training; but disappointing to see the substantial amount of relevant subject matter submitted by physical therapists seemingly dismissed for opinions, hearsay and blatant financial interests of another profession. It is still my hope the committee will be open to feedback and revision of this draft, thus allowing physical therapists the opportunity to establish regulation and standards around dry needling.

Per the rationale provided for the initial summary to not support the physical therapist proposal, please accept the rebuttals below for consideration to revise the sunrise review.

I. Dry needling is an invasive procedure with potential serious risks of injury.

Safety is perhaps the most important aspect of this topic and one the Department of Health recognizes in its role to protect the public. Physical therapists agree safety for the public is paramount and clinicians do appreciate dry needling as having the potential for adverse outcome, however severe adverse events are very rare with peer-review research assessing a statistical value of <.04%. This statistical risk of <.04 is based off of zero pneumothorax occurring during 7,629 treatment sessions, but with the chosen statistical analysis method of the study was appropriately assigned a risk of <.04%¹. There were zero severe adverse events during this study of physical therapists utilizing dry needling.

Furthermore, a study on the severe complications of acupuncture by Peucker and Groenemeyer² concluded knowledge and application of anatomy was the primary contributor to reducing the risk of adverse event with acupuncture.

“All traumatic injuries described in this article could be avoided if practitioners had better anatomical knowledge, applied existing anatomical knowledge better, or both.”²

As stated within the initial Sunrise Review draft - “Physical therapists have vast training in anatomy and physiology, including supervised clinical experience”. Our profession is recognized as musculoskeletal and anatomical experts with the training and ability to implement evaluation, treatment and mitigating of adverse events appropriately.

Lastly, it is worth recognizing that the supporting research on the clinical safety of dry needling submitted by the applicant is seemingly being overlooked for the sake of case reports. The committee has been presented with peer-reviewed prospective clinical research supporting the safe implementation of dry needling by physical therapists (n=7629) and this is reinforced by the low incidence of claims reported by CNA associated with dry needling – but this has unjustifiably been overshadowed by the very few adverse events sensationalized by our opposition. On the hierarchy of research evidence, there is a substantial discrepancy with peer-reviewed data significantly more relevant than individual case reports (n=1).

II. The applicant did not demonstrate that 54 hours of training is sufficient to ensure professional ability of physical therapists to perform dry needling. The required training proposed in the bill was not based on the HumRRO practice analysis cited in the applicant report.

The objectives as listed in the FSBPT-commissioned HumRRO report were as follows -

1. Define Dry Needling – constructed a definition of dry needling that clearly communicates the purpose and defining features of the intervention

2. Define the Standard for Competence (Safe and Effective Practice) – clarified the standard of competence for dry needling representing the minimum level of proficiency needed to perform the technique competently
3. Review and Refine Dry Needling Tasks – identified job tasks that PTs perform when applying dry needling as part of a physical therapy treatment plan Dry Needling Practice Analysis iii
4. Review and Refine Dry Needling Knowledge Requirements – identified the knowledge required to carry out the tasks identified in the previous activity
5. Identify Dry Needling Skills and Abilities

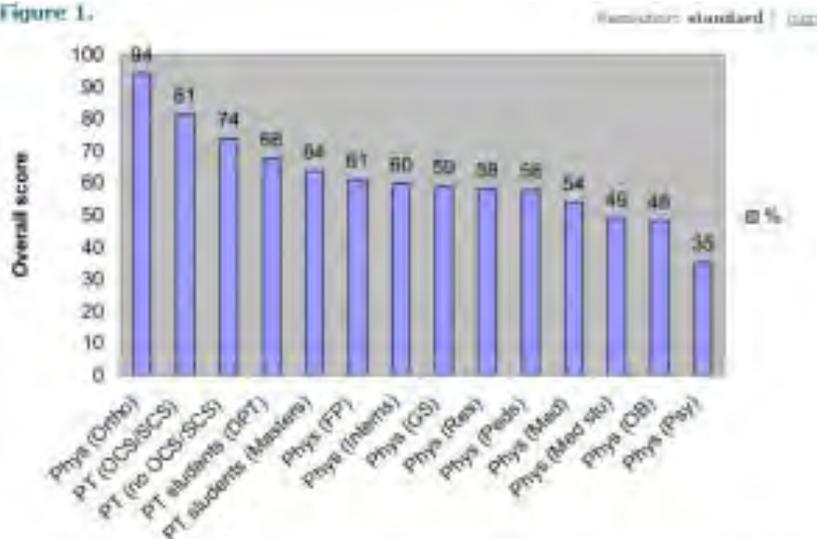
The objectives established herein were not to specifically identify the number of hours needed for dry needling competency, thus the applicant group proposal could not be solely based on this report. A 54-hour endorsement is the precedent established by other state jurisdictions adding dry needling to the physical therapy scope of practice, which now is over 35 states. Should the Washington DOH feel these standards are insufficient; it contains the authority to suggest a mandate for physical therapy training requirements, clinical supervision and educational degree surrounding dry needling. This would be a more appropriate outcome for the sunrise review process versus outright denial of our attempts to work with legislature to formally regulate dry needling in Washington State.

III. There is no supervised clinical experience requirement. Physical therapists have vast training in anatomy and physiology, including supervised clinical experience. However, physical therapist training does not include invasive techniques like needling of anatomic structures.

Specific to Washington State – sharp wound debridement, needle EMG and nerve conduction studies are all tissue-penetrating procedures currently included in physical therapy practice with advanced training. PT practice aside – nursing techniques and phlebotomy, which involve tissue penetration, are within other provider scope of practice with far less foundational education and advanced training. Again, should the DOH feel there ought to necessarily be more strict clinical experience requirements – it contains the authority to recommend so in its report.

A study published in the *BMC Journal of Musculoskeletal Disorders* used a standardized examination to assess the knowledge of a variety of healthcare professional with leveling experience in managing musculoskeletal conditions commonly encountered in the primary care setting (i.e. fractures, dislocations, low back pain, sciatica, and arthritis). The researchers found that “physical therapists had higher levels of knowledge in managing musculoskeletal conditions than medical students, physician interns and residents, and all physician specialists except for orthopedists.” Refer to Figure 1 below for the overall test scores of the different healthcare professionals who took the standardized test.³

Figure 1.



Overall scores on the musculoskeletal knowledge examination among physical therapist students, licensed physical therapists, and previous data using the same examination among physicians: all physician-related data was derived from Matzkin et al. (12) except data for the subgroup of physician exams, which was derived from Friedman and Bernstein (7). PT = physical therapist; Phys = physician; OCSS = Orthopaedic Clinical Specialist; SCS = Sports Clinical Specialist; DPT = doctoral physical therapy program; MPT = master's physical therapy program; Ortho = orthopaedics; Other = anesthesiology, emergency medicine, ophthalmology, radiology, and transitional; FP = family practice; GS = general surgery; Gen = General; Peds = Pediatrics; Med = Internal medicine; Med stu = medical student; OB = obstetrics/gynecology; and Psy = psychiatry.
 Chyla et al. BMC Musculoskeletal Disorders 2002, 6:32 (doi:10.1186/1471-2475-6-32)

Personally being an educator for dry needling coursework throughout the US for over 2 years, I'd corroborate that instruction of needling anatomic structures is directly correlated to the foundational education and anatomical proficiency of the clinician being trained. Meaning clinicians with such expertise can be quickly taught to safely implement dry needling upon the foundation of pre-requisite physical therapy education and training. As stated earlier, safety with inserting needles into the human body is based almost exclusively on anatomical knowledge² – of which you have appropriately identified physical therapists as having vast training.

IV. The applicant report states that the majority of education necessary to perform dry needling is taught in entry-level physical therapy doctoral education. However, not all Physical Therapy Dry Needling Sunrise 4 physical therapists practicing in Washington have completed doctoral-level training and a doctorate is not required for licensure.

The DOH accurately identifies that not all licensed physical therapists have obtained doctorate-level training, in fact per CAPTE publication –

“The evolution from certificate programs to baccalaureate programs occurred over the years between 1928 and 1970. Graduate programs offering master’s degrees developed in the late 1960s; by 2002, all programs culminated in a post-baccalaureate degree.”⁴

All 3 physical therapy programs in Washington State offer only doctorate level training, which has become the standard of physical therapy nationwide for over a decade. Per the CAPTE information, any physical therapist graduating after 2002 has obtained post-baccalaureate education. Aside from this, it seems physical therapy education was not analyzed thoroughly in the preparation of this report, especially in comparison to acupuncture training as even a Master’s level physical therapy education involves a curriculum more anatomically and western medically-based than acupuncture.

On the topic of education, the prohibition of innovative techniques and the suppression of professional maturation would directly affect graduating clinician’s interest in establishing a practice in Washington, as well as prospective DPT student interest in Washington programs. This would have global effect

economically and on the healthcare system as a whole, and is not too dissimilar from the previous difficulties adding spinal manipulation to PT scope of practice. For a state proud of technological advancement and progressive culture, Washington is regarded as “lagging behind” in many healthcare arenas for such decisions. Physical therapy is growing in national regard as an alternative to opioid medication; and dry needling specifically has garnered a significantly increasing amount of support in both research and national recognition for these reasons.

V. During the development of the HumRRO analysis, only physical therapists were consulted. There was no apparent collaboration with other types of health care providers, such as East Asian Medicine Practitioners (EAMP) and medical acupuncturists, who have more training and expertise in needling. The department finds that this type of collaboration would be helpful in identifying minimum training and clinical oversight requirements for safe and effective safe use of needles.

Personally, I am unable to comment on the commissioning of the HumRRO report, but as a physical therapist active in PTWA advocacy efforts can state that PTWA met with WEAMA on two separate occasions in attempts to reach a mutual agreement on training requirements or to bring forth a compromised effort to legislature. On both occasions, WEAMA was unwilling to compromise on physical therapist dry needling – stating education and licensure as an acupuncturist was the only option. Which is worsened further with the fact acupuncture programs in this state extend educational reciprocity for physicians and chiropractors, but not physical therapists. This stance and unwillingness to compromise is based primarily on the financial interests of our opposition, not public safety as they claim. The DOH ought to objectively appraise the subject matter, education and professionalism of the applicant group without impedance and collusion from the financial interests of a competing profession.

My final appeal to the Department of Health committee is to consider all information objectively, analyze the applicant group’s request thoroughly, and to do so without the interference of a competing and financially-vested acupuncture profession. Our efforts are solely to come to a compromised regulation of the practice of dry needling to protect the public and better serve our patients. Surveying the national and worldwide landscape of physical therapists dry needling – what you will *not* see is a public who has been unduly harmed, but rather patients achieving relief where they have not found relief elsewhere. That is and always will be the focus of the physical therapy profession.

Paul Killoren PT, DPT, CSCS

Citations

1) Sarah Brady, Johnson McEvoy, Jan Dommerholt, and Catherine Doody. Adverse events following trigger point dry needling: a prospective survey of chartered physiotherapists. *Journal of Manual and Manipulative Therapy*. Vol. 22 , Iss. 3,2014
Available online at
(<http://www.tandfonline.com/doi/citedby/10.1179/2042618613Y.0000000044?scroll=top&needAccess=true>)

2) Peuker E, Groenemeyer D. Rare but serious complications of acupuncture: traumatic lesions. *Acupunct Med* 2001 19: 103-108. Available online at (<http://aim.bmj.com/content/19/2/103.full.pdf+html>)

3) Childs J, Whitman JM, Sizer P, Pugia M, Flynn TW, Delitto A. Description of physical therapist’ knowledge in managing musculoskeletal conditions. *BMC Musculoskeletal Disorders*. 2005; 6:32. Available online at (<http://bmcmusculoskeletdisord.biomedcentral.com/articles/10.1186/1471-2474-6-32>)

4) CAPTE Evaluative Criteria for PT Programs. August 2014. Available online at
(http://www.capteonline.org/uploadedFiles/CAPTEorg/About_CAPTE/Resources/Accreditation_Handbook/EvaluativeCriteria_PT.pdf)

Paul Killoren, DPT

As a physical therapist , after formal training in Dry Needling, I would like to be able to perform dry needling on my patients. I would like my patients to have an option for a non medication form of pain control. With the rise in opioid addictions this comes at a critical time. Physical therapists have the diagnostic skills, and background in anatomy and physiology to safely apply this modality. In more than half the other states in the USA, all of Canada, and around the rest of the world physical therapists are safely applying this modality and providing a needed service to patients in pain. We in Washington state would like to do the same.

Thank you, Ann Ralston PT, CLT

Physical therapists are a great resource of knowledge when speaking of the human body and the true movement specialists with a great understanding of nerve to muscle to bone interactions. We have gained this title of movement specialists through at least 4 years of undergraduate work focusing on chemical and biological sciences with a vast number of physical therapists achieving their professional doctorate with further instruction on the science surround the movement and interactions of the human body from gross movements down to the physiological reactions that allow us to perform all the actions we need to move through space. This is accomplished over a 4-7 year period with many hours spent in labs dissecting cadavers to understand the placement of all structures in the human body as well as memorization of nerve levels and muscle innervation to better understand an injury or undesirable movement from the level of the whole body.

Our profession works out of evidence based practice that is ever present in our schooling and clinical rotations in the hundreds and thousands of hours it takes to earn a degree to be called a physical therapist. With further education on theory behind placement and safe practices with needles used as a tool in our repertoire of tools to ease pain and decrease dysfunction we can adequately and safely implement the use of this tool to help our patients to return to the activities they desire with decreased pain.

We are not referring to ourselves as acupuncturists as we are using the acupuncture needles in a different way backed by evidence based practices in peer reviewed journals. We are strictly treating movement disorders with our needles as a tool and are not encroaching on the acupuncturists empirical practices of which they claim to assist with nearly all of life's maladies through different points on the body which can be hard to study due to the subjective nature of some claims. Our goal as physical therapists using dry needling as a treatment method is to create a physiological healing response in the body and decrease areas of muscle tension with skilled placement guided by our vast knowledge of human anatomy and interaction of all of the bodily structures.

Please use these facts to guide your decision in who is able to use acupuncture needles in practice in your state as all professionals who are currently using the needles are trained in the way that is needed for them to safely practice in their desired setting. Physical therapists have no desire to utilize needles in the way that acupuncturists do and are not attempting to take business from them. The public's perception of dry needling being heavily associated with acupuncture is understandably confused, but at a professional level there is no reason that there should be a limit on how the needles are used with the current training practices and continuing education requirements needed for certification.

Zachary Skaggs PT, DPT

My name is Michael Tankovich and I am the physical therapist for the Seattle Seahawks' football team. I would like to refute the findings of the Sunrise review on physical therapists and dry needling. Physical therapists have extensive training in anatomy and differential diagnosis related to musculoskeletal and medical conditions and this gives them a solid foundation with which to safely add dry needling as a therapeutic treatment. Most states require 54 hours or less of continuing education for physical

therapists to perform dry needling. Adverse events from dry needling by physical therapists is extremely rare and less than or equal to those from licensed acupuncturists. While dry needling and acupuncture utilize a similar tool they are based on completely different methodologies. Dry needling by physical therapists is a Western medicine technique that utilizes a musculoskeletal and movement assessment to guide treatment to restore a patient's movement ability and decrease pain.

Michael Tankovich PT,DPT, L/ATC, CSCS
Physical Therapists for the Seattle Seahawks

Physical Therapists are more than qualified to perform dry needling. We are Doctorate level trained medical practitioners who have extensive education in anatomy and physiology. For example I did my PT school gross anatomy at Harvard Medical School. The head professors said that we, PTs, learn more about **the musculoskeletal system then the MDs.**

The Acupuncturist argument that we may injury a PT is just not valid and is quite frankly offensive. We go through much more rigorous and extensive training than any Acupuncturist. They argue that PTs may "puncture a lung" or do other harm and this is just inaccurate. Out of the millions of PT treatments performed between 2009 and 2014 there were 3600 complaints issued against PTs, this is a tiny percent of complaints. Out of those complaints only 20 involved dry needling, which is a much smaller percent. Acupuncturists are using the argument of "patient safety" is a guise. The true concern is they feel like they would lose business.

I ask you how are 41 other states successfully allowing PTs to perform dry needling if it is not safe or appropriate?

Maybe the training should be more than 54 hours but PTs are skilled enough and well trained to safely perform dry needling!!

I support physical therapists adding dry needling to their scope of practice. I would like the right to choose to see a PT for dry needling, or an acupuncturist for acupuncture, as I believe they provide different treatments. I know physical therapists will provide safe and effective care.

Patient care and the ability for them to appropriately receive the services they need should be the issue here, not Acupuncturists being concerned about losing business. Physical Therapists are without a doubt qualified to perform dry needling. We are trained in differential diagnosis which allows us to know when a patient is appropriate for PT or needs some other service.

Thank you for taking the time to read this and make a decision based on what is best for the patient, not what is best for Acupuncture business.

Ben Larner DPT, OCS

I am writing to express my support for the inclusion of dry needling within the scope of practice for physical therapists in Washington State.

Dry needling can be an effective intervention within a physical therapist's plan of care for patients with musculoskeletal conditions, such as tight, sore muscles.

Physical therapists receive doctoral level education including extensive training in anatomy and physiology prior to being licensed. In addition to this training, those engaging in dry needling typically pursue additional training to learn special techniques utilizing monofilament needles and cover safety and health issues related to using these tools. I can't think of a more competent provider to treat musculoskeletal conditions with a monofilament needle than a PT!

When physical therapists use dry needling, they are practicing physical therapy NOT acupuncture.

Physical therapy is a profession that safely serves patients and the public with many tools and interventions. Please allow dry needling to be one of them in Washington State, just as is the case in many other jurisdictions across the United States.

David B. Bond, PT, DPT

I support physical therapists adding dry needling to their scope of practice. I would like the right to choose to see a PT for dry needling, or an acupuncturist for acupuncture, as I believe they provide different treatments. I know physical therapists will provide safe and effective care.

Jeannett Penner, DPT, OCS, GCS

The practice of dry needling depends on physical examination of patients and requires knowledge of anatomy, physiology and the effect of muscle tightness and trigger points on the kinetic chain and human function.

Acupuncture is a form of Eastern medicine depending on evaluation of pulses, tongue and ear to determine treatments of meridians for energy flow. They are not the same thing, and share only the tool used. The training required for the two different forms of treatment are not the same. Acupuncturists are not trained to perform Western medicine, nor should they be doing that. Physical therapists are not trained to work in the area of Eastern medicine and should not be doing that.

The issue is very much bigger than what tool is being used. The apparent lack of understanding of these issues has led to incorrect judgement about scope of practice.

Kim Bennett PT PhD

Lecturer, Department of Rehabilitation Medicine PT Curriculum University of Washington

I am writing in response to your surprising sunrise review draft report related to dry needling and physical therapy practice.

OVERLAPPING SCOPES OF PRACTICE

I subscribe to the historical view that overlap is to be expected between disciplines in order for access to high quality care. No one profession owns a particular treatment technique. Trigger points and acupuncture points may overlap, but the difference between Western and Eastern medicine treatment philosophies remains. This is precisely the reason that “acupuncturists” in Washington recently changed their practice act title:

18.06.005 Intent—2010 c 286.

The legislature intends to recognize that acupuncturists licensed by the state of Washington engage in a system of medicine to maintain and promote wellness and to prevent, diagnose, and treat disease drawing upon the experience, learning, and traditions originating in East Asia, which include more than acupuncture alone. To reflect this reality, the legislature intends to change the state's professional designation of acupuncturists to East Asian medicine practitioners and to incorporate current statutory provisions governing acupuncture, while recognizing treatments, methods, and techniques used in East Asian medicine. The legislature does not intend to require persons licensed under chapter 286, Laws of 2010 to change the business name of their practice if otherwise in compliance with chapter 286, Laws of 2010. It is further the intent that any federal law, regulation, or health insurance program applicable to licensed acupuncturists apply to persons licensed under chapter 286, Laws of 2010 as East Asian medicine practitioners.

[[2010 c 286 § 1.](#)]

When East Asian Medicine Practitioners refer to Qigong, or Tai Chi, physical therapists do not expect them to reference exercise, nor does any profession expect Tui Na to be reported as massage. These are certainly overlapping areas of practice, with different names based on practice philosophy.

QUESTIONS REGARDING YOUR RECOMMENDATIONS:

The recommendations made by the Department of Health seem somewhat contradictory. It seems that dry needling **could be** within the scope of practice but should only be added upon completion of your recommendations. In the past it seems you would actually make the recommendation that it **should be added** to the scope of practice with the legislature's approval, meeting your recommended terms? In the past this was the route taken with spinal manipulation for example. Are you recommending that we first have another sunrise review, or proceed directly to the legislature with more detailed bill language?

As a person who was directly involved with the spinal manipulation debacle please be aware that we immediately took the tack of negotiation with the WEAMA: Washington East Asian Medicine Association, but they were unwilling to negotiate with us beyond the suggestion that we go to acupuncture school. They did not meet after one meeting with the leadership at the PTWA, Physical Therapy Association of Washington.

Recommendation: The department recommends:

- Further study to identify the appropriate level of training needed for physical therapists to safely perform dry needling that includes supervised clinical experience. Collaboration with needling experts, such as EAMPs and medical acupuncturists is strongly encouraged to identify core training and supervised clinical oversight for physical therapists to safely perform this procedure.
- Any future proposed bills to add dry needling to the physical therapy scope of practice should clearly limit the definition to treatment of trigger points within the practice of physical therapy.
- The applicant group should acknowledge the overlap between dry needling and acupuncture. Proposed legislation should clearly include authority for physical therapists to perform acupuncture in the limited practice of dry needling and should clearly authorize them to use acupuncture needles in this limited practice.

The recommendation by EAMPs and their representative organizations of requiring an EAMP degree as the minimum level of training to perform dry needling does not appear to be the least burdensome alternative to the proposal. Some acupuncture training may be beneficial for performing dry needling, but completing a full EAMP training curriculum and clinical experience would not be necessary to safely perform dry needling in the scope of physical therapy practice.

PERSONAL COMMENT

It seems surprising, to me, that you would in detail explain all of the differences and overlap in the realm of acupuncture v. dry needling, rather than make a suggestion as to what would be a more appropriate depth of additional patient casework for physical therapists to safely perform trigger point "needling" in the future, to create a means of expeditious patient care.

This also seems to be an inappropriate quote, there is likely only one physical therapist that may have possibly stated this. "Some **physical therapists** contradict the applicant report, stating that there are studies that show using traditional acupuncture points is more accurate than palpation for identifying where to needle trigger points." Regardless, its place in your report seems baseless and inappropriate.

I would truly appreciate a response to the questions I've posted to clarify the direction from your recommendations. My comment is my own personal opinion and does not reflect that of my professional association.

I am writing in response to statements in the dry needling sunrise review draft report, regarding the safety of needling techniques during pregnancy. Specifically:

“WEAMA also noted that not all dry needling resources are in agreement on the safety of dry needling during pregnancy, noting that Dr. Gunn of IMS dry needling considers dry needling to be contraindicated during pregnancy.”

Attached below is a critical review of this topic, currently being reviewed for publication. I ask that the scientific, physiological, and clinical implications highlighted in this article be given weight in the Department of Health’s review of this topic and that the aforementioned reference be removed or significantly modified based on the current scientific evidence.

Dry Needling of “Forbidden Points” During Pregnancy:

Does the Evidence Support the Stated Risk?

Dry needling using a thin filiform needle by physical therapists to treat and stimulate peri-neural, muscular, and connective tissues for pain and functional impairments is becoming increasingly common.¹ There is emerging literature suggesting dry needling as a treatment modality for an array of diagnosis² including: osteoarthritis, lumbosacral pain, pelvic pain, myofascial neck pain, plantar fasciitis, fibromyalgia, and functional impairments after CVA^{2,3,4,5,6,7,8} is beneficial. Unfortunately for people suffering from these conditions, dry needling provided by a physical therapist is not always regionally available to them. One such region is Washington State.

A bill was introduced to the Washington State legislature to specifically include dry needling in the physical therapy practice act.⁹ This bill stalled in the Senate committee, at least in part due to testimony by opposing stakeholders that the limited knowledge of traditional acupuncture points called “forbidden points” would cause a physical therapist performing dry needling during pregnancy to inadvertently harm or cause a miscarriage.¹⁰ A powerful statement, that certainly resounded with healthcare committee members. Without question a mother and her developing child should be treated by the healthcare community with the utmost care and caution. No healthcare professional would wish to provide a treatment endangering either. A physical therapist adopting or applying a new treatment technique such as dry needling should proceed with caution. However, it does beg the question, is it true?

Truth is often elusive in healthcare, and the best we can do is search using the pillars of evidence based medicine.¹¹ Needling therapies during pregnancy remain controversial among traditional and western trained acupuncturists,¹² as well as physical therapists performing dry needling.^{13,14} Examination of the merits regarding safety of intentional or inadvertent needling to ‘forbidden points’ during pregnancy raises three questions. First, is there sufficient research evidence that needling of these points poses a significant risk? Secondly, is there evidence a physical therapist using dry needling for a neuro-musculoskeletal diagnosis¹⁵ could inadvertently needle traditional ‘forbidden points’ with enough intensity to create a pregnancy related adverse event? Finally, can best practice clinical recommendations from utilizing needle techniques during pregnancy be identified, to enhance patient safety and technique effectiveness?

The concept of ‘forbidden points’ in pregnancy is prevalent in traditional acupuncture literature. However, the actual points seem to vary according to different schools, authors, and ancient texts.¹⁵ The most frequently cited points in the literature include upper extremity points near the first dorsal interosseous muscle (LI4); proximal to the radial crease of wrist (LU7); and in the upper trapezius partway between the acromion and the spinous process of C7 (GB21).¹⁶ Several points in the lower extremity are frequently cited, including the posterior medial tibia, approximately 4 finger breaths cephalad to the malleoli (SP6); the lateral nail bed of the fifth toe (BL67); a point just posterior to the lateral malleoli (BL60); and the distal musculotendinous junction of the iliopsoas (SP 12).^{15,16} Furthermore, points along the pubic bone (KI11); pubic symphysis, extending to the lower abdomen (CV2-7); as well as, on the sacrum near the foramina (BL27-34) are frequently cited.

The clinical indications for these points in the literature are wide ranging and include dyspepsia, tension-type headache, nausea, pelvic pain, low back pain, fetal malposition, depression, insomnia, and lateral epicondylitis to name a few.¹⁷ Although the clinical indications for needle techniques to these points appears broad, it has been suggested by some in the literature,¹⁸ ancient texts,¹² and public testimony¹⁰ that combining

these points during pregnancy has abortifacient qualities. Yet, in a review by Chen et al.¹⁹ examining the use of acupuncture for abortion in China, the authors found no studies were successful in completing abortive procedures without the addition of pharmacological agent's mifepristone and misoprostol. Furthermore, Tsuei et al.²⁰ and Ying et al.²¹ found no abortifacient qualities with the use of electro-acupuncture to 'forbidden points.' Moreover, there are no conclusive reports that needling procedures can induce labor or miscarriage under favorable conditions, such as, approaching term, post-dates, or intrauterine fetal death.¹⁶ This is consistent with the recent systematic review by Park et al.¹⁷ examining studies from Europe, Asia, Australia, and the UK. The authors found no association between miscarriage and needling procedures which included hand, leg, and sacral forbidden points.

Current literature on adverse events with acupuncture and needling techniques during pregnancy have not found evidence for miscarriage, premature labor, or perinatal complications.^{17,22,23} However, it seems reasonable to examine the physiological constructs in which adverse events or complications may occur. Early embryonic development occurs in a low oxygen environment.²⁴ Acupuncture and dry needling techniques, especially electro-acupuncture have been associated with increased blood flow.²⁵ Theoretically, needling points purported to increase uterine blood flow may have an adverse effect on the developing embryo during early pregnancy.²⁶ However, according to Burton,²⁷ the oxygenation level of fluid surrounding the developing embryo is maintained by invading trophoblastic plugs in the spiral arteries of the placenta. Therefore, increased blood flow to the uterus is unlikely to have any effect on placental oxygenation levels.²⁴ It has also been suggested acupuncture and dry needling to 'forbidden points' could negatively affect progesterone levels.²⁶ Progesterone production in early pregnancy is stimulated by β HCG released from the developing trophoblast.^{28,29} The effect of acupuncture and dry needling on hormone levels appears to be mediated via the hypothalamic-pituitary-adrenal axis with increased adrenocorticotropic hormone noted after needling techniques.³⁰ Additionally, increases in gonadotropin releasing hormone from the pituitary gland may be effected by acupuncture, but this would not result in decreased progesterone levels.³¹ Finally, some observational studies have reported stimulation of SP6 at term has led to uterine contractions.¹⁶ Yet, coordinated uterine contractions are known to occur throughout normal pregnancy. Additionally, stimulation of bilateral extremity points LI4 and SP6 had inhibitory effects on preterm labor.³² Moreover, systematic review data on initiating labor with acupuncture has been inconclusive,³³ and the most recent randomized control trial data has been consistently negative.³⁴

Studies have also questioned if the beneficial effects of acupuncture and dry needling are due to specific acupoint and myofascial trigger point stimulation, or rather non-specific physiological effects triggered by regional needle penetration. In a study by Haake et al.³⁵ the authors compared verum acupuncture, penetrating sham acupuncture, and conventional treatment. They found significant improvement in pain and disability in patients who received needling techniques when compared to conventional treatment. However, there were no differences between verum and sham groups. This has caused several authors to raise concerns regarding reliable identification of traditionally described acupuncture points, which would include 'forbidden points.'¹⁷

It is also reasonable to consider which health conditions a physical therapist providing treatment with dry needling would consistently stimulate multiple 'forbidden points.' For example, a physical therapist utilizing dry needling techniques for lateral epicondylitis or carpal tunnel syndrome may in fact stimulate tissue near proposed 'forbidden points' for the hand and wrist. However, in this case they would have no clinical or physiological rationale for treating foot, ankle or sacral points with dry needling. Furthermore, an examination of the specific points used to stimulate labor, increase uterine contraction, or heighten abortifacient qualities suggests that simultaneous stimulation of either bilateral extremities or upper and lower extremity points is necessary to achieve the desired clinical outcome.^{19,34}

A recent review by Liddle and Pennick,³⁶ found two-thirds of pregnant women reported low back pain and one-fifth report pelvic pain during pregnancy. Several treatment approaches including manual therapy, osteomanipulative therapy, exercise and acupuncture have been shown to provide some relief for low back and pelvic pain. The stated risks of inadvertently dry needling 'forbidden points' would seem to be greatest when treating this patient population. Yet, in a study by Elden et al.,³⁷ examining adverse events in the treatment of pelvic pain during pregnancy, the authors compared women receiving standard medical care, standard medical with stabilization exercise, and acupuncture. Seventeen acupuncture points were utilized, several of which were considered traditional 'forbidden points.' The needles were inserted intramuscularly and manipulated at each site. The authors found no adverse effects during pregnancy, delivery, or in the

fetuses/neonates.³⁷ This would suggest, even with a needle technique that could be considered strong, there is minimal risk of serious adverse events in this population.

Despite consistent literature suggesting the risk of an adverse event is very low with needle techniques during pregnancy,^{17,19,22,23} it is reasonable to exercise clinical caution when treating musculoskeletal conditions with dry needling during pregnancy.^{26,38} Evidence based practice is a blend of research evidence, patient preference, and clinical experience. Thus, experience and observational data at the clinical level should not be discounted.²⁶ Certainly, concerns about the utilization of manual or electro needling techniques during a difficult pregnancy are valid and should prompt the clinician to exercise caution. Recommendations suggesting minimizing the number of needles used, the intensity of the manipulation, and the duration the needles are left in place are reasonable for this population.¹⁴

Physical therapists treating women for neuro-musculoskeletal conditions during pregnancy should be expected to utilize caution and conduct a thorough risk-benefit analysis before proceeding with any treatment technique, including dry needling. In regard to dry needling, this analysis should include the best available objective evidence and clinical experience from all allied health professions treating this population. There continues to be a lack of objective systematic review, controlled trial, or case report data linking dry needling or acupuncture treatment with miscarriage or other significant adverse events during the first, second, or third trimester. Thus, statements that the inadvertent dry needling of 'forbidden points' by physical therapists poses a real health risk to women during pregnancy are misleading and not based on current scientific literature or clinical practice guidelines.

Benjamin Boyle DPT

I am a Physical Therapist in Washington and I am emphatically pro PTs being allowed to perform dry needling. I think it's crucial to remember that PTs have to dissect this tissue as part of their curriculum. Not only did we sit through anatomy, biology, kinesiology, neurology, pathology, etc... We labored for HOURS dissecting skeletal muscles. This entails separating out the blood vessels and nerve tissue. We had to dissect down to the tendon insertions of these muscles keeping blood vessels and nerves intact!! This is an element that Acupuncturists don't get in their education. I took some time and looked through the curriculum of the 10 top rated acupuncture schools. Not one had dissection.

Hearing over and over again that we only get 54 hours to learn this technique is maddening. We have seen the tissue we're treating. We have dissected out blood vessels and nerves. We've seen the insertions into the bone, how deep the tissue goes and how the different layers of muscle move upon one another. It's crazy that we're being told we're under qualified to treat this tissue. This is only one more technique in treating this tissue. We've already spent hours upon hours learning how it's affected with different modalities, including massage, ultrasound, electricity, exercise, pharmaceuticals etc. Now we're being told we should go to acupuncture school to treat with this modality.

I implore the committee to reconsider the education that PTs already have. We are experts at treating skeletal muscle.

Andrea "Andi" Love

I support physical therapists adding dry needling to their scope of practice. I would like patients to have the right to choose to see a PT for dry needling, or an acupuncturist for acupuncture, as I believe they provide different treatments. Both are effective for different patients, but THEY ARE NOT THE SAME THING. I know physical therapists will provide safe and effective care.

As a new PT graduate, practicing full time in the field, I feel competent to make safe choices for my patients, and to use my knowledge of anatomy to employ dry needling to address myofascial pain and muscles with trigger points.

The fact that I have heard arguments against dry needling because the boxes of monofilament needles say “for acupuncture” is ridiculous. It is not the choice of a manufacturer to employ a tool. A company that makes a set of tree pruners cannot say, “for use by arborists only”.

Tyler Howe, PT, DPT

I just wanted to share my opinion regarding this issue. I believe that the initial sunrise report made some excellent points. My primary disagreement is in what is considered “training” in dry needling and how much of that training needs to include physical needle insertion practice.

I’ve been teaching dry needling to physical therapists in the Army for the past 5 years- both during entry level training (DPT) and post-professionally. I would estimate that at least 95% of the knowledge and skills that are required to practice dry needling are academic. Specifically detailed knowledge of 3D anatomy, physiology, and pathophysiology of common musculoskeletal conditions along with palpatory and diagnostic skills are essential pre-requisites.

I would draw the comparison to training for medical doctors. Medical school obviously entails very robust and comprehensive academic instruction, but relatively few hours of “hands-on” training with needles or other invasive tools. These sort of “physical skills” (e.g. dry needling, injections, sharp debridement) are important, but require relatively few hours compared with the foundational knowledge requirements that most healthcare providers undergo.

Similar comparisons could be made to other healthcare professions that perform invasive techniques such as nurses and podiatrists.

54 hours of physical hands-on needling training in my opinion, is more than enough when added to the hundreds of hours of foundational academic preparation that physical therapists undergo. This opinion would seem to be substantiated by any legitimate estimates (published studies) of risk associated with physical therapists performing dry needling.

Shane Koppenhaver PT, PhD, OCS, FAAOMPT
Associate Professor | US Army Baylor University Doctoral Physical Therapy Program
Associate Professor | South College School of Physical Therapy
Faculty | Eastern Washington University Doctoral Physical Therapy Program
Primary Investigator | Geneva Foundation

The Draft Sunrise Review regarding the expansion of the scope of Physical Therapy to include dry needling provides insight and feedback that clarify the necessary language to explicitly allow Physical Therapists to leverage the dry needling technique in their practice. However, the Draft Sunrise Review fails to clearly illustrate why the Sunrise Criterion are not met. The opening paragraph of the Draft Sunrise Review report states that “the Washington State Legislature’s intent, as stated in chapter 18.120 RCW, is to permit all qualified people to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession.” Thus, in order to justifiably deny Physical Therapists the ability to include dry needling techniques in their practice, there should be significant evidence indicating endangerment or harm to the public as a direct result of dry needling. However, the Draft Sunrise Review report fails to indicate any evidence with a solid basis in fact that dry needling is a technique from which the public needs to be protected.

A principal weakness of the report is that it seems to accept, without any detailed investigation or analysis, that acupuncture has an exclusive right to any treatment or technique involving needles. This assumption clouds the issue at hand; the purpose of the Sunrise Review Committee is not to protect acupuncturists’ corner of the healthcare market, but to protect the public from undeniably harmful healthcare practices.

Where the intent of the Sunrise Review is to establish whether or not dry needling puts the public at risk and

renders them in need of protection, the report fails to illustrate that allowing Physical Therapists to dry needle increases the risk to public safety in any way. The report also fails to acknowledge the benefits of dry needling to its patients, which drastically outweigh any statistical evidence of potential harm. The findings of the report and the ensuing recommendation are not consistent with the intention of Washington State legislature in the determination of safe and legal healthcare practices. Furthermore, the opposition has significant motivation to raise this issue in order to protect their corner of the healthcare market, and such motivation compromises their ability to objectively view dry needling by Physical Therapists for its benefits to the public.

The interests and safety of the public are at the heart of this issue, and as previously stated, the report does not in any way demonstrate that there is an overwhelming need to protect the public in regards to dry needling by Physical Therapists. Dry needling, like many other healthcare techniques, is not without risk. However, the facts and data cited in the Draft Sunrise Review report only illustrate that the associated risk is extremely low; low enough that insurance companies providing malpractice insurance consider it to be statistically insignificant:

“A 2012 request from APTA to CNA, the largest healthcare malpractice insurer of physical therapists to provide information on claims against PTs nationally related to dry needling. CNA found no trends relative to dry needling in 5,800 claims and stated “CNA does not foresee the practice of dry needling by a licensed physical therapist as having an immediate claim or rate impact.” (Page 14)

Risk assessment is a pivotal part of insurance companies’ business; their profitability and success is determined entirely by the accuracy of their risk analysis. As dry needling by Physical Therapists is allowed in over half of the United States and every province in Canada, it would be naive to suggest that insurance companies are either ignoring data or failing to do their research. Such a suggestion implies that insurance companies are ignoring data that would quantify the risk associated with dry needling as significant enough to warrant intervention due to an “overwhelming need...to protect the interests of the public.” However, as data that significant would drastically impact the profitability of insurance companies providing malpractice insurance to Physical Therapists using dry needling techniques, it is highly unlikely that is the case.

Other statistics cited in the report include a “less than .04 percent” risk associated with dry needling, as well as a study showing zero instances of pneumothorax in 7,629 dry needling treatments. It is worth noting that these studies were provided by the applicant, and are the only studies referenced in the Sunrise Review Draft Report without any question as to the credibility of the sources or the data. Additionally, the report does not show data that in any way suggests that the public would be at higher risk as a result of dry needling. Without providing any evidence that there is an “overwhelming need” to protect the public, this report is incomplete and provides insufficient analysis to logically recommend against allowing dry needling--a technique that is both proven to be an excellent complementary form of treatment in physical therapy and that is allowed in the majority of the United States and all of Canada. Based on the data given in the report, the logical recommendation would be to allow dry needling as a healthcare practice to continue because of the immense benefits it provides patients and the minimal--statistically insignificant--risk it involves. As aforementioned, the recommendation given by the Sunrise Review Committee is inconsistent with the intention of Washington State Legislature and demonstrates minimal logic or basis in fact.

The scope of this decision is much wider than it seems. The consequences of prohibiting dry needling in Washington State are not limited to Physical Therapists who incorporate dry needling techniques in their practice and their patients, but also Washington State healthcare overall. Dry needling is an approved technique in many states as well as other countries around the world. By limiting Physical Therapists in Washington State and excluding dry needling from the realm of healthcare practices here, we limit the tools our healthcare providers have to help their patients and we put a ceiling on the quality of healthcare providers who choose to practice in our State as a direct result of this decision.

Instead of focusing on how dry needling impacts public health and safety, the report focuses heavily on defining a “qualified” person and the training requirements to meet this definition. While these definitions

and requirements are certainly important in the legislative process moving forward, a disproportionately large amount of the focus of the report is centered around determining the proper amount of training needed to use a filiform needle. Furthermore, the report appears to be heavily influenced by public challenges from the acupuncture community, a community that seems to believe it has exclusive rights to any use of a thin filiform needle. It is true that acupuncturists use needles in their practice, a distinct characteristic of acupuncture in the public eye; it is also true that the only legislation on the books in Washington State regarding the use of thin filiform needles is legislation pertaining to acupuncture. However, the existing legislation does not state that acupuncturists are the only healthcare providers allowed to use dry needles. There is no logical basis to restrict the use of thin filiform needles to acupuncturists only, since the needle is simply a tool which can be utilized in many different manners to serve a wide variety of purposes--all of which could benefit the patient. However, once again the opposition being a member of the acupuncture community calls into question the ability of the opposition to objectively view dry needling as a credible technique for Physical Therapists, separate from the threat it supposedly poses to the unique nature of acupuncture for the use of needles. The reality is that acupuncture and dry needling provide very different forms of relief for patients and dry needling by Physical Therapists poses little to no threat to the corner of the market the opposition wishes to protect for himself.

Returning to the charter of the Sunrise Review Committee, which is to “permit all qualified people to provide health services,” the entire comparison of dry needling techniques in Physical Therapy to acupuncture is almost entirely irrelevant. The only place a comparison has any relevance is where data from each profession can be used to help assess public risk or assist in defining reasonable training requirements for the use of a filiform needle. It seems that the opposition’s argument aims to focus on the training requirements for both professions in order to demonstrate that acupuncturists are more qualified. However, the facts and data provided in the report fail to illustrate how the training requirements for the use of dry needling by Physical Therapists are inadequate when compared side-by-side with acupuncture training requirements. In order to illustrate anything of the sort, the committee would have to do an in-depth comparison between all acupuncture certification programs allowed in Washington State and the full curriculum of the physical therapist degree programs which allow therapists to practice in Washington. A credible comparison would have to establish how each classroom course, supervised clinical experience requirement, supplemental training program, etc. prepare the physical therapist or acupuncturist for the specific act of dry needling as it pertains to treating acute musculoskeletal inflammation or conditions. This treatment as opposed to needling for the purposes of holistic or full-body health, mental issues, illnesses, diseases, etc. which acupuncturists would be qualified to treat. The draft report clearly does not document such a comparison or perform the necessary research to do so, and therefore the continued references to acupuncture and training requirements for certification are irrelevant and further cloud the issue at hand--whether or not dry needling technique provides overwhelming concern for public health and safety.

Given that the training analysis is incomplete, it is very concerning that the report focuses so heavily on acupuncture. The acupuncturist community evidently believes that their business will be significantly impacted if physical therapists are allowed to perform dry needling, a misguided notion with little basis in fact. However misguided the notion, the acupuncturist community would then be financially motivated to oppose the applicants’ proposal, and the arguments introduced by the opposition only serve to generate fear, doubt and confusion surrounding the legitimacy and safety of dry needling as a healthcare practice. The Sunrise Review Committee has an obligation to identify and understand these motivations, as well as to distinguish what is relevant to their criteria and purpose from what is not. From there their task is to make an objective recommendation as to whether or not dry needling by physical therapist poses a threat to public health and safety, independent from politically or financially motivated lobbying from the opposition.

The data and analysis provided in the report and ensuing recommendation do not make it clear that this report is objective. The committee therefore has a responsibility to re-evaluate its review and either provide a recommendation based on the data in the report, or conduct further research and analysis into the relevant subject matter before making a final recommendation.

Strictly based on the data included in this report, the following recommendations could be factually supported:

1. Modify the proposed legislation to require a doctoral degree for dry needling certification in Washington. The fact that current legislation in Washington does not require a doctoral degree indeed appears to be a gap in the applicants' proposal and should be addressed.
2. Recommend that the proposed legislation better clarify the definition of dry needling and its intended purpose. It is evident that there is a need for clarification surrounding the use of needles in healthcare practices such as dry needling. As aforementioned, the assumption that acupuncturists have the exclusive right to use filiform needles in their practice clouds the issue at hand; however, it may be necessary to clarify in writing that acupuncturists do not, in fact, have that exclusive right. Additionally, the use of the word "trigger point" as a word commonly associated with acupuncture adds to the confusion. While acupuncturists may indeed be referring to the same points in the human body, that does not mean that a specific profession has ownership of that form of therapy. Physical therapists, massage therapists, chiropractors, gym trainers, and even private citizens perform various types of trigger point therapy every day. However, the Committee's recommendation to use more specific language in defining dry needling and the purpose it serves in physical therapists' practices certainly has merit.
3. Recommend that the legislation include periodic training program reviews by the State Physical Therapists Board to ensure that Washington remains aligned with national and global best practices in dry needling training. The 54 hour training requirement for dry needling certification is called into question in the report, but no specific technical or knowledge gaps in the training are identified. The data in the report shows that the current requirement of 54 hours is aligned with (or superior to) training requirements for dry needling in other states, so it is reasonable to conclude that the training is sufficient since the practice has not exposed a public safety risk in any other jurisdiction. A 54 hour training requirement would therefore at the very least be a satisfactory starting point in Washington, and supplemental periodic reviews would ensure that if the risks associated with dry needling increase in the future, the training requirements would be adjusted accordingly.

In conclusion, the principal purpose of the Sunrise Review Committee is to protect the interests and safety of the public in Washington and make a recommendation that is aligned with public interest and supported by significant statistical evidence. Based on the report provided by the Sunrise Review Committee, there is no reason for concern regarding the safety of dry needling by physical therapists--in fact, the risk is so low it is considered by the risk assessment experts at the insurance companies to be statistically insignificant. Thus, the consequent recommendation is inconsistent with the intention of Washington State legislature and employs very little logic or basis in fact; if it is not reversed, this recommendation will take away a valuable healthcare practice from patients in Washington State.

Aaron McLuen

My name is Luke Willson and I am a professional football player for the Seattle Seahawks. I have benefitted from dry needling by physical therapists in Canada to recover from injuries that occurred while playing football. Not allowing physical therapists to perform dry needling is unfortunate and will delay the recovery from injury for many professional athletes in Washington State. Please allow physical therapists to add dry needling to their scope of practice so patients may benefit from this effective treatment.

Thank you for considering this rebuttal,
Luke Willson

Please approve dry needling in WA state there is nothing else I can do for my chronic pain. I used to see acupuncturists in the past, they gave me no relief unless they inserted needles into trigger points or sore painful areas I asked them to do. Dry needling helps me to go to work if taken away I have to apply for disability. I also had epidural injections twice this year, if I could avoid doing that with dry needling it would be much more cheaper and efficient.

S Varga

Personally, I was first exposed to Functional Dry Needle (FDN) Therapy in December of 2014. I am a competitive weightlifter and suffered a shoulder injury that my orthopedist was unable to diagnose. Despite rest, it did not get better. I reached out to my national weightlifting community and was introduced to FDN via KinetaCore (a company that does continuing education for PTs) through a national-level lifter that I respect.

After quite a bit of research (I am a former journalist), I contacted Dr. Austin Woods in Kirkland. He is on the teaching staff for KinetaCore, which meant to me that he was among the more knowledgeable in regards to FDN. I went in a little apprehensive, as I generally don't like needles. He put me at ease about the treatment and, after three appointments -- which are covered by insurance, thanks to a progressive company like Mountlake Terrace-based Premera! -- my shoulder pain was gone! I was back to lifting without pain by January and doing additional strength work to keep the injury from coming back.

In Washington State, there are less than a dozen practicing Functional Dry Needle therapists in the state of Washington, which I am sure is a large part of the reason behind the resounding passing of the bill. However, nationally, more than half of the states in the USA have approved FDN as part of physical therapy care.

What I am having a hard time processing is that this was originally sponsored by Democratic House members. Being a born and raised (District 46) Seattle/Washington Native, I take pride in living in and being from one of the more progressive states in the USA. We are already among the latter half of the country to support it, and since when is Washington one of the last states to adopt progressive standards on an issue?

I worry that the state is being pushed to support anti-dry-needle work without having all the information about the successful effects of FDN. I expect better from Washington.

Mindi Rice

I am a master's prepared registered nurse with 30 years' experience. I have sought help for musculoskeletal issues from a physical therapist with dry needling and experienced relief from the treatments. As a health care professional I am very critical of how I receive treatment as far as hygiene and pain management go, and I suffered absolutely no ill effects from the dry needling. This isn't because I know, perhaps better than most of the general public, what to look for as early signs of infection. It was because there were no issues. None. I experienced immediate relief and 4 years later have not had a return of those symptoms.

As a health care professional who is also very aware of the rising cost of health care, I was astonished to hear that my physical therapist has been prevented from continuing this dry needling treatment because it's not "in the scope of practice". In my visits she would describe exactly where she was going to treat in the painful area and that's what she did. In my early nursing education in anatomy class, the physical therapists were right there with the medical students at the top of the class, knowing exactly where every little part of the body was and what it did. **They are as well-prepared as medical students.** That's why I agreed to try dry needling, and due to the relief I got from it, I am very happy that I did.

Please change the physical therapist's scope of practice to include dry needling. I suffered no ill effects and to the contrary, was able to discontinue treatment for that issue after one session. Isn't that what we want, to treat the patient correctly and efficiently? That's how I practice nursing, and I expect it of the professionals who treat me.

Thank you for your time and consideration in this matter.

Margaret M. Carlson, MSN, RN, NCSN

I am a Canadian resident of WA state. I moved here to be with my now wife 5 years ago (who is American). I am an avid athlete and worked many years as a professional snowboarder. I have injured myself many times and seen physios for recovery multiple times. In Canada, they perform dry needling, also called IMS, and I have had this treatment many times for muscle pain. It has made a huge impact on my recovery times and pain in general. I also have friends that are acupuncturists, and have had acupuncture treatments many times. **THEY ARE VERY DIFFERENT.**

Dry needling/IMS by physios is a fast, intense treatment where you feel the muscle start twitching sometimes and then release. In my experience, it takes 30-60 seconds in one area, and the physio is there the entire time holding the needle. This was usually performed at the end of a therapy session when I would exercise and have other therapy treatments beforehand.

When I've had acupuncture, they have rarely asked me many questions at all about my problems, and usually have me in a quiet, dark room, and insert needles all over my arms, legs, back, and head. I've had them in my hand, in the webbing of my thumb, multiple times being told it was to treat my body pain. Then the acupuncturist leaves the room, coming back once or twice to tap or gently twist the needles, leaving me there for 30-40 minutes unattended.

I've had the best results treating my muscle pain from physiotherapists/ PTs, and highly support adding dry needling/IMS to their scope of practice in WA state.

Physiotherapists in the USA earn a Doctor of Physical Therapy, a higher degree than a Masters for acupuncture. They are safe, spend 3 years studying the body, and are an appropriate profession to offer a life changing treatment for body pain.

Please make the right decision and allow physical therapists to perform dry needling/IMS in WA state.

Brendan Keenan

To my representatives at Wa Stare Department of Health. I support physical therapists adding dry needling to their scope of practice. I would like the right to choose to see a PT for dry needling, or an acupuncturist for acupuncture, as I believe they provide different treatments. I know physical therapists will provide safe and effective care.

Thank you,
Washington resident, Bernadette Castner

Received the same letter from 12 patients and physical therapists, four physical therapists, two physical therapy assistants, and one physical therapy student

In the 3 years I've been recovering from IT Band Syndrome, I have seen 2 General Practitioners, 3 Orthopedic Doctors, 1 hip surgeon, 3 Physical Therapists, and 4 Acupuncturists. It wasn't until I recently found a PT that does dry needling that I finally started to heal. Dry needling was able to reach the deep down muscles in my hips and release the compression. None of the 4 Acupuncturists I went to were able to do this.

The main reason Acupuncturists were not able to heal me is because of the Chi. The Oriental influences that Acupuncturists follow required them to needle me in the opposite part of the body - a healthy part of the body totally unrelated to the injury! Their method of healing centered around balancing the Chi. I went to an Acupuncturist every week for 6 months and my IT Band Syndrome did not heal one bit.

Regarding the education and training of Acupuncturists vs. Physical Therapists, my dry needling Physical Therapist has a Doctorate, completed his Residency, and has over 4 years experience on top of his Residency. He was able to pin point the compressed muscles and release them all in one session. All 4 of the Acupuncturists I saw had only a 2 year degree from Bastyr College.

While the luxuries of acupuncture draw a cult following, serious injuries need more of a logical, scientific remedy.

Please do not do away with dry needling in Washington. I agree not all PT's should have the ability to perform dry needling but perhaps only those with a high level certification.

Sarah Temmerman

Having submitted testimony previously, I'm disappointed to see the initial Sunrise draft on this topic. The efficacy is proven in medical literature and this treatment is not available from acupuncturists, whatever they may tell you.

Clearly, better regulation/guidance can be provided so that qualified/approved DPTs can continue to offer this treatment, but disallowing it altogether is a disservice to the residents of Washington.

Brian Schultz

I'm very disappointed to learn that dry needling may not be available from physical therapists in Washington. I fractured a cervical vertebrae 7 years ago and very nearly lost my job and marriage due to chronic pain. After seeing numerous doctors, chiropractors, spine physiatrists, acupuncturists, massage therapists, a good friend and PT pulled me aside and said, I think I know what is wrong with your neck and I know who can fix it. He was right. He referred me to Peak Spine and Sports and Doctors of Physical Therapy and I saw both due to proximity and availability. After 6 years of suffering, it is reduced from disabling to a minor nuisance thanks to PT, a substantial part of which was dry needling. It is already hard to get in quickly and I occasionally need a follow up. I can't imagine that will improve if PT's are no longer able to do this. Please do not prohibit PT's from dry needling. I've tried everything the traditional and non-traditional medical community offered and it was a PT performing dry needling that saved me.

Scott Hogan

It is with great concern that I read of the decision to add restrictions to the practice of dry needling in our state. As I read through the Sunrise Report, I found several points which made me feel like the Department of Health is making a mistake that will be overall detrimental to public health. I will raise the following concerns:

1. The criteria in the Sunrise act for regulating a profession states a requirement that "the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument." However, in the section detailing evidence of harm, there were only a small number of anecdotes. Honest scientific inquiry places little value on anecdotes, depending instead on data and studies. On the section that detailed evidence of safety, data and studies were provided, showing that risk of injury is exceedingly remote.
2. Restricting the practice of dry needling will drive many of those who have relied on it to using pain medication as an alternative. There is far more data about the dangers and risks of pain medication than there is of dry needling. Further, pain medication can also threaten those around the patient, and I would like to raise in counter to your anecdotes one of my own. My cousin, a police officer, was nearly killed in the line of duty less than a week ago when, while standing in a spot that would have been completely safe from any lucid driver, he was hit by a speeding car. (news story here: <http://fox13now.com/2016/09/29/man-acting>)

irrationally-found-to-be-hit-and-run-victim-officer-injured-after-suv-hits-police-car/). Though not explained in this article, further investigation showed that the driver had been overdosed on painkillers.

3. Progress comes from freedom: We progress as a society by trying things and in doing so, we learn. The more you restrict the freedom of consenting adults to enter into mutually agreed-upon activities, the more our knowledge stagnates.

I urge you to reconsider your choice and allow those who have benefited from dry needling in this state to continue to do so.

Joshua McDonald

I am deeply saddened to here that you are moving in a direction that will not allow trained physical therapists to perform dry needling to patients. Dry Needling has revolutionized my life. This is not an exaggeration. I am baffled that you would do something like this. I am an adult, I consent and seek out this treatment. You are literally decreasing the quality of my life from this choice and I weep because of it.

Nearly 10 years ago I injured my back and as a result my right leg used to go numb whenever I tried to walk even around the block in my neighborhood. I tried doing just regularly physical therapy, which helped, but did not alleviate the numbness or pain I experienced every day of my life. I did physical therapy - but beyond that the only path is back surgery. Which is complicated, expensive, and involves a whole new set of risks. Risks I do not feel willing to take at this point in my life.

Two years ago I moved to Washington and a friend recommended dry needling. My whole life changed. I have read the bulk of your 28 page proposal to ban physical therapists from dry needling. One of your claims is that if there were evidence that people already seeing physical therapists could benefit from dry needling financially it would be given greater consideration. Well, I am that example, and I am certain there are many more like me who simply haven't spoken up. My insurance does not pay for my dry needling. I get both therapy exercises and dry needling in one visit from one doctor. I cannot afford to visit an acupuncturist as well.

And, on the subject of acupuncturists, I have visited them in the past and it was a terrible experience for me. I was left alone in a room with needles in my body, some quite uncomfortable, for 30 minutes. I was stressed, nervous, and in pain. My physical therapist has never left me alone. He is by my side all the time he is working on me. I feel safe, comfortable, and confident in his abilities.

I feel at such a loss. I know to you I am no one. But to me you are people who condemn me to pain and immobility. I don't want to live dependent on pain killers. And I do not feel confident or comfortable with an acupuncturist, and as mentioned, I cannot afford to see them. My physical therapist works with me on things that an acupuncturist cannot.

I have heard this described as a turf war - and that is what it looks like to me. People who just want to maintain control of something to keep the money in their pockets.

Following through with this law would lead me to seriously consider moving out of the state - to somewhere it is allowed.

There is so much more I want to say. I would be happy to write again or even come in and meet with someone face to face. This is that important to me and I wish I had written sooner, I just had a hard time believing this would actually pass. Clearly I was wrong. Please reconsider this choice and allow physical therapists to continue to dry needle in the state of Washington.

Tami McDonald

I wholeheartedly support PTs practicing dry needling. After hip surgery, dry needling is basically the only therapy that gives me pain relief and improves mobility. I have received all dry needling from PTs in both WA and MA state

Dermot Kennedy

My name is Michael Fitzsimmons, I have suffered for over 25 years with chronic lower back pain. I and my insurance company have spent literally thousands of dollars on treatments to alleviate the pain. The treatments have included acupuncture, many bouts with chiropractic adjustment, and medication all to no results. I heard about dry needling from a personal fitness trainer and although skeptical, I decided to give it a try. After 3 sessions and possibly semi annual follow ups with the PT, I am completely pain free and found the cure for my pain. It is extremely disturbing to me that this treatment is going to be withheld from the public based on the educational biases of certain interest groups. Please don't make me move to a different state in order to continue my quality of life.

M. K. Fitzsimmons

I have utilized dry needling treatment on 3 occasions over the last 4 years for various issues. All results have been phenomenal. We have the right to choose our treatments and it makes no sense what you are trying to regulate. Patients have the responsibility to be informed and have options available. I am deeply saddened by your actions and my health will suffer at your hands.

Julie Coombs

To whom it may concern, dry needling in Washington is a welcomed treatment and expands the diversity of available treatments to all in our state.

I personally investigated dry needling approx. 10 years ago in the UK. I read that it has been regularly used by the US military for many years. I also read that the medical advisors to a couple of Presidents of the US also endorsed it. (reference https://en.wikipedia.org/wiki/Janet_G_Travell)

This was enough of an argument *for* the treatment for me, although I read many books on the subject before forming an honest opinion.

Janet G. Travell - Wikipedia, the free encyclopedia
en.wikipedia.org

Janet Graeme Travell, M.D. (December 17, 1901 – August 1, 1997) was an American physician and medical researcher. She was born in 1901 to John Willard and Janet ...

My love for the treatment comes from 2 main viewpoints -

* the first is that practitioners of dry needling are very much of the opinion that invasive surgery is not necessarily recommended **as a first step** to rehabilitation. Often, after careful examination by PTs specializing in dry needling, symptoms are recognized as synonymous with referred pain or pain from damaged muscle tissue. In these cases (which are common) the patient notices fast progress towards recovery after some dry needling. Of course, in other cases, the patients have symptoms that can only be resolved by invasive surgery - but what have they to fear from dry needling? The only possible outcome is that they gave the right amount of time for careful consideration before going for invasive surgery. Too often we find doctors over eager to make referrals to surgeons without (in my opinion) exhausting some non invasive options first.

*Secondly, my personal experience has been that the practitioners of dry needling are also experts in sports injury rehabilitation. This has helped me, my wife and other family members get back to a good level of

fitness and ranges of motion without surgery. Some members have been recommended surgery only to be 'fixed' by dry needling before surgery.

Lastly, dry needling is *similar* in some ways to acupuncture

e - except that dry needling works on physical muscular knots or damage which can be verified by practical science. Acupuncture claims to work on physical and non-physical systems which cannot all be examined practically by science. I am not arguing against acupuncture here but question will acupuncture also be removed from Washington State? I cant imagine so.

My opinion may not count all that much but I as a resident of the state I wanted to express my support.

Thanks for your time reading this from chris woods (supporter of dry needling in WA!)

I just heard that dry needling is not being formalized to be within the scope of PT in Washington. I am literally filling up with tears. Dry needling is the most amazing treatment. I had two running injuries that nothing but dry needling could solve. I had high hamstring tendinopathy. I sought numerous treatments: regular PT, Chiropractor, Massage Therapy, Active Release Technique, and Dry Needling. Dry needling was the ONLY treatment that fixed my problem. A few months later I hurt my psoas and obliques. Again, dry needling saved me. I go in for treatments once a month for maintenance or when I feel like I tweaked something. Since I started treatment, none of the injuries have recurred. I honestly don't know what I would do without it. I am begging you to please reconsider and formalize it. I don't what I would do without it.

Thank you and feel free to contact me if you want more feedback.

Jennifer Margolis

Hi, my name is Fallon Frederick, I am a student of PTA, and have worked as a caregiver and cna for nearly 15 years. I am also poor. CNA's don't typically get paid well, and I have been on state insurance for the last seven years. State insurance doesn't cover alternative medicines, like acupuncture and chiropractic and massage. If the state currently doesn't think these medicines are viable enough to pay for them, then why are they trying to keep their tools isolated to those fields? If we can prove, and we have, that these tools can be helpful in specific treatment, like muscle therapy, rather than vague disorders like depression, why wouldn't we want the public to access these as a way to get better, faster? I would think that you might want to save money by giving access to treatments that help, so that people don't spend months in therapies that aren't helping enough.

I am putting my support behind PT's, DOCTORS, who know what they are doing, and can learn even more to help even more people. Or are we saying that the only people who deserve these helpful treatments are those who can afford them, themselves? Either force insurance companies to accept alternative medicine as viable, or support our PT's to be able to do this allowing access to therapy for EVERYONE.

Fallon Frederick

Thank you for sending this. It's very unfortunate your obviously narrow knowledge of dry needling vs acupuncture is so dominant and you're not open to exploring more than what a few individuals have offered in a formal and probably quite expensive setting. If you did you would realize they have nothing in common. As a patient I've had both. Acupuncture puts pins in your skin and works on energy. Dry needling finds the troubled muscle and makes it react so it can then relax. It has saved me from a shoulder and knee surgery. I am from Canada where it is recognized and accepted as normal physical therapy. I have been back in Washington now for 2 years and thankfully had my most recent sports injuries dealt with by dry needling but I will now have to drive to Vancouver if I hurt myself again and I know it will. I was literally in therapy for 6 months and had acupuncture for my last tear in which 1/2 my body went into protect mode and

would not let go. It caused lower back, hip, knee and ankle issues. I was looking to fly to a foreign country to buy surgery (you can't pay privately in Canada) when I found dry needling/ims and it saved me from something that would have caused more damage and cost excessively more money than 3-5 sessions with the right therapist cost. I know in Seattle (as of yesterday) I could get dry needling by a therapist for \$125/session (less for 3 sessions). Or by a doctor (who isn't affected by your decision) for \$250/session. This doctor used to say they would charge the health care provider for physical therapy and the I would pay the difference which would bring it down to the therapists out of pocket cost with no insurance. Now they are no longer offering this option so the out of pocket, I've been told, is \$250 for treatment.

I have to reiterate how disappointed I am in your decision and though I am not a lawyer I think I've read that you are basically leaving all analysis of this treatment up to acupuncturist who don't even know the technique. That is the hardest thing to understand. If you want to require more training that is fine but why have someone who doesn't even know the basis for the procedure have say over it?!? I encourage you all to leave your offices and actually visit the therapists who offer this treatment. I will volunteer to be the patient so you can watch it take place and will sign away any liability you wish. Then we can go to a acupuncturist and literally see how they approach the same concern. You will be witness to the completely different procedure each is. All medical experts study the body, it's muscles, bones, organs and how things work together. They approach each uniquely even if they share some foundation because the body, the foundation, doesn't change. What works for one person doesn't always work for the other but this is an extraordinarily effective treatment you just took away from the people of Washington. It's legal in so many states and in many countries. We need to evolve and not hold ourselves back from helping people especially with the immense cost of health care and how's it's weighing on our countries and the citizens. This is only helpful. Please take my offer seriously as a test subject for live examples of how each procedure works. I would do anything if it would help you make this accessible by everyone in Washington state who needs it to feel better incredibly quickly.

Thank you -
Kathleen

I am aware that dry needling is not now included in the scope of treatments currently being provided by physical therapists in Washington. This is wrong. The ideal place for needling to be done is under the expertise of physical therapists. In cases where it is indicated, it would be wrong for that patient to be referred to an acupuncturist. This is not acupuncture, it is physical therapy and belongs as such.

Please add dry needling to the scope of practice for physical therapists in the state of Washington.
Thank You, Robert Bjerck DVM

This letter provides rebuttal comments to the draft Physical Therapy Dry Needling Sunrise Review, dated 9/26/16. Thank you for requesting feedback on this draft. The draft raised a serious discrepancy in the position logic.

The draft document leads one to believe that the WA State DOH is not supportive of medical training provided by the US Military. Perhaps Congress needs to review the WA State DOH concerns regarding the US Military training protocol because, as implied in the draft review, the military trained dry needling physical therapists have been deemed to be not qualified to perform said procedure within the State of Washington.

Likewise, the draft document implies that physical therapists who have earned Doctorate degrees in Physical Therapy are less capable than an acupuncturist with far less education.

Both positions are illogical. Therefore, please reconsider the position paper and approve physical therapist dry needling with an initial scope limited to physical therapists holding Doctorate degrees and/or have satisfactory prior military experience.

Thank you, in advance, for your support.

Anne Coxon

Please accept the following for the discussion on Dry Needling.

New malpractice info from PTs is loaded with increased claims and injuries to patients from the use of Dry Needling. Page 22 is a good start but there are claims throughout.

(linked to 2016 CNA report, Physical Therapy Professional Liability Exposure: 2016 Claim Report Update – however link is now broken)

See below for FDA report on injury performed by those with under the 2000 hours of training.

http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfmaude/detail.cfm?mdrfoi_id=5383935

Attached - American Academy of Medical Acupuncture Position Statement and AMA position regarding dry needling

James Shinol

Please do not allow Dry Needling within Physical Therapy's scope of practice. Their training is too limited for this dangerous medically invasive procedure.

Thank you,
Evan Mahoney

Please do not allow Dry Needling to fall under a physical therapist's scope.
Christine and Doug Lodmill

As a Washington State resident, I have used the services of both physical therapists (PT) and acupuncturists for my own health care needs. I see both of these two health care provision disciplines as very important but different areas of expertise. I believe that each should continue to have its own separate and extensive educational requirements.

It appears to me that dry needling IS acupuncture given a different name. I personally would not want “dry needling” to be allowed to be performed by a person with any less education and supervised experience than what is required of those who receive an acupuncture license.

I agree with the Sunrise Review Committee’s decision to deny the physical therapist’s request to allow dry needling within their scope.

I think that the additional suggestions in the draft regarding future applications to the legislature to have dry needling become part of the the PT scope should NOT be included in the final draft. These comments leave open a door that should remain closed.

Physical therapists who wish to perform acupuncture, whether or not they rename it “dry needling” are welcome to seek out the training needed to become dual licensed as an acupuncturist. Similarly,

acupuncturists who wish to perform physical therapy on their clients are welcome to undertake the education and training necessary to become licensed as a PT. The current system was designed to protect the safety of the consumer and it does just that. It does not need fixing.

As a health care consumer, I trust that the level of training acupuncturists are required to undergo is a necessary level of training. Why would the Health Department or the legislature give PT's a "short cut" around that level of training? It doesn't seem safe or fair to me.

Thank you for considering my comments.

Mary Ann Swain

As you are aware I submitted written testimony of my objection to the proposed expansion of physical therapists' scope of practice to include dry needling. Despite being very unwell on the day of the hearing, I felt the issue sufficiently critical to attend and deliver a verbal reading and take Q&A. During Q&A I didn't accurately comprehend a question regarding appropriate hours of training and inadvertently concurred that 300 hours of training would be sufficient for physical therapists to perform dry needling. I hereby respectfully ask you to strike my inadvertent concurrence.

I unequivocally believe that 300 hours of training is INSUFFICIENT for a physical therapist to safely perform dry needling. More specifically, I stand by my written testimony and my position regarding training required for physical therapists to perform dry needling is that of WEAMA. I fully support WEAMA's position on this matter.

Thank you for your understanding.

*Iman Majd MD, MS, EAMP, Dip. ABFM, ABoIM, Dip. Ac NCCAOM, DABMA, ABIHM, CGIMS
Clinical Adjunct Faculty, Bastyr Clinic for Natural Health, and Faculty, Department of Family Medicine,
University of Washington*

My name is Mona Lee-Yuan. I am a NYS licensed physical therapist and acupuncturist with a degree in Oriental Medicine. My training as a physical therapist is extensive, with a background in orthopedics, neurology, anatomy/physiology and western diseases. My extensive training in the western sciences, and my 30 years of experience as a physical therapist, has taught me that Dry Needling performed by any profession other than a licensed acupuncturist or MD poses a serious public safety issue. My training in Oriental Medicine, included 2,625 hours of didactic studies and 410 clinic hours before I was qualified to sit for the NCCAOM exams. Physical therapists are allowed to perform dry needling only after 54 hours of course work which is profoundly unsafe! There are no benchmark exams given after the course work is completed. There has been multiple accidents that include bone infections, nerve damage, and pneumothorax (punctured lungs) due to DN being performed by untrained individuals such as PTs. A recent report was published by HPSCO which is an insurance company that provides malpractice insurance to physical therapists. In that report, they stated that malpractice insurance for physical therapists will increase due to an increase in malpractice law suits caused by DN.

The public is at high risk for serious, and even irreversible injury if Dry Needling continues to be performed by unlicensed professionals. I do not object to physical therapists performing acupuncture, what I object to is their lack of training. If they want to perform acupuncture or DN, then at least satisfy the benchmark for the didactic and clinical experience as all acupuncturists must go through in order to practice in their state.

Thank you,

Mona Lee-Yuan, L.AC, Diplomate in Oriental Medicine (NCCAOM), National Commission for Certification for Acupuncture and Oriental Medicine

I agree with the sunrise review panel's decision to NOT approve the request by PTWA for the addition of "dry needling" to the physical therapy scope of practice. The applicant clearly did not meet the three sunrise review requirements for the increase to their scope of practice.

However, because the applicant has not provided any evidence of a clear and easily recognizable threat to public health, safety, and welfare if authority to perform acupuncture in the limited practice of dry needling is not added to the physical therapy scope of practice, I recommend that the panel **WITHDRAW IN FULL the panel's three recommendations** to the legislature on page four (4) of the draft report.

These three recommendations will:

1) Put public health and safety at risk:

The panel's recommendation "to identify core training and supervised clinical oversight for physical therapists to safely perform this procedure" circumvents the safe guards that have been in place for over 31 years in Washington State law since the acupuncture/East Asian medicine statute was created in RCW 18.06 and the rules that define it. *RCW 18.06 and its rules already list the minimum requirements for core training and supervised clinical oversight to protect public health and safety.* In 1999 the Department of Health denied the application by naturopathic physicians to perform acupuncture under their scope of practice. Even naturopaths who want to perform acupuncture need to become dual licensed as an EAMP. Physical therapists are not trained to the level of physicians. Therefore, as some PTs have done already, any PT who wants to perform acupuncture should become dual licensed as an EAMP in order to continue to protect public health and safety.

2) Create confusion to the public:

The panel's recommendation for legislation "for physical therapists to perform acupuncture in the limited practice of dry needling and...clearly authorize them to use acupuncture needles in this limited practice" is extremely confusing. It creates a false distinction between acupuncture and dry needling where a difference does not exist. Rebranding acupuncture calling it dry needling and allowing a non-acupuncturist/EAMP to perform it under a scope of practice other than a practitioner licensed under the EAMP scope (RCW 18.06) or an MD or DO will cause further confusion as to what each invasive medical procedure it is and who can perform it legally. Dry needling is acupuncture **and all trigger points are acupuncture points.** (See: Melzack R, Stillwell DM, Fox EJ. Trigger points and acupuncture points for pain: correlations and implications. *Pain.* 1977;3(1):3-23.) If a distinction is created how will the public know the PT is practicing "only dry needling" versus acupuncture? Currently PTs practicing it illegally in Washington and other states have been known to describe it as, "like acupuncture, but not acupuncture." This recommendation by the panel would further the confusion.

3) Create a billing nightmare and confusion:

The Medicare billing code for manual therapy does not include the use of acupuncture or syringe needles. The panel's recommendation will create a billing nightmare and confusion as to how the client is to be billed for the procedure of dry needling, and who will pay for it, or be forced to pay out of pocket. If the PTs are going to bill for acupuncture then they need to meet the full requirements of and be licensed under RCW 18.06. Nor do the panel's recommendations address the financial burden faced by clients if injured by a PT using acupuncture needles. Allowing physical therapists to practice acupuncture without completing the full training and education standards required in RCW 18.06, exposes the client to unnecessary health and financial risk.

Alternatively, the panel's recommendation to the legislature should instead include the following:

Because the applicant has **not provided evidence demonstrating the need** for the practice of dry needling (i.e., acupuncture) to be added to their scope of practice, and as acupuncture is available state-wide from urban centers to rural areas, the department recommends physical therapists follow the requirement in their scope of practice, RCW **18.74.015 Referral to health care practitioners—When required.** "(1) Physical therapists shall refer persons under their care to authorized health care practitioners if they have reasonable cause to believe symptoms or conditions are present which require services beyond the scope of their

practice or for which physical therapy is contraindicated. (2) A violation of this section is unprofessional conduct under this chapter and chapter [18.130](#) RCW.”

Again, I recommend the WITHDRAWAL IN FULL of the panel’s three final recommendations on page four (4) of the draft report, and replace with the above recommendation.

Thank you for your consideration.

Lisa vanHaagen, MS, EAMP

Received this same letter from approximately 13 others

I am writing on behalf of the American Alliance for Professional Acupuncture Safety (AAPAS), which is a federation of more than 30 acupuncture associations from around the United States representing primarily Chinese acupuncture practitioners. We are writing to provide comments to the Washington State Department of Health (DOH) on the Information Summary and Recommendations Physical Therapy Dry Needling Sunrise Review (Review Draft). We support the report's draft conclusion recommending against expanding Washington's physical therapy scope of practice to include what the applicant describes as "dry needling."

We do so because what the applicant attempts to re-brand as "dry needling" plainly constitutes the practice of acupuncture. There is no justification for adopting a training or licensure standard that provides any weaker or different level of protection for public health than that required for the practice of acupuncture. For physical therapists who wish to practice both acupuncture and physical therapy, there is a clear and existing path to do so by complying with Washington's current training and licensure requirements for the practice of acupuncture.

While we support the draft recommendation, we believe strongly that the language in the draft report must be changed to accurately reflect the medical and scientific reality that the insertion of acupuncture needles for the purpose of curing,mitigating,treating,or preventing disease or other conditions, especially musculoskeletal and connective tissue disorders, including musculoskeletal pain,is the practice of acupuncture. The report hedges on this fact when it states, for example, that, "many trigger points correspond with acupuncture points and meridians" and "[m]any trigger points correlate with traditional acupuncture points and meridians." At 4, 6,23.

The notion forwarded by the applicant that the practice of acupuncture is somehow defined by the insertion of needles into fixed or static "acupuncture points" and the stimulation of "meridians" is simply factually wrong. It also reflects a disrespectful ignorance about both the practice of acupuncture as it was invented and developed in China and as it has been continuously used for more than 2,000 years. Acupuncture has always included the insertion of acupuncture needles into "reactive (painful) acupuncture points," which are the very taut or sore areas of muscle the applicant asserts are "trigger points."

Inserting an acupuncture needle into trigger points for the purpose of curing,mitigating, treating,or preventing disease or other conditions, especially musculoskeletal and connective tissue disorders, including musculoskeletal pain, is the practice of acupuncture regardless of whether the persons engaged in such acts intend to practice acupuncture or are even aware they are practicing acupuncture. This point and others demonstrating that dry needling is acupuncture are addressed in a recently published paper titled, "Evidence That Dry Needling is the Intent to Bypass Regulation to Practice Acupuncture in the United States.." See Attachment 1.1 The paper accurately describes the 2,000-year use of "trigger points" in the practice of acupuncture and documents a number of the primary promoters of dry needling acknowledging in a non-regulatory context that dry needling is based in acupuncture. For example, the paper quotes Dr. Yuntao Ma (the founder of the American Dry Needling Institute and Dr. Ma's Integrative Dry Needling,one of the largest dry needling training companies in the United States): "ON [Dry needling] originated in Traditional Chinese methods, and has developed from the ancient empirical approach to become modern,evidence-based practice."23 Dr. Ma is himself a licensed acupuncturist.

The attempt by the applicant to frame "dry needling" as an invention of Western medicine distinct from acupuncture constitutes a classic case of cultural appropriation that disrespects an important aspect of Chinese history and culture. This attempt is unacceptable, and the State of Washington should not validate the applicant's unsupported and non-factual claims. To be clear, while we believe it is critical for the Sunrise Review Committee to explicitly recognize the reality that "dry needling" is the practice of acupuncture, and not merely similar or related to it, we recognize that this does not directly answer the broader question of whether physical therapists should be authorized to practice acupuncture.

On this larger point, we believe that there is simply no public safety or medical basis for requiring a weaker or different level of training for the insertion of acupuncture needles when such acts are engaged in by a physical therapist as opposed to an acupuncturist. We represent and support many practitioners who opted to treat patients as dual-licensed practitioners. Any interest by physical therapists in avoiding the requirements of dual licensures as a matter of convenience, however, cannot justify the serious public health risks that would be presented by supporting their proposed training framework, which would result in grossly inadequate training in the use and safety of acupuncture needles.

1. Fan AV, Zheng L, Yang G. Evidence that dry needling is the intent to bypass regulation to practice acupuncture in the United States. *J Alrn Complement Med.* 2016 Aug;22(8):591-3.
2. Id. at 2 quoting from Ma YT. *Biomedical Acupuncture for Sports and Trauma Rehabilitation: Dry Needling Techniques.* St. Louis, MO: Churchill Livingstone Elsevier, 2011.
3. Integrative Dry Needling website. <https://intemivedrvneedling.com/about-us/dr-yun-tao-ma/>. Accessed August 9, 2016.

Pei Li Zhong-Fong, Lac, FABORM
Vice-President, AAPAS

Attached is the Society for Acupuncture Safety's (SAS) rebuttal to the Sunrise Review Panel's draft report on dry needling. Included with this document are two attachments, "Top Two Facts You Really Need to Know about Dry Needling" as well as the "Motion for Partial Summary Judgment" in the State of WA ex rel South Sound Acupuncture vs. Kinetacore, et al, King County Superior Court, dated 10-14-2014. Please include these two attachments with the rebuttal document as part of the official public record. I request that these documents be referenced in the final report.

The Society for Acupuncture Safety (SAS) represents the interests and concerns of licensed acupuncturists (EAMPs) and patients receiving acupuncture in the State of Washington. SAS seeks 1) to provide accurate information to regulatory entities, health care providers, and the public regarding the safe and effective practice of acupuncture and 2) to advocate that only those providers who have attained appropriate formal training in acupuncture/East Asian medicine practice this surgical procedure.

SAS commends the Sunrise Review Panel ("Panel") for its recommendation not to add so-called "dry needling" to the physical therapy scope of practice. We concur that the applicant provided no meaningful evidence regarding its specious claims regarding cost-effectiveness, patient preference, and safety, while simultaneously neglecting to include vital information related to patient injuries caused by physical therapists inserting acupuncture needles into patients' bodies.

While we agree with the Panel's decision not to recommend the addition of acupuncture to the physical therapy scope of practice, we believe there are some fundamental deficiencies in the draft, and respectfully provide this rebuttal to the Physical Therapy Dry Needling Sunrise Review (Review Draft) in order to clarify some statements in the document.

We assert the following:

- So-called "dry needling" is acupuncture¹

- The State of Washington already has stringent educational and training requirements for non-physicians wishing to practice acupuncture (RCW 18.06)
- In the State of Washington, it is illegal for anyone not licensed as an EAMP or MD/PA to perform acupuncture
- In the State of Washington, it is illegal for anyone not licensed as an EAMP or MD/PA to purchase, possess, or use acupuncture needles, which are Class II (special controls) medical devices regulated by the Federal Food, Drug, and Cosmetic Act (FDCA)
- No special dispensation or double-standard with regard to acupuncture training is acceptable; all persons should be subject to the same level of appropriate formal training
- The Washington Legislature ensures the public's health and safety through respective practice acts to ensure that only well-trained practitioners may practice surgical procedures like acupuncture
- Should a Physical Therapist (or any other allied health professional) wish to practice acupuncture, he or she should acquire appropriate formal training as stipulated by the Legislature in 18.06 RCW , and acquire a dual-license as an EAMP

ACUPUNCTURE

So-called “dry needling” is acupuncture. To be clear, it is not a technique, a subset, or a form of acupuncture; it is acupuncture. Even the American Medical Association (AMA) has stated that so-called “dry needling is indistinguishable from acupuncture.”² The act of piercing and stimulating tissues with an acupuncture needle to cure, mitigate, treat, or prevent disease or other conditions constitutes the practice of acupuncture, regardless of practitioner training or intention.

Acupuncture is an act—a surgical procedure, and efforts on behalf of the physical therapy profession to re-define and appropriate acupuncture by promulgating the term “dry needling” are deliberately misleading. The repeated use of false terminology (“dry needling”) intended to re-define an existing term (acupuncture) in intended to create a distinction without a difference.

TRAINING

In its Review Draft, the Panel states that “there is no supervised clinical experience requirement (Page 3),” and “there is no standard curriculum for dry needling courses” (Page 19) for so-called “dry needling.”

- There is, in fact, a supervised clinical experience requirement, as well as a standard curriculum; RCW 18.06 stipulates the appropriate formal training required by the Legislature for a person to practice acupuncture. We recommend that the Department include language affirming this fact in its final draft and strike the second bullet point from its Findings on Page 19, since this statement is inaccurate.

The Review Draft states, “the department finds that this type of collaboration would be helpful in identifying minimum training and clinical oversight requirements for safe and effective use of needles” (Page 4).

- Again, the Legislature has already established minimum training and clinical oversight requirements for the safe and effective use of needles; those requirements are set forth in RCW 18.06, the acupuncture practice act. We assert that the Legislature, as well as Washington Courts,³ has already made it clear that anyone wishing to insert acupuncture needles into a patient's body for therapeutic purposes must acquire an EAMP license, or be a licensed physician. We do not agree that a double-standard should be created for physical therapists to practice acupuncture with less training that stipulated by RCW 18.06. Our position is that any physical therapist wishing to perform acupuncture should acquire a dual-license. We recommend that the Department affirm that dual-licensure is the appropriate avenue for a physical therapist to practice acupuncture.

correspond with acupuncture points and meridians, this definition is confusing and would be difficult to enforce” (Page 4).

- All trigger points are acupuncture points. There is no difference between a so-called trigger point and an acupuncture point. In a study by Melzack, *et al.* published in the journal *Pain*, research showed that “every trigger point has a corresponding acupuncture point.”⁴ *Trigger points are acupuncture points*; the insertion of needles into these points is the practice of acupuncture. We suggest the Review Draft be corrected to include accurate information stating that all trigger points are acupuncture points (see Page 4, Paragraph 3; Page 6, Paragraph 3).

We concur that this definition is problematic because it is patently false. If the physical therapy scope of practice is ever expanded to include acupuncture, will the Department monitor each physical therapist that is practicing this procedure to ensure that he or she is only needling painful trigger points (i.e., painful acupuncture points)? The answer is, of course, no. Will any needling of a point that is not specifically painful constitute a violation of the physical therapy practice act? If yes, how will the Washington State Department of Health (DOH) monitor safe practice, and enforce the practice act? The answer is, it cannot, so the expansion of the physical therapy scope of practice to include a limited practice of acupuncture is unenforceable and, therefore, untenable.

The Review Draft states, “any future proposed bills to add dry needling to the physical therapy scope of practice should clearly limit the definition to treatment of trigger points within the practice of physical therapy” (Page 4).

- As stated above, we do not agree that the physical therapy practice act should be expanded to include acupuncture, which is a surgical procedure. The needling of trigger points (i.e., acupuncture points), which is the practice of acupuncture, is already a regulated procedure under RCW 18.06.

The Review Draft states, “proposed legislation should clearly include authority for physical therapists to perform acupuncture in the limited practice of dry needling” (Page 4).

- We object to this recommendation and believe it should be stricken from the report. As stated earlier, we assert that if a physical therapist, or any other allied health professional, wishes to practice acupuncture, he or she should acquire the appropriate formal training stipulated by the Legislature and acquire a dual-license. We do not agree that physical therapists should be granted the legislative authority to practice acupuncture at a reduced standard and do not believe a “limited practice” which involves the invasive insertion of acupuncture needles through the skin and into patients’ bodies is pragmatic or enforceable, nor can it be assumed to ensure the public’s health and safety. Either a person has the legislative authority to insert acupuncture needles into a person’s body or s/he does not. There is no way to limit the practice of needle insertion, and, as stated earlier, we reiterate that the Legislature has already made clear the training requirements for the practice of acupuncture in RCW 18.06.

The Review Draft states, “the recommendation by EAMPs and their representative organizations of requiring an EAMP degree as the minimum level of training to perform dry needling does not appear to be the least burdensome alternative to the proposal. Some acupuncture training may be beneficial for performing dry needling, but completing a full EAMP training curriculum and clinical experience would not be necessary to safely perform dry needling in the scope of physical therapy practice” (Page 19).

- We respectfully disagree, and ask that this bullet be stricken from the Review Draft. First, we again assert that so-called “dry needling” is acupuncture. We assert that the “least burdensome alternative” does not translate into ensuring safe practice, and truncated training for the benefit of the physical therapy profession cannot safely ensure that only well-trained providers practice acupuncture. We do not agree that any such arrangement to enable a physical therapist to perform acupuncture at a reduced training standard would benefit the public, as the Legislature has already stipulated which requirements are necessary to practice acupuncture safely and effectively. Since the applicant failed to provide any evidence of efficacy, safety, cost-effectiveness, or benefit to the public—while simultaneously neglecting to include available evidence of patient harm caused by

dual-licensure is not appropriate? We assert that training in the practice of acupuncture requires time, effort, and dedication, and the appropriate venue to learn this surgical procedure is in acupuncture school, where proper safe practice can be taught and supervised. We affirm that the Legislature was clear in determining the training required for a profession to perform invasive therapeutic (surgical) procedures, none of which a physical therapist is allowed to perform under Washington law.

ILLEGALITY OF PHYSICAL THERAPISTS PERFORMING ACUPUNCTURE IN WASHINGTON

In the State of Washington, it is illegal for physical therapists to purchase, possess, or use acupuncture needles (i.e., to insert an acupuncture needle, or any similar device) through a patient's skin and into his/her body. Purchasing, possessing, or using acupuncture needles constitutes a violation of the Federal Food, Drug, and Cosmetic Act (FDCA) and FDA's regulations. The Washington Legislature has not deemed physical therapists "qualified practitioners of acupuncture" which is the requirement of the FDCA and FDA's regulations.

The Washington Courts have ruled physical therapists may not practice acupuncture. Such act constitutes the practice of medicine and is a surgical procedure (*SSAA vs. Kinetacore, et al.*; *State vs. Kelsey*; *State vs. Wilson*). Case law in Washington courts has consistently upheld that acupuncture is a surgical procedure, one which physical therapists may not legally perform. The King County Superior Court was clear in its 2014 injunction barring physical therapists from engaging in illegal practice.

The Washington Legislature has decided that health professions should be regulated in such a way as to protect the public's health and safety by preventing untrained, unlicensed, or otherwise unsafe practitioners from engaging in harmful or unethical behavior. The scopes of practice of each health profession delineate what procedures a given practitioner may perform, based on appropriate training and licensure requirements. Those procedures which entail risk of harm to public health and safety are, therefore, more closely regulated and include invasive therapeutic (surgical) procedures like acupuncture.

The scope of practice for the physical therapy profession is very clear, and does not include the practice of acupuncture (or so-called dry needling, which constitutes the practice of acupuncture). Nor does it include the practice of any invasive therapeutic (surgical) procedure on viable human tissue. The Attorney General and Senate Health Committee have likewise said "no" to physical therapists performing acupuncture—the Attorney General in his opinion, which was requested by Rep. Eileen Cody, and the Senate Health Committee when it voted down SB-6374.

We reiterate that the practice of acupuncture by physical therapists who do not also have a dual-license as an EAMP is patently illegal, and assert that state laws should be enforced by the DOH, as per its charge by state law.

Because so-called dry needling constitutes the practice of acupuncture, and because the state of Washington has stringent laws for the performance of acupuncture, we assert that the only appropriate avenue for physical therapists to practice acupuncture is through a dual-license. The creation of a double-standard in training for physical therapists sets a precedent that dilutes the quality and stringency of appropriate formal training in health professions and does not adequately ensure the health and safety of the public.

Thank you for your kind attention to these comments. We trust that they provided clarification in the sunrise review process, and ask that this letter and its attachments be referenced in the public commentary of any future drafts of the Panel's report.

Respectfully submitted,
John F. Moore, EAMP, LAc
President, Society for Acupuncture Safety

Top Two Things You Really Need to Know about Dry Needling

Motion for Partial Summary Judgment, *State of Washington ex rel South Sound Acupuncture Association vs. Kinetacore, et al*, October 14, 2014

Top Two Facts

You REALLY Need to Know about

DRY NEEDLING

1. Dry needling is acupuncture.

More specifically, dry needling is acupuncture that involves inserting an acupuncture needle (a U.S. Food and Drug Administration [FDA]-regulated medical device) through the skin and into an acupuncture point (a circumscribed area of muscle or connective tissue) that is eliciting a flinch reaction on palpation, now commonly referred to as a trigger point, to cure, mitigate, treat, or prevent disease or other conditions—especially musculoskeletal and connective tissue disorders, including musculoskeletal pain (1).

Dry needling is not new. It was first described more than 2,000 years ago in the Chinese medical literature (1).

2. Dry needling is unsafe when performed by physical therapists.

Dry needling is safe when performed by qualified practitioners of acupuncture, such as physicians and acupuncturists, but it is unsafe when performed by physical therapists—due to inadequate and improper training in acupuncture—as evidenced by the following examples:

- In Colorado, a physical therapist punctured freeskier Torin Yater-Wallace's right lung with an acupuncture needle, causing damage to the lung that led to a pneumothorax (an accumulation of air between the lung and the chest wall, causing the lung to collapse) (2,3). He required surgery to treat the pneumothorax and was hospitalized for five days (2).
- In Georgia, a physical therapist performed dry needling on a 15-year-old girl without obtaining the consent of her mother (4). She collapsed from the dry needling (4).



Freeskier Torin Yater-Wallace gives a thumbs down in the St. Anthony Summit Medical Center in Frisco, Colorado, on November 29, 2013, during recovery from surgery to treat a pneumothorax that he suffered after a physical therapist punctured his right lung with an acupuncture needle. (Photo: @TorinWallace)

- In Maryland, a physical therapist punctured a nerve in high school teacher Emily Kuykendall's left leg with an acupuncture needle, causing damage to the nerve that led to pain, numbness, and paresthesias (abnormal sensations of tingling [pins-and-needles]) (5). She required drugs to treat the pain (5).

"This [nerve injury] is really taking a physical and emotional toll on me," Ms. Kuykendall wrote three weeks after the adverse event. "There is almost not a minute in the day that goes by that I wish that I had not gone to see [the physical therapist]" (5).

- In Arizona, three physical therapists performed dry needling through patients' clothing, which resulted in "findings of substandard care" (6-8). This action placed the patients at risk for injuries (for example, to the heart or lungs) and infections (for example, with "flesh-eating" *Streptococcus pyogenes* or methicillin-resistant *Staphylococcus aureus* [MRSA]) (6).
- In Arizona, a physical therapist disposed of used acupuncture needles in a public recycling container, which violated Arizona's Biohazardous Medical Waste Regulations (Arizona Administrative Code [A.A.C.] R18-13-1401 et seq.) (9). This action placed the public and recycling workers at risk for needlestick injuries and infections (for example, with hepatitis B virus [HBV], hepatitis C virus [HCV], or human immunodeficiency virus [HIV]).

"Dry needling is unsafe when performed by physical therapists."

CNA, a professional liability insurance company, provided the following examples:

- A physical therapist punctured a patient's right lung with an acupuncture needle, causing damage to the lung that led to a pneumothorax

(10). She was hospitalized and underwent treatment for the pneumothorax (10).

- A physical therapist punctured a patient's left lung with an acupuncture needle, causing damage to the lung that led to a pneumothorax (10). She was hospitalized and underwent treatment for the pneumothorax (10).
- A physical therapist punctured a patient's lung with an acupuncture needle, causing damage to the lung that led to a pneumothorax (10). She required surgery to treat the pneumothorax and was hospitalized for three days (10).
- A physical therapist was performing dry needling on a patient's hip when the handle of the acupuncture needle broke off (probably due to the physical therapist using excessive force when manipulating [rotating or pistoning] the acupuncture needle), leaving the shaft of the acupuncture needle lodged in the hip (10). She was hospitalized and underwent surgery to remove the shaft of the acupuncture needle (10).
- A physical therapist performed dry needling on a patient's calf while failing to adhere to basic infection prevention and control practices, resulting in the patient developing a calf infection (10). She required "intravenous therapy and two surgical procedures" to treat the calf infection (10).

Patient safety and quality of care are paramount. Therefore, the National Center for Acupuncture Safety and Integrity (NCASI) agrees with the American Medical Association (AMA) that dry needling should only be performed by qualified practitioners of acupuncture, such as physicians and acupuncturists (11).

Learn More

Learn more about dry needling by visiting NCASI's website at www.acupuncturesafety.org.

References

1. Yellow Emperor's inner classic (黃帝內經, *Huáng Dì nèi jīng*). China; compiled in the first century BCE.
2. Axon R. Torin Yater-Wallace bounces back from collapsed lung with top run. USA Today. 2013 Dec 14. <http://www.usatoday.com/story/sports/olympics/sochi/2013/12/13/torin-yater-wallace-dew-tour-ion-mountain-championship-halfpipe-qualifying/4019707/>.
3. Mutrie T. Torin under pressure. X Games. 2014 Jan 13. <http://xgames.espn.go.com/xgames/skiing/article/10269254/torin-yater-wallace-ski-halfpipe-favorite-winter-olympics>.
4. Adrian L. Dry needling competencies require a minimum of specialized skills. Forum Magazine. 2015;30(2):1-3. http://www.fsbpt.org/Portals/0/documents/free-resources/Forum_Winter2015_DryNeedlingCompetencies.pdf.
5. Kuykendall E. Complaint. 2012 Oct 22. (Internal emphasis removed.)
6. Arizona State Board of Physical Therapy. Consent agreement and order for probation (concerning Michael Duncan, PT). Phoenix, AZ: Arizona State Board of Physical Therapy; 2014 Aug 8. <http://directoryptboard.az.gov/docmgt/10347-14-11-1.PDF>.
7. Arizona State Board of Physical Therapy. Consent agreement and order (concerning Carol Dickman, PT). Phoenix, AZ: Arizona State Board of Physical Therapy; 2014 Oct 31. <http://directoryptboard.az.gov/docmgt/4210-14-30-1.PDF>.
8. Arizona State Board of Physical Therapy. Consent agreement and order (concerning Jacob La Shot, PT). Phoenix, AZ: Arizona State Board of Physical Therapy; 2014 Oct 31. <http://directoryptboard.az.gov/docmgt/8937-14-31-1.PDF>.
9. Arizona State Board of Physical Therapy. Regular session meeting minutes (concerning Noah Abrahams, PT). Phoenix, AZ: Arizona State Board of Physical Therapy; 2014 Sep 23. <https://ptboard.az.gov/sites/default/files/Board%20Meeting%20Minutes%20-%20092314.pdf>.
10. CNA, Healthcare Providers Service Organization. Physical therapy professional liability exposure: 2016 claim report update. Chicago, IL: CNA Financial Corporation; 2016. https://www.cna.com/web/wcm/connect/2d3eaa76-aca2-4f6f-bfd8-e7706368cdac/RC_Healt_PT_Claim_Report_Update.pdf?MOD=AJPERES&CACHEID=2d3eaa76-aca2-4f6f-bfd8-e7706368cdac.
11. American Medical Association. Physicians take on timely public health issues. AMA Wire. 2016 Jun 15. <http://www.ama-assn.org/ama/ama-wire/post/physicians-timely-public-health-issues>.

The National Center for Acupuncture Safety and Integrity (NCASI) is an all-volunteer 501(c)(3) charitable organization. Contributions to NCASI are tax-deductible to the fullest extent of the law.

Copyright © 2016 National Center for Acupuncture Safety and Integrity. All rights reserved.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

SUPERIOR COURT FOR THE STATE OF WASHINGTON
COUNTY OF KING

STATE OF WASHINGTON *ex rel.*
SOUTH SOUND ACUPUNCTURE
ASSOCIATION, a State of
Washington non-profit corporation,

Plaintiff,

vs.

KINETACORE, a Colorado LLC doing
business in the State of Washington; **EDO
ZYLSTRA**, CEO and owner of
Kinetacore; **KERI MAYWHORT**, a
Kinetacore instructor; **EMERALD
CITY PHYSICAL THERAPY
SERVICES LLC** doing business as
**SALMON BAY PHYSICAL THERAPY
LLC**, a limited liability company; **JOHN
DOES 1-10**; and **JANE DOES 1-10**.

ORIGINAL

NO. 13-2-04894-9 SEA

**ORDER FOR PARTIAL SUMMARY
JUDGMENT**

This matter came before the Court upon Plaintiff's Motion for Partial Summary
Judgment and Defendants Motion for Summary Judgment which the parties argued before the
Court on October 10th, 2014.

The Court has reviewed and considered the following:

1. Plaintiff's Motion for Partial Summary Judgment, and the declarations from Brent
**ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 1**

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE,
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

- 1 Foster and Daniel Dingle and all supporting exhibits;
- 2 2. Defendants' Motion for Summary Judgment and supporting declarations and
- 3 exhibits;
- 4 3. Plaintiffs Response to Defendants' Motion for Summary Judgment and supporting
- 5 declarations and exhibits;
- 6 4. Defendants Response to Plaintiff's Motion for Partial Summary Judgment and
- 7 supporting declarations and exhibits;
- 8 5. Plaintiffs Reply to Defendants' Response to Plaintiffs' Motion for Partial Summary
- 9 Judgment and supporting declarations and exhibits;
- 10 6. Defendants Reply to Plaintiff's Response to Plaintiffs' Motion for Partial Summary
- 11 Judgment and supporting declarations and exhibits;
- 12 7. The parties' oral arguments before the court;

13 Based on the foregoing, and after consideration of the standard in Civil Rule 56,
14 NOW THEREFORE IT IS HEREBY ORDERED that Plaintiff's Motion for Partial Summary
15 Judgment is GRANTED and Defendants Motion for Summary Judgment is DENIED. It is
16 further declared that:

- 17 A. A person that "penetrates the tissues of human beings" with an acupuncture
18 needle or any other needle for purpose of "dry needling" or any similar named
19 act ("dry needling") is practicing medicine under the statutory definition
20 provided at RCW § 18.71.011(3) and is prohibited absent a physicians license
21 as required by RCW § 18.71.021; *or other statutory authority;*
- 22 B. ~~There is no factual dispute that defendants are not licensed physicians but have~~
23 ~~penetrated the tissues of human beings with acupuncture needles during the~~
24 ~~Kinetacore workshop and subsequent to the workshop and describe such acts as~~

25 ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 2

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE,
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 "dry needling;"

2 C. The penetration of human tissue with an acupuncture needle or any similar needle
3 used for dry needling is outside the plain text of the authorized scope of practice
4 for physical therapy as adopted by the Washington Legislature in RCW §
5 18.74.010(8);

6 D. The plain text of the physical therapy statute, applicable case law, and the
7 legislative history of RCW § 18.74.010(8) each support that there was no
8 legislative intent to authorize physical therapists to insert acupuncture needles
9 into human tissue for the purpose of dry needling or any similar purpose;

10 E. As such, physical therapists are not exempt from the requirement for a
11 physicians license pursuant to RCW § 18.71.030(4) prior to the penetration of
12 human tissue with acupuncture needles or similar needles.

13 F. Unless otherwise specifically authorized to practice acupuncture under another
14 professional licensures, such as a physician or practitioner of East Asian
15 Medicine, a licensed physical therapists lacks the legal authority to penetrate
16 human tissue with acupuncture needles, or any similar needle, for the purpose
17 of dry needling. Such act constitutes the unauthorized practice of medicine
18 which is prohibited under Washington statute. RCW § 18.71.021; RCW §
19 18.71.011(3).

20
21
22 It is further declared that:

23 6. Defendants are hereby enjoined from inserting acupuncture needles or any similar
24 needles for the purpose of dry needling in the State of Washington;

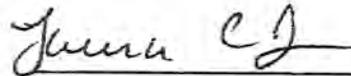
25 ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 3

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE,
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

1 H. Defendant Kinetacore is hereby enjoined from holding any workshops, classes or
2 similar trainings in the State of Washington that involve ~~any~~ ^{conducting} penetration of human
3 tissue with acupuncture needles or similar needles by physical therapists that lack
4 the legal authority to penetrate human tissue pursuant to the findings above.

5 E. _____
6 _____
7 _____
8 _____

9
10 Dated this 10 day of October, 2014.

11
12
13 

14 _____
15 C. Inveen

The Honorable Laura

16 Presented by:

17 **CRANE DUNHAM PLLC**

18 s/ Jason T. Leehan

19 s/Stephen J. Crane

20 WSBA No. 42463

21 2121 Fifth Ave

22 Seattle, WA 98121

23 206-292-9090

24 scrane@cranedunham.com

25 jleeahan@cranedunham.com

LAW OFFICES OF BRENT FOSTER

s/ Brent Foster, Pro Hac Vice

Oregon Bar No. 99263

Attorneys for Plaintiff

ORDER GRANTING PARTIAL SUMMARY
JUDGMENT - 4

CRANE DUNHAM, PLLC
2121 FIFTH AVENUE,
SEATTLE, WASHINGTON 98121-2510
206.292.9090 FAX 206.292.9736

October 10, 2016

Washington State Department of Health
Sunrise Reviews
PO Box 47850
Olympia, WA 98504-7850
sunrise@doh.wa.gov

RE: Sunrise Review Panel Draft Recommendations

Dear Washington State Department of Health Sunrise Review Panel:

Thank you for your time and consideration of my comments. I am encouraged by your draft report's findings and recommendation that dry needling not be included in the physical therapy scope of practice.

However, your draft report and recommendations failed to articulate several salient points regarding the issue of dry needling. I request that you consider these as you formulate your final report and recommendations.

On page 6, the Panel states "Trigger points are described as taut bands of muscle fibers and the applicant attributes the work of Janet Travell, M.D. and David Simons, M.D. with the theoretical origin of dry needling and mapping of myofascial trigger points."

Firstly, dry needling and trigger points are not new. The classical Chinese medical texts describe these anatomical and physiological features as acupuncture points. Furthermore, the terms "dry needling" and "trigger points," as well as the mapping of referred pain patterns, predate the work of Janet G. Travell, MD.

Dr. Travell was very much aware of Dr. Sir William Osler's endorsement of acupuncture and recommended that a quote from Dr. Osler be included in her *Trigger Point Manual*. A letter that she wrote to her co-author David G. Simons, MD, states:

Here is something from [Sir William] Osler's text of 1912, deleted from later editions, on the myalgias and *acupuncture (dry needling)* of the lumbar muscles in acute lumbago. He was really wise.¹ [Emphasis added.]

The first news briefs about dry needling reported the findings presented by Dr. Travell and Dr. Audrie L. Bobb as confirmation of the effectiveness of Chinese acupuncture for ankle sprains and explicitly stated the procedure was acupuncture:

¹ Janet G. Travell Papers, University Archives, Special Collections Research Center, The George Washington University.

The medical way of saying it is "acupuncture." In our language that means sticking a needle into somebody. And according to the scientists it works fine...The American scientists, in that one respect, turned way back to the period B.C. for help.²

See Exhibit 1.

Dr. Travell was very knowledgeable about acupuncture. In addition to her 1912 copy of Sir William Osler's *The Practice of Medicine*, she also cited a French acupuncture text by Roger De La Fuÿe as part of her research for procaine injections under "dry needling... acupuncture."³ This illustrated acupuncture text entitled, "Traité d'Acupuncture: La Synthèse de l'Acupuncture et de l'Homéopathie l'Homéosiniatrie Diathermique, Tome I, l'Utilization Diagnostique et Thérapeutique des Points Cutanés Douloureux," was devoted to "the diagnostic and therapeutic use of painful acupuncture points" (trigger points). During the 1960s, Dr. Travell reported that she had been "corresponding with a Chinese doctor in the World Health Organization concerning the basis of acupuncture."⁴

In interviews, Dr. Travell consistently acknowledged that dry needling is acupuncture and not a new procedure:

Travell said that back in the 1940s when she was giving procaine injections, she experimented with "dry needling" – insertion of the needle without injecting procaine. The procedure was effective in relieving pain, she said, pointing out that acupuncture is not new in Western medicine.⁵

See Exhibit 2.

During the 1970s, Dr. Travell and Dr. Simons exchanged acupuncture articles and acupuncture research studies. Dr. Travell routinely referred to her use of ethyl chloride spray and ischemic compression, which she called "Spray and Stretch" as "acupuncture without needles." In 1974, she was invited to join the editorial board of *The Journal for Research in Acupuncture and Electro-Therapeutics*, an international acupuncture research publication. That same year, she wrote a letter to David Rubin, MD, describing her ideas for an upcoming seminar as follows:

²H. W. N, Albany Democrat-Herald (Albany), March 21, 1947, accessed October 3, 2016, www.newspapers.com

³ *Janet G. Travell Papers, University Archives, Special Collections Research Center, The George Washington University.*

⁴ *Id.*

⁵ B. Z, "Pain Not Where You Think It Is, JFK Doctor Says," Independent Press Telegram (Long Beach), October 26, 1974, accessed October 3, 2016, www.newspapers.com.

The title suggested for the USC presentations is "Acupuncture." I would like to add to that, ... "and acupuncture without needles." That would allow Sung Liao to talk about classical acupuncture, while I could present some basic aspects involved in that and in the use of the vapocoolant spray technic, electrical stimulation, etc.⁶ [Emphasis in original.]

Another interview with Dr. Travell asserts that the insertion of a needle into a trigger point is acupuncture:

Acupuncture and its Japanese version, shiatzu [*sic*], make use of trigger points by inserting needles or, in the Japanese version, by exerting strong finger or hand pressure over the trigger point.⁷

Dr. Travell was mentioned in several acupuncture publications, including "Acupuncture in Western Medicine" by Jean A. Curran, MD, published in 1973, and "More Than Herbs and Acupuncture" by E. Grey Dimond, MD, published in 1975. Dr. Curran's article highlighted Dr. Travell within his history of acupuncture in Western medicine stating:

Apparently acupuncture remained a lost art in the 20th century as far as American medicine was concerned, except for Travell and co-workers at Cornell...Dr. Travell appears to have been one of the very few aware of Osler's endorsement.⁸

Dr. Travell regularly corresponded about acupuncture with several notable physicians who specialized in acupuncture, including Joseph M. Helms, MD; George Yu, MD; and Yoshiaki Omura, MD. For example, she offered her advice to Dr. Yu on study design for his acupuncture research.⁹

Not only did Dr. Travell recognize dry needling is acupuncture, she made clear her opposition to physical therapists performing dry needling in a letter that she wrote to Steven J. Finando, PhD, dated November 11, 1991, stating:

I hope that the New York State Board will *maintain its ban* on the right of physical therapists to perform fine needle insertion into trigger points (dry needling).¹⁰ [Emphasis added.]

⁶ *Id.*

⁷ J. D. "Doctors Manipulate Muscles to Curb Pain," The Arizona Republic (Phoenix), October 24, 1975, accessed October 3, 2016, www.newspapers.com.

⁸ J. C. "Acupuncture in Western Medicine." The Harvard Medical Alumni Review, November/December 1973, 15. Accessed October 3, 2016. <https://archive.org/details/harvardmedical48harv>.

⁹ Janet G. Travell Papers, University Archives, Special Collections Research Center, The George Washington University.

¹⁰ *Id.*

See Exhibit 3.

Concerning dry needling, Dr. Janet G. Travell, Dr. Yun-Tao Ma , and Dr. Chan Gunn did not rediscover or invent anything new or original. Translating classical Chinese medical terminology into English does not equate novelty. What they have done, quite frankly, is appropriated a Chinese surgical procedure, its medical terminology, and the Chinese understanding of how needle therapy affects anatomy, physiology, and pathology as if these were their own discoveries.

Furthermore, physical therapist and proponents of dry needling perpetuate an Orientalist narrative about acupuncture that originated during its early adoption in Europe. Portraying Chinese acupuncture as a foreign, exoticised, uninformed “Other” has allowed physical therapists to present dry needling as an originally Western innovation and therefore palatable to the medical establishment. The rebranding of acupuncture as dry needling is unequivocally the scientific and cultural appropriation of Chinese medicine.

By stating on pages 4 and 23 that “*many* trigger points correspond with acupuncture points” and on page 6 that “*many* trigger points correlate with traditional acupuncture points,” the Panel has inadvertently supported the Applicant’s false narrative. [Emphasis added]

Acupuncture is one of the preeminent and emblematic contributions to World medicine from China and is, and has been for more than 2,000 years, based on anatomy, physiology, and pathology. The Applicant’s framing of acupuncture solely in terms of European metaphysical concepts where by Qi is incorrectly equated to “energy” and Meridians to “lines on the body” is ignorant, inaccurate, and a perpetuation of historic Orientalist rhetorical devices projected onto Chinese culture in order to justify Anglo-American imperialist colonial exploitation of the Far East.

Based on the preponderance of historical evidence included in this letter, Dr. Janet G. Travell did not discover or invent dry needling, nor did she endorse physical therapists performing it.

Thank you for your time and consideration of this important issue.

Sincerely,

L.A. DeLorme
National Center for Acupuncture Safety and Integrity (NCASI) Board Member

Herald **Wednesday, May 21, 1947**

Ancient Pain-Killing Method Works, But U. S. Scientists Don't Know Why

By Harman W. Nichols

CHICAGO, May 21. (U.P.)—Ancient Chinese doctors gave their patients the needle, and two American scientists admitted today they probably had something there.

Particularly when it comes to treating simple sprains, like puffed up ankles.

Janet Travell and Audrie L. Bobb of the Cornell university medical college presented their views on the subject before the 34th annual meeting of the Federation of American Societies for Experimental Biology.

The medical way of saying it is "acupuncture." In our language that means sticking a needle into somebody.

And, according to the scientists, it works fine.

Chinese doctors have been doing it for two thousand years, apparently with good results. And all of this time—or since the early days of American medicine, any-

how—our physicians have been experimenting with this drug and that in order to get a man up and about after he falls and sprains an ankle.

Sometimes that took quite a little spell.

But now comes the needle, and the American scientists, in that one respect, turned way back to the period B. C. for help.

Scientists Travell and Bobb were pretty technical in their paper.

But the sum substance was this: If a needle is inserted (by a skilled practitioner, of course) into a sprained area of the body, the pain is spread to a point where it more or less disappears in a hurry. The swelling is still there, but the pain—no.

They call it "dry needling," and it must have come about by accident. In inserting drugs to pained areas with a needle, the scientists finally came to the conclusion that it was the needle and not the drug which scattered the hurt.

They don't know why—but there it was.

ELIVER TO YOU

H. W. N, Albany Democrat-Herald (Albany), March 21, 1947, accessed October 3, 2016,

www.newspapers.com

Doctors manipulate muscles to help curb pain

By JULIAN DeVRIES
 Republic Medical Editor

SCOTTSDALE — Nerve or muscle dysfunction in the upper part of the back can be a pain in the neck, Dr. Janet Travell of Washington told doctors at the 10th annual meeting of the North American Academy of Manipulative Medicine Thursday in the Safari Hotel here.

Dr. Travell is associate clinical professor emerita at George Washington University School of Medicine, and was President Kennedy's personal physician.

The areas in the body responsible for neck pain, some types of headache, toothache and other pains not ascribable to a direct cause, Dr. Travell said, are distant from the painful area. They are called trigger points, she said.

Acupuncture and its Japanese version, shi-atzu, make use of trigger points by inserting needles or, in the Japanese version, by exerting strong finger or hand pressure over the trigger point.

Pain emanating from a trigger point, Dr. Travell said, usually is caused by muscle spasm, but instead of using acupuncture or shi-atzu, she and Dr. John Mennell of Martinez, Calif., use a cooling, nonanesthetic spray on the affected muscle. The muscle is held in a

stretched position while being sprayed.

Mennell is chief of the department of physical medicine at the Martinez VA Hospital.

The method, both doctors said, also can help in diagnosis. If spraying and stretching of the muscle relieve the spasm but worsen the pain, the cause of the pain may not be in the muscle.

In another talk Thursday, Dr. Irvin M. Korr of East Lansing, Mich., outlined a new theory for the role played by muscle spindles.

Korr is professor of physiology at the College of Osteopathic Medicine at Michigan State University.

Muscle spindles are specialized tissues between the fibers of muscles that are attached to bones. They have nerve connections to the spinal cord. They are the mechanisms that enable muscles to stretch.

Normally, Korr said, muscle spindle nerve activity is constant to keep muscles ready for instant action. When muscles are

stretched, that activity increases.

Because there are changes in the activity of the spindles and their nerves in cases of muscular dysfunction, Korr said, the dysfunction can be the result of an abnormality in those organs rather than in the muscle itself.

According to Dr. C. R. Hooper of Youngtown, secretary-treasurer of the academy, careful manipulation of the spinal column often is instrumental in relieving pain.

Hooper, who is both an osteopathic physician and a doctor of medicine, said that in some cases, a displaced vertebra can be made to go back into place by moving the spine in the direction of the displacement.

Chronic pain, said Dr. Audrie L. Bobb of Santa Fe, is the No. 3 health problem in the United States, trailing heart disease and strokes. Dr. Bobb is president of the academy.

"There is a growing

body of patients for whom medication for the relief of pain is not the answer," Dr. Bobb said. "not only because of their refusal to take drugs, but also because of allergies and other unfavorable reactions. To them, manipulative medicine is a boon."

Membership in the academy, Dr. Bobb said, is limited to doctors of medicine and osteopathic physicians.

IMPLANTED HAIR
 "Look what they did for me!"
New! Millistrand Process!
 Thousands of vibrant strands of natural hair implanted in a micro-thin transparent tissue, that blends perfectly with your very own texture and color.
SWIM IN IT! SLEEP IN IT! SHOWER IN IT!
 For Private Home Showing
DIAL 248-0058
 TERMS AVAILABLE
 4700 N. 12th ST.
 Suite 105
 2 Bks. S. of Camelback
 Hair Pieces and Hair Weaving

CHAIN SAW SALE
 (GAS)
 REMINGTON



J. D, "Doctors Manipulate Muscles to Curb Pain," The Arizona Republic (Phoenix), October 24, 1975, accessed October 3, 2016, www.newspapers.com.

EXHIBIT 3

November 11, 1991

Tri- Steven J. Finando, Ph.D., Lic. Ac.
New York State Institute of
Traditional Chinese Acupuncture
Post Office Box 890, Planetarium Station
New York, New York 10024-0890

Dear Dr. Finando:

Thank you for your letter of October 25, 1991. I hope that the New York State Board will maintain its ban on the right of physical therapists to perform fine needle insertion into trigger points (dry needling).

Enclosed is an updated short biographical note that I had sent to the American Academy of Pain Management early this year. This entire program may interest you, if you have not seen it already.

I have received the February 6-9, 1992 Symposium program of the American Academy of Medical Acupuncture, and I see that John C. Slocumb, M.D. will lecture on myofascial therapy in relation to pelvic pain. Please send me copies of his advance material for this session.

With best wishes,

Sincerely,

Janet G. Travell, M.D.

Enclosure

P.S. Has the hotel been selected yet for our May 1992 Symposium in New York City?

J.G.T.

Janet G. Travell Papers, University Archives, Special Collections Research Center, The George Washington University. October, 2015

October 10, 2016

Washington State Department of Health
Sunrise Reviews
PO Box 47850
Olympia, WA 98504-7850
sunrise@doh.wa.gov

**RE: Rebuttal to the Physical Therapy Dry Needling Sunrise Review (Review Draft):
Acupuncture Needles**

Dear Washington State Department of Health Sunrise Review Panel:

The National Center for Acupuncture Safety and Integrity (NCASI) is an all-volunteer 501(c)(3) charitable organization. NCASI is committed to maintaining public trust in acupuncture by working to ensure its safety and integrity.

NCASI strongly opposes expanding the physical therapy scope of practice to include dry needling (i.e., acupuncture).

NCASI submits the following rebuttal to the Physical Therapy Dry Needling Sunrise Review (Review Draft) (“Review Draft”):

1. On Page 8 of the Review Draft, the Washington State Department of Health Sunrise Review Panel (“Panel”) states the following:

Another *debate* brought to our attention during this review is whether physical therapists are authorized to purchase acupuncture needles, which are regulated by the Federal Food and Drug Administration (FDA). (Emphasis added.)

AND

This analysis *interprets* the FDA regulations to mean that federal law restricts the devices to sale by or on the order of “*qualified practitioners of acupuncture*” as determined by the states. (Emphasis added.)

These statements are inaccurate because the U.S. Food and Drug Administration (FDA) emphatically states that the “sale [of acupuncture needles] must be clearly restricted to *qualified practitioners of acupuncture* as determined by the States,” as reported in the Federal Register of December 6, 1996 (61 FR 64616). (Emphasis added.) See Exhibit 1.

This restriction is not a matter for “debate” or “interpret[ation].”

Accordingly, the Federal Food, Drug, and Cosmetic Act (FDCA) and FDA’s regulations require that the label on a box of acupuncture needles bears the prescription statement “Caution: Federal law restricts this device to sale by or on the order of *qualified practitioners of acupuncture* as determined by the States.” See, *for example*, the label on a box of Seirin-brand acupuncture needles (emphasis added).



The label on a box of Seirin-brand acupuncture needles bares the prescription statement “Caution: Federal law restricts this device to sale by or on the order of qualified practitioners of acupuncture as determined by the States.”

2. On Page 10 of the Review Draft, the Panel states the following:

There is an *FDA-approved* needle that states on the label it is for use in dry needling. (Emphasis added.)

This statement is inaccurate because the FDA has not approved any medical device with device name “Dry Needling Needle” or “Physiotherapy Needle,” as evidenced by a search of

the FDA's 510(k) Premarket Notification database by device name, which returned the following results:

- (1) "No records were found with **Device Name:** *Dry Needling Needle* **Decision Date To:** *10/11/2016.*" See Exhibit 2.
- (2) "No records were found with **Device Name:** *Physiotherapy Needle* **Decision Date To:** *10/11/2016.*" See Exhibit 3.

This database is updated once a week.

Pursuant to the FDCA and FDA's regulations, medical device manufacturers are required to submit a premarket notification or 510(k) if they intend to introduce a device into commercial distribution for the first time or reintroduce a device that will be significantly changed or modified to the extent that its safety or effectiveness could be affected.

It bears repeating that the FDA has not approved any medical device with device name "Dry Needling Needle" or "Physiotherapy Needle."

3. On Page 19 of the Review Draft, the Panel states the following:

However, acupuncture needles are, and have always been, one of the main *tools* used by EAMPs. (Emphasis added.)

This statement is inaccurate because acupuncture needles are medical devices, not "tools." More specifically, acupuncture needles are Class II prescription medical devices under 21 CFR § 880.5580 and must comply with all applicable requirements of the FDCA and FDA's regulations.

Thank you for your time and consideration of this important issue.

Sincerely,

L.A. DeLorme
NCASI, Board Member

Therefore, a regulatory flexibility analysis as provided in Public Law 96-354, the Regulatory Flexibility Act, is not required.

Paperwork Reduction Act

This regulation imposes no reporting/recordkeeping requirements necessitating clearance by OMB.

(Catalog of Federal Domestic Assistance Program Nos. 96.001, Social Security-Disability Insurance; 96.002, Social Security-Retirement Insurance; 96.004, Social Security-Survivors Insurance; 96.006, Supplemental Security Income)

List of Subjects in 20 CFR Part 404

Administrative practice and procedure, Blind, Disability benefits, Old-Age, Survivors and Disability Insurance, Reporting and recordkeeping requirements, Social Security.

Dated: December 2, 1996.
Shirley S. Chater,
Commissioner of Social Security.

For the reasons set forth in the preamble, part 404, subpart P, chapter III of title 20 of the Code of Federal Regulations is amended as set forth below:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE (1950—)

Subpart P—[Amended]

1. The authority citation for subpart P of part 404 continues to read as follows:

Authority: Secs. 202, 205(a), (b), and (d)–(h), 216(i), 221(a) and (i), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a), (b), and (d)–(h), 416(i), 421(a) and (i), 422(c), 423, 425, and 902(a)(5)).

2. Appendix 1 to subpart P of part 404 is amended by revising item 1 of the introductory text before part A to read as follows:

Appendix 1 to Subpart P—Listing of Impairments

* * * * *

1. Growth Impairment (100.00):
December 7, 1998.

* * * * *

[FR Doc. 96-31037 Filed 12-5-96; 8:45 am]

BILLING CODE 4190-29-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 880

[Docket Number 94P-0443]

Medical Devices; Reclassification of Acupuncture Needles for the Practice of Acupuncture

AGENCY: Food and Drug Administration, HHS.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is announcing that it is reclassifying acupuncture needles for the practice of acupuncture and substantially equivalent devices of this generic type from class III (premarket approval) into class II (special controls). FDA is also announcing it has issued an order in the form of a letter to the Acupuncture Coalition reclassifying acupuncture needles. This action is in response to petitions filed by the Acupuncture Coalition and in keeping with, but not dependent upon, the recommendation of FDA's Anesthesiology Devices Advisory Panel (the Panel). This action is being taken because the agency believes that there is sufficient information to establish that special controls will provide reasonable assurance of the safety and effectiveness of acupuncture needles.

EFFECTIVE DATE: December 6, 1996.

FOR FURTHER INFORMATION CONTACT: Timothy A. Ulatowski, Center for Devices and Radiological Health (HFZ-480), Food and Drug Administration, 9200 Corporate Blvd., Rockville, MD 20850, 301-443-8879.

SUPPLEMENTARY INFORMATION: On December 6, 1995, FDA filed reclassification petitions from the Acupuncture Coalition, which includes representatives of the following manufacturers: Carbo (Mfg.), China; Hwa-To, China; Chung Wha, South Korea; Taki, South Korea; Dong Bang, South Korea; Tseng Shyh Co., Taiwan; HCD, France; Sedatelec, France; Seirin-Kasei (Mfg.), Japan; Ito Co., Japan; and Ido-No-Nippon-Sha, Japan, requesting reclassification of acupuncture needles from class III to class II. On March 29, 1996, FDA issued an order (Ref. 1) in the form of a letter, to the petitioners reclassifying acupuncture needles for the practice of acupuncture and substantially equivalent devices of this generic type from class III to class II. Section 513(f)(2) of the Federal Food, Drug, and Cosmetic Act (the act) (21

U.S.C. 360c(f)(2)) and § 860.134 (21 CFR 860.134) provide for the reclassification by order of devices not in commercial distribution before May 28, 1976, the date of enactment of the Medical Device Amendments.

Under section 513(f)(2) of the act and § 860.134, FDA may refer a reclassification petition to an appropriate panel. Although FDA did not refer the reclassification petitions submitted by the Acupuncture Coalition to a panel, the Anesthesiology Devices Advisory Panel (the Panel) had previously considered the classification of acupuncture needles and other acupuncture devices and recommended that acupuncture needles be placed into class II, as reported in the Federal Register of November 2, 1979 (44 FR 63292 at 63299) (Ref. 2). The supplemental data sheet completed by the Panel on November 30, 1976 (Ref. 3), listed sepsis, excessive trauma, and perforation of blood vessels and organs as specific risks, and recommended restricting the device to prescription use. FDA's decision to reclassify acupuncture needles as class II is in keeping with, but not dependent upon, the recommendation of the Panel.

FDA determined that acupuncture needles could safely be reclassified from class III to class II with the implementation of special controls. Acupuncture needles are devices intended to pierce the skin in the practice of acupuncture. The device consists of a solid, stainless steel needle and may have a handle attached to the needle to facilitate the delivery of acupuncture treatment.

The order identified the special controls needed to provide reasonable assurance of the safety and effectiveness of acupuncture needles. Those special controls are in compliance with: (1) Labeling provisions for single use only and the prescription statement in § 801.109 (21 CFR 801.109) (restriction to use by or on the order of qualified practitioners as determined by the States), (2) device material biocompatibility, and (3) device sterility. FDA believes that information for use, including: Indications, effects, routes, methods, and frequency and duration of administration; and any hazards, contraindications, side effects, and precautions are commonly known to qualified practitioners of acupuncture. Therefore, under § 801.109(c), such indications do not need to be on the dispensing packaging, but sale must be clearly restricted to qualified practitioners of acupuncture as determined by the States. Guidance on the type of information needed to support biocompatibility and sterility of

acupuncture needles is available in the General Hospital Branch guidance document entitled "Guidance on the Content of Premarket Notification (510(k)) Submissions for Hypodermic Single Lumen Needles" (draft), April 1993 (Ref. 4). A copy of this guidance document is available from the Division of Small Manufacturers Assistance (HFZ-220), Center for Devices and Radiological Health, Food and Drug Administration, 1350 Piccard Dr., Rockville, MD 20850-4307, 301-443-6597 or 800-638-2041 and FAX 301-443-8818.

Consistent with the act and the regulations, after thorough review of the clinical data submitted in the petitions, and after FDA's own literature search, on March 29, 1996, FDA sent the Acupuncture Coalition a letter (order) reclassifying acupuncture needles for general acupuncture use, and substantially equivalent devices of this generic type, from class III to class II (special controls). As required by § 860.134(b)(7), FDA is announcing the reclassification of the generic type of device. Additionally, FDA is amending part 880 (21 CFR part 880) to include the classification of acupuncture needles for the practice of acupuncture by adding new § 880.5580.

Environmental Impact

The agency has determined that this action is of a type that does not individually or cumulatively have a significant effect on the human environment. Under 21 CFR 25.24(e)(2), the reclassification of a device is categorically exempt from environmental assessment and environmental impact statement requirements. Therefore, neither an environmental assessment nor an environmental impact statement is required.

Analysis of Impacts

FDA has examined the impacts of the final rule under Executive Order 12866 and the Regulatory Flexibility Act (Pub. L. 96-354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The agency believes that this final rule is consistent with the regulatory philosophy and principles identified in the Executive Order. In addition, the final rule is not a significant regulatory action as defined by the Executive Order and so is not

subject to review under the Executive Order.

The Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. Because reclassification of devices from class III to class II will relieve some manufacturers of the cost of complying with the premarket approval requirements of section 515 of the act (21 U.S.C. 360e), and may permit small potential competitors to enter the marketplace by lowering their costs, the agency certifies that the final rule will not have a significant economic impact on a substantial number of small entities. Therefore, under the Regulatory Flexibility Act, no further analysis is required.

Paperwork Reduction Act of 1995

FDA concludes that the labeling requirements in this final rule are not subject to review by the Office of Management and Budget because they do not constitute a "collection of information" under the Paperwork Reduction Act of 1995 (Pub. L. 104-13). Rather, the proposed warning statements are "public disclosure of information originally supplied by the Federal Government to the recipient for the purpose of disclosure to the public" (5 CFR 1320.3(c)(2)).

References

The following references have been placed on display in the Dockets Management Branch (HFA-305), Food and Drug Administration, 12420 Parklawn Dr., rm. 1-23, Rockville, MD 20857 and may be seen by interested persons between 9 a.m. and 4 p.m., Monday through Friday.

1. FDA letter (order) to the Acupuncture Coalition dated March 29, 1996.
2. Classification of anesthesiology devices, development of general provisions; 44 FR 63292 at 63299, November 2, 1979.
3. Anesthesiology Devices Advisory Panel's supplemental data sheet, November 30, 1976.
4. Guidance on the Content of Premarket (510(k)) Submissions for Hypodermic Single Lumen Needles (draft), April 1993.

List of Subjects in 21 CFR Part 880

Medical devices.

Therefore, under the Federal Food, Drug, and Cosmetic Act and under authority delegated to the Commissioner of Food and Drugs, 21 CFR part 880 is amended as follows:

PART 880—GENERAL HOSPITAL AND PERSONAL USE DEVICES

1. The authority citation for 21 CFR part 880 continues to read as follows:

Authority: Secs. 501, 510, 513, 515, 520, 701 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351, 360, 360c, 360e, 360j, 371).

2. New § 880.5580 is added to subpart F to read as follows:

§ 880.5580 Acupuncture needle.

(a) *Identification.* An acupuncture needle is a device intended to pierce the skin in the practice of acupuncture. The device consists of a solid, stainless steel needle. The device may have a handle attached to the needle to facilitate the delivery of acupuncture treatment.

(b) *Classification.* Class II (special controls). Acupuncture needles must comply with the following special controls:

(1) Labeling for single use only and conformance to the requirements for prescription devices set out in 21 CFR 801.109,

(2) Device material biocompatibility, and

(3) Device sterility.

Dated: November 20, 1996.

D. B. Burlington,

Director, Center for Devices and Radiological Health.

[FR Doc. 96-31047 Filed 12-5-96; 8:45 am]

BILLING CODE 4160-01-F

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

24 CFR Part 5

[Docket No. FR-4154-C-02]

RIN 2501-AC36

Revised Restrictions on Assistance to Noncitizens; Correction

AGENCY: Office of the Secretary, HUD.

ACTION: Interim rule, correction.

SUMMARY: On November 29, 1996 (61 FR 60535), HUD published an interim rule implementing the changes made to Section 214 of the Housing and Community Development Act of 1980 by the Use of Assisted Housing by Aliens Act of 1996. Section 214 prohibits HUD from making certain financial assistance available to persons other than United States citizens, nationals, or certain categories of eligible noncitizens. The November 29, 1996 interim rule incorrectly provided for a public comment due date of November 29, 1996. The public comment due date should have been January 28, 1997, 60 days after publication of the November 29, 1996 interim rule. The purpose of this document is to correct the due date for public comments in the November 29, 1996 rule.



[FDA Home](#)³ [Medical Devices](#)⁴ [Databases](#)⁵

510(k) Premarket Notification

[New Search](#) No records were found with **Device Name:** *Dry Needling Needle* **Decision Date To:** 10/11/2016

Links on this page:

1. <http://www.addthis.com/bookmark.php?u508=true&v=152&username=fdomain>
2. <http://www.addthis.com/bookmark.php>
3. <http://www.fda.gov/default.htm>
4. <http://www.fda.gov/MedicalDevices/default.htm>
5. <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Databases/default.htm>

Page Last Updated: 10/03/2016

Note: If you need help accessing information in different file formats, see [Instructions for Downloading Viewers and Players](#).

[Accessibility Contact FDA Careers FDA Basics FOIA No FEAR Act Site Map Transparency Website Policies](#)



U.S. Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993
Ph. 1-888-INFO-FDA (1-888-463-6332)
[Contact FDA](#)



[For Government For Press](#)

[Combination Products Advisory Committees Science & Research Regulatory Information Safety Emergency Preparedness International Programs News & Events Training and Continuing Education Inspections/Compliance State & Local Officials Consumers Industry Health Professionals FDA Archive](#)



U.S. Department of **Health & Human Services**

Links on this page:

1. <http://www.addthis.com/bookmark.php?u508=true&v=152&username=fdomain>
2. <http://www.addthis.com/bookmark.php>
3. <http://www.fda.gov/default.htm>
4. <http://www.fda.gov/MedicalDevices/default.htm>
5. <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Databases/default.htm>



[FDA Home](#)³ [Medical Devices](#)⁴ [Databases](#)⁵

510(k) Premarket Notification

[New Search](#) No records were found with **Device Name:** *Physiotherapy Needle* **Decision Date To:**
10/11/2016

Links on this page:

1. <http://www.addthis.com/bookmark.php?u508=true&v=152&username=fdomain>
2. <http://www.addthis.com/bookmark.php>
3. <http://www.fda.gov/default.htm>
4. <http://www.fda.gov/MedicalDevices/default.htm>
5. <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Databases/default.htm>

Page Last Updated: 10/03/2016

Note: If you need help accessing information in different file formats, see [Instructions for Downloading Viewers and Players](#).

[Accessibility Contact FDA Careers FDA Basics FOIA No FEAR Act Site Map Transparency Website Policies](#)



U.S. Food and Drug Administration
10903 New Hampshire Avenue
Silver Spring, MD 20993
Ph. 1-888-INFO-FDA (1-888-463-6332)
[Contact FDA](#)



[For Government For Press](#)

[Combination Products Advisory Committees Science & Research Regulatory Information Safety Emergency Preparedness International Programs News & Events Training and Continuing Education Inspections/Compliance State & Local Officials Consumers Industry Health Professionals FDA Archive](#)



U.S. Department of **Health & Human Services**

Links on this page:

1. <http://www.addthis.com/bookmark.php?u508=true&v=152&username=fdomain>
2. <http://www.addthis.com/bookmark.php>
3. <http://www.fda.gov/default.htm>
4. <http://www.fda.gov/MedicalDevices/default.htm>
5. <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/Databases/default.htm>