

# Appendix A

Request from Legislature and Draft Bill

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## 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 with a long horizontal line extending to the right.

Senator Randi Becker  
Chair, Health Care Committee

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SENATE BILL 6374

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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.

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# Appendix B

## Applicant Report and Follow Up

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### **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.

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## **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 <b>CREDITS</b> required for completion of the program:	
<b>Pre-professional phase</b>	180
<b>Professional phase</b> - Classroom/Laboratory courses (including independent study courses, distance learning courses, etc.)	12
<b>Professional phase</b> - Clinical Education courses	34
Total number of <b>CONTACT HOURS</b> 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.

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## **11. APPENDICES**

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

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Institution	Number of CEUs	Levels	Description of class
KinetaCore	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 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><b>Level 1: Objectives</b></p> <ul style="list-style-type: none"> <li>- Define and understand what trigger points and motor banding are and how they relate to treatment with Dry Needling.</li> <li>- Present and review both the common and uncommon presentations of neuromuscular dysfunction as well as utilize other common evaluation procedures.</li> <li>- Review and become familiar with current literature regarding efficacy and treatment rationale for Dry Needling.</li> <li>- Review anatomy, function and safety concerns of regions which are covered in the Functional Dry Needling Level 1 course.</li> <li>- Instruct and apply Dry Needling technique which considers safety, indications and contraindications for treatment and proper integration into the clinical or sports setting.</li> <li>- Muscles that will be taught include: Hip, Lumbar Spine, Thigh, Cervical Spine, Shoulder, Upper and lower extremity.</li> </ul> <p><b>Level 2: Objectives:</b></p> <ul style="list-style-type: none"> <li>- Define trigger points, motor banding, and neurological presentations of neuromuscular dysfunction.</li> <li>- Review literature supporting efficacy and treatment rationale for FDN.</li> <li>- Instruct application of FDN for more advanced orthopedic and neuromuscular conditions.</li> <li>- Review anatomy of regions to be taught in Level 2 course.</li> <li>- Review and Discuss safety concerns.</li> <li>- Discuss indications and contraindications for treatment.</li> <li>- Discuss indications and contraindications for various diagnoses.</li> <li>- Muscles will be needling U/LE, L/LE, advanced lumbar spine, TMJ/face, advanced cervical spine, thoracic spine, advanced U/LE, tendons/ligaments.</li> </ul> <p><b>Functional Therapeutics: Objectives:</b></p> <ul style="list-style-type: none"> <li>- Take material learned in Level 1 FDN and apply it clinically from start to finish (Evaluation =&gt; treatment approach =&gt; assessment =&gt; follow-up care =&gt; end of episode).</li> <li>- Further reasoning for evaluation, assessment and application for dry needling</li> <li>- Improve understanding of how dysfunction and pain may affect movement patterns</li> <li>- Provide a more systematic approach to dry needling treatment</li> <li>- When to incorporate other manual techniques and modalities with dry needling</li> <li>- Proper follow-up care to enhance and sustain results from dry needling</li> </ul> <p><b>DN-1: objectives include</b></p> <ul style="list-style-type: none"> <li>- Understand the basic principles of applied pain sciences</li> <li>- Identify select muscles of the body by surface anatomy and by function</li> <li>- Identify the features of the trigger point by physical examination and apply this knowledge to individual muscles in different regions of the body</li> <li>- Understand common precipitating and perpetuating factors of trigger points.</li> <li>- Perform muscle and region-specific manual therapy treatments to inactivate myofascial trigger points and restore movement patterns and posture, integrating various treatment techniques including dry needling and manual trigger point therapy.</li> <li>- Understand basic principles of dry needling and trigger point injections.</li> <li>- Muscles include: pectoralis profundus/proximalis, triceps, biceps, brachialis, levator scapulae (partially), the latissimus dorsi (partially), the subscapularis (partially), brachioradialis, the vastus extensor, the supinator and extensor carpi radialis (partially), the quadratus lumborum, the iliocostalis, the gluteal muscles (minimus, medius, and maximus), the hip adductor muscles, the quadriceps and hamstrings, and gastrocnemius and soleus muscles.</li> </ul> <p><b>DN-2</b></p> <ul style="list-style-type: none"> <li>- Identify select muscles of the body by surface anatomy and by function</li> <li>- Identify the features of the trigger point by physical examination and apply this knowledge to individual muscles in different regions of the body</li> <li>- Understand common precipitating and perpetuating factors of trigger points.</li> <li>- Perform muscle and region-specific manual therapy treatments to inactivate myofascial trigger points and restore movement patterns and posture, integrating various treatment techniques including dry needling and manual trigger point therapy.</li> <li>- Understand the basic principles of dry needling</li> <li>- Many muscles commonly addressed in clinical practice are included, such as 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 paraspinals, the serratus anterior, rhomboids, and the pelvic floor muscles.</li> </ul> <p><b>DN-3</b></p> <ul style="list-style-type: none"> <li>- Identify select muscles of the body by surface anatomy and by function</li> <li>- Identify the features of the trigger point by physical examination and apply this knowledge to individual muscles in different regions of the body</li> <li>- Perform muscle and region-specific manual therapy treatments to inactivate myofascial trigger points and restore movement patterns and posture, integrating various treatment techniques including dry needling and manual trigger point therapy.</li> <li>- Perform dry needling for scar tissue, fascial adhesions, enthesopathies, and tendinopathies.</li> </ul>
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>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 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 designates a specific treatment approach to create an inter-related system and directly treats the functional malfunctions while involving clinical efforts. As a result, clinical practice participants 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: - 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 techniques, 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 tool assisted soft tissue mobilization, manual stretching, and therapeutic exercise. - Level 1 lower quarter muscles and level 2 upper quarter muscles.</p> <p>DN- 1: Dry Needling for Cervicofacial, Cervicohoracic &amp; Upper Extremity Conditions (Part 1 of Certification in Dry Needling) "Participants will learn superficial and deep dry needling techniques for the purpose of improving microcirculation and disrupting fibrosis in chronic neurogenic conditions. This course does include, but is not limited to, needling of that bands of muscle (ie, trigger points) as originally introduced by Travell &amp; Simons. That is, peri-neural needling will be taught as well as intramuscular 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>DN- 2: Dry Needling for Lumbo pelvic &amp; 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 lumbo pelvic and lower extremity musculoskeletal conditions. This course does include, but is not limited to, needling of that bands of muscle (ie, trigger points) as originally introduced by Travell &amp; Simons. That is, peri-neural needling will be taught as well as intramuscular 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>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 of 3S 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 depending on state requirements for CEUs not clear these can be taken out of order or if there are requirements to take the courses.</p> <p>DN-1: 3 days, 24 hours (no pre req) DN-2: 3 days, 24 hrs (no pre req)</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 (IAOM)</p>	<p>Level 1 - Pending 36.5 CEU Level 2 - Pending 32.5 CEU Anatomy - pending 8 CEU</p>	<p>Dry Needling Level 1 3 days 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>Objectives for both courses are the same: - Understand the various theories and models that underlie dry needling technique - Learn and apply the various dry needling techniques in all body areas to the instructor - Apply dry needling technique 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"> <li>- Level I: 20 contact hrs: 2, 8hr days</li> <li>- Level II: 20 contact hrs: 2, 8hr days</li> <li>- Level III: no information currently available</li> <li>- Understanding is PT must understand own state's laws before practicing***</li> </ul>	<ul style="list-style-type: none"> <li>- 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, taping and functional case based treatments."</li> <li>- 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."</li> <li>- 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."</li> </ul>
Therapy Concepts Inc	Level I: 23777 (not stated) Level II: 23 contact hrs	<ul style="list-style-type: none"> <li>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.</li> <li>– Muscle groups included: cervical and lumbar spine, hip, lower extremity, shoulder and forearm.</li> <li>– 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 admission to this course. All participants must have a minimum of 2 years of experience.</li> <li>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.</li> <li>– Will benefit physical therapists, medical doctors, and doctors of osteopathy who work with patients suffering from chronic myofascial pain.</li> <li>– 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.</li> <li>– 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.</li> <li>– Participants should also be prepared to share their experiences since integrating Trigger Point Dry Needling into their practice.</li> </ul>	<ul style="list-style-type: none"> <li>Level I: Objectives: <ul style="list-style-type: none"> <li>- Define trigger points, motor haphing, and neurological presentations of neuromuscular dysfunction.</li> <li>- Review the history of Trigger Point Dry Needling and its application of Trigger Point Dry Needling for more advanced orthopedic and neuromuscular conditions.– Review anatomy of regions to be taught in Level II course.</li> <li>- Discuss with participants their own experiences regarding legal and billing issues integrating Trigger Point Dry Needling into their practice setting.</li> <li>- Discuss indications and contraindications for treatment.</li> <li>- Discuss specific treatment rationale for various diagnoses.</li> </ul> </li> <li>Level II: Objectives: <ul style="list-style-type: none"> <li>- Define trigger points, motor haphing, and neurological presentations of neuromuscular dysfunction.</li> <li>- Review the history of Trigger Point Dry Needling and its application of Trigger Point Dry Needling for more advanced orthopedic and neuromuscular conditions.– Review anatomy of regions to be taught in Level II course.</li> <li>- Discuss with participants their own experiences regarding legal and billing issues integrating Trigger Point Dry Needling into their practice setting.</li> <li>- Discuss indications and contraindications for treatment.</li> <li>- Discuss specific treatment rationale for various diagnoses.</li> </ul> </li> </ul>
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"> <li>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.</li> <li>Level II: 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.</li> <li>Purpose: <ul style="list-style-type: none"> <li>- 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 for effectively finding trigger points then practice applying dry needling and their hands-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.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Level I: Objectives: <ul style="list-style-type: none"> <li>- Discuss the history of myofascial pain.</li> <li>- Review and define the concept of trigger points and supporting literature around this concept.</li> <li>- Define trigger point, taut band, and neurological presentations of neuromuscular dysfunction.</li> <li>- Define and understand the concept of trigger points, their pathogenesis, and hypothetical constructs of Chad Gunn and Janet Travell.</li> <li>- Discuss and define attributes/features of trigger points and discuss the various interventions used in the treatment of trigger points that are appropriate.</li> <li>- Explain understanding of appropriate use of trigger point dry needling within a clinical reasoning framework.</li> <li>- Practice understanding of dry needling and develop moderate proficiency using trigger point needling on select muscles of the spine, lower, and upper quadrant.</li> </ul> </li> <li>Level II: Objectives: <ul style="list-style-type: none"> <li>- 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.</li> <li>- Employ trigger point dry needling in muscles over the lung fields with full safety and confidence.</li> <li>- 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.</li> <li>- Utilize as many as five different varieties of style safety to tailor dry needling to the individual case and patient.</li> <li>- 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.</li> </ul> </li> </ul>

**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	Certified or licensed with at least 1850 hours of training (of that, 800 hours of clinical training) <a href="#">A.R.S. § 32-3924</a>  ***Only 1050 hours of in class hours needed to practice	Graduate of an accredited Physical Therapy Program*  Successfully passed national board exam  Successfully passed Arizona State Jurisprudence Exam  (*All current entry level physical therapy programs are at the <b>professional doctorate level</b> ) <a href="#">A.R.S. § 32-2022</a> )
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)

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

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

DRAFT



# Analysis of Competencies for Dry Needling by Physical Therapists

## Final Report

**Prepared for:** Federation of State Boards of Physical Therapy  
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**Date:** July 10, 2015

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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.

DRAFT

## 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**

<b>ID#</b>	<b>Tasks</b>
<b>PATIENT/CLIENT ASSESSMENT</b>	
<b>Information Gathering &amp; Synthesis</b>	
	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.
<b>INTERVENTIONS</b>	
<b>Manual Therapy Techniques</b>	
	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
<b>ID#</b>	<b>Tasks</b>
<b>Education</b>	
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)
<b>Patient/client &amp; Staff Safety</b>	
<b>Emergency Procedures</b>	
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)**

<b>ID#</b>	<b>Tasks</b>
<b>Environmental Safety</b>	
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
<b>Infection Control</b>	
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
<b>Professional Responsibilities</b>	
26.	Determine own ability to perform dry needling safely and effectively

**Table ii. Specialized Knowledge Required for Competency in Dry Needling**

<b>Anatomy and Physiology</b>	
1.	Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks
<b>Emergency Preparedness and Response</b>	
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)
<b>Safety and Protection</b>	
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.<sup>1</sup>

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.

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<sup>1</sup> 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).<sup>2</sup> 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.<sup>3</sup>

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:

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<sup>2</sup> Available at: [https://www.fsbpt.org/download/pa2011\\_ptfinalreport20111109.pdf](https://www.fsbpt.org/download/pa2011_ptfinalreport20111109.pdf)

<sup>3</sup> 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.<sup>4</sup>

*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.*<sup>5</sup>

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)**

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<sup>4</sup> 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.

<sup>5</sup> 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.<sup>6</sup> 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

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<sup>6</sup> 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
<b>PATIENT/CLIENT ASSESSMENT</b>	
<b>Information Gathering &amp; Synthesis</b>	
	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.
<b>INTERVENTIONS</b>	
<b>Manual Therapy Techniques</b>	
	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)**

<b>ID#</b>	<b>Tasks</b>
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
<b>Education</b>	
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)
<b>Patient/client &amp; Staff Safety</b>	
<b>Emergency Procedures</b>	
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)
<b>Environmental Safety</b>	
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
<b>Infection Control</b>	
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
<b>Professional Responsibilities</b>	
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.<sup>7</sup> 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**

<b>DRY NEEDLING-SPECIFIC KNOWLEDGE</b>	
<b>Anatomy and Physiology</b>	
1.	Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks
<b>Emergency Preparedness and Response</b>	
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)
<b>Safety and Protection</b>	
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**

<sup>7</sup> 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.<sup>8</sup> 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

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<sup>8</sup> 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).

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.

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## Appendix A

### Background Review Source Materials

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## Appendix B

### Draft Dry Needling-Specific Tasks and Knowledge Requirements

**Table B1. Draft List of Dry Needling Tasks**

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#### **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)

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#### **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

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#### **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)

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##### **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)

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##### **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

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##### **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

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## Appendix D

### Physical Therapy Tasks Required for the Competent Performance of Dry Needling

ID#	Tasks
<b>PATIENT/CLIENT ASSESSMENT</b>	
<b>Information Gathering &amp; Synthesis</b>	
	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)
<b>Systems Review</b>	
	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)
<b>Tests &amp; Measures</b>	
<b>Cardiovascular and Pulmonary</b>	
	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)
<b>Anthropomorphic</b>	
24.	Quantify edema (e.g., palpation, volume test, circumference)
<b>Arousal, Attention, &amp; Cognition</b>	
	Select and perform tests and measures of...

<b>ID#</b>	<b>Tasks</b>
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)
<b><i>Nerve Integrity</i></b>	
	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)
<b><i>Ergonomics and Body Mechanics</i></b>	
	Select and perform tests and measures of...
33.	...postural alignment and position (static and dynamic)
<b><i>Functional Mobility, Balance, &amp; Vestibular</i></b>	
	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)
<b><i>Integumentary Integrity</i></b>	
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)
<b><i>Joint Integrity &amp; Range of Motion</i></b>	
	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)
<b><i>Muscle Performance &amp; Motor Function</i></b>	
	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)
<b><i>Reflex Integrity</i></b>	
	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)
<b><i>Pain &amp; Sensory Integrity</i></b>	
	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
<b>Development of Prognosis, Plan of Care, &amp; Goals</b>	
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.
<b>INTERVENTIONS</b>	
<b>Manual Therapy Techniques</b>	
	Position the patient/client to
70.	expose the area(s) to be needled
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 needled
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
<b>Non-procedural Interventions</b>	
<b>Communication</b>	
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)

<b>ID#</b>	<b>Tasks</b>
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
<b>Documentation</b>	
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)
<b>Education</b>	
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)
<b>Patient/client &amp; Staff Safety</b>	
<b>Emergency Procedures</b>	
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)
<b>Environmental Safety</b>	
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
<b>Infection Control</b>	
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
<b>Research &amp; Evidence-Based Practice</b>	
114.	Integrate current best evidence, clinical experience, and patient values in clinical practice (e.g., clinical prediction rules, patient preference)
<b>Professional Responsibilities</b>	
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

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## Appendix E

### Tasks NOT Related to Competency in Dry Needling

ID#	Tasks
<b>PATIENT/CLIENT ASSESSMENT</b>	
<b>Tests &amp; Measures</b>	
<b>Cardiovascular and Pulmonary</b>	
	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)
<b>Anthropomorphic</b>	
	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)
<b>Muscle Performance</b>	
	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)
<b>Environmental &amp; Community Integration/Reintegration (Home, Work, Job, School, Play, &amp; Leisure)</b>	
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
<b>Ergonomics and Body Mechanics</b>	
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)
<b>Functional Mobility, Balance, &amp; Vestibular</b>	
	Select and perform tests and measures of...
18.	...vestibular function (e.g., peripheral dysfunction, central dysfunction)
<b>Integumentary Integrity</b>	
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

<b>ID#</b>	<b>Tasks</b>
21.	Assess wound characteristics (e.g., tissue involvement, depth, tunneling, burn degree)
<b>Muscle Performance &amp; Motor Function</b>	
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)
<b>Neuromotor Development &amp; Sensory Integration</b>	
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)
<b>Evaluation &amp; Diagnosis</b>	
	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
<b>Development of Prognosis, Plan of Care, &amp; Goals</b>	
<b>INTERVENTIONS</b>	
<b>Procedural Interventions</b>	
<b>Therapeutic Exercise/Therapeutic Activities</b>	
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)

<b>ID#</b>	<b>Tasks</b>
<b><i>Pulmonary Interventions</i></b>	
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)
<b><i>Functional Training</i></b>	
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
<b><i>Manual Therapy Techniques</i></b>	
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)
<b><i>Devices &amp; Equipment</i></b>	
	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)

<b>ID#</b>	<b>Tasks</b>
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)
<b>Integumentary Repair</b>	
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)
<b>Therapeutic Modalities</b>	
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
<b>Mechanical Modalities</b>	
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
<b>Documentation</b>	
106.	Document intervention/plan of care for specialized services and settings (e.g., individual education plan, individual family service plan, vocational transition plan)
<b>Education</b>	
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
<b>Patient/client &amp; Staff Safety</b>	
<b>Emergency Procedures</b>	
109.	Implement disaster response procedures
<b>Environmental Safety</b>	
110.	Perform risk assessment of the physical environment (e.g., barrier-free environment, outlets, windows, floors, lighting)

<b>ID#</b>	<b>Tasks</b>
<b><i>Infection Control</i></b>	
<b><i>Research &amp; Evidence-Based Practice</i></b>	
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
<b><i>Professional Responsibilities</i></b>	
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)

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## Appendix F

### Knowledge Requirements Related to Competency in Dry Needling

ID#	Knowledge
<b>CARDIOVASCULAR/PULMONARY &amp; LYMPHATIC SYSTEMS</b>	
<b><i>Physical Therapy Examination</i></b>	
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)
<b><i>Foundations for Evaluation, Differential Diagnosis, &amp; Prognosis</i></b>	
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
<b><i>Interventions</i></b>	
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
<b>MUSCULOSKELETAL SYSTEM</b>	
<b><i>Physical Therapy Examination</i></b>	
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
<b><i>Foundations for Evaluation, Differential Diagnosis, &amp; Prognosis</i></b>	
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

<b>ID#</b>	<b>Knowledge</b>
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

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## **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

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## **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

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**ID# Knowledge**


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**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)
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<b>ID#</b>	<b>Knowledge</b>
72.	Pharmacological management of the genitourinary system
73.	Differential diagnoses related to diseases/conditions of the genitourinary system

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### **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

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### **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)

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### **THERAPEUTIC MODALITIES**

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

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### **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

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### **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)

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<b>ID#</b>	<b>Knowledge</b>
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
<b>DRY NEEDLING-SPECIFIC KNOWLEDGE</b>	
<b><i>Anatomy and Physiology</i></b>	
102.	Surface anatomy as it relates to underlying tissues, organs, and other structures, including variations in form, proportion, and anatomical landmarks
<b><i>Emergency Preparedness and Response</i></b>	
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)
<b><i>Safety &amp; Protection</i></b>	
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
<b>CARDIOVASCULAR/PULMONARY &amp; LYMPHATIC SYSTEMS</b>	
<b>Interventions</b>	
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
<b>MUSCULOSKELETAL SYSTEM</b>	
<b>Interventions</b>	
3.	Physical therapy ultrasound imaging of the musculoskeletal system
<b>INTEGUMENTARY SYSTEM</b>	
<b>Interventions</b>	
4.	Integumentary system physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
<b>METABOLIC &amp; ENDOCRINE SYSTEMS</b>	
<b>Physical Therapy Examination</b>	
5.	Metabolic and endocrine systems physical therapy interventions and their applications for rehabilitation, health promotion, and performance according to current best evidence
<b>GASTROINTESTINAL SYSTEM</b>	
<b>Interventions</b>	
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)
<b>EQUIPMENT &amp; DEVICES</b>	
<b>Interventions</b>	
8.	Assistive and adaptive devices
9.	Prosthetic devices
10.	Protective, supportive, and orthotic devices
<b>THERAPEUTIC MODALITIES</b>	
<b>Foundations for Evaluation, Differential Diagnosis, &amp; Prognosis</b>	
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)
<b>SAFETY &amp; PROTECTION</b>	
<b>Foundations for Evaluation, Differential Diagnosis, &amp; Prognosis</b>	
17.	Function, implications, and precautions related to intravenous lines, tubes, catheters, and monitoring devices

<b>ID#</b>	<b>Knowledge Requirement</b>
<b>RESEARCH &amp; EVIDENCE-BASED PRACTICE</b>	
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)
<b>Dry Needling-specific Knowledge</b>	
	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
<b>Communicating with patients</b>	
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.
<b>Adapting behavior or treatment to accommodate patient's needs/preferences</b>	
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.
<b>Reflecting on and evaluating own competence to perform dry needling</b>	
9. Judgment and Decision Making	Considering the relative costs and benefits of potential actions to choose the most appropriate one.
<b>Abiding by professional and ethical standards</b>	
10. Judgment and Decision Making	Considering the relative costs and benefits of potential actions to choose the most appropriate one.
<b>Handling and controlling needles and palpating tissues</b>	
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**

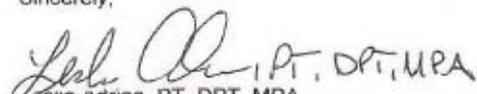
The Federation of State Boards of Physical Therapy (FSBPT or Federation) is an organization made up of the 53 physical therapy licensing jurisdictions within the United States. The mission of the FSBPT is to protect the public by providing service and leadership that promote safe and competent physical 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



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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.



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DRAFT

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 Fox<sup>1</sup> 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,<sup>2</sup> 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.<sup>3</sup> Trigger point acupuncture is now an established part of this field.<sup>4</sup> 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.<sup>1</sup> 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.<sup>1,5</sup> 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 2003<sup>5</sup> 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

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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 Birch<sup>5</sup> for references), which have as associated symptoms muscle pain, muscle spasms, joint pain<sup>6</sup>—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 Simons<sup>2</sup> 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.<sup>7</sup> 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 text<sup>8</sup> 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,<sup>9</sup> 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 colleagues<sup>1</sup> and Dorsher try to argue that these are just distant points that utilize similar neurologic mechanisms. In my 2003 study,<sup>5</sup> 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.<sup>2,5</sup> 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,<sup>5</sup> 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.<sup>5</sup> 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.<sup>2</sup> 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.<sup>3,10–12</sup> 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.<sup>5,10,13</sup> 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<sup>14–16</sup>)

“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.<sup>14</sup> See also Sunu and Lee<sup>15</sup> and Wu.<sup>16</sup>) 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 article<sup>1</sup> that the 1977 analysis was incorrect. These 2 entities do not appear to show a correlation.<sup>5</sup> I also agree with Travell and Simons’<sup>2</sup> 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.<sup>3,11</sup> 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.<sup>3,17</sup>

Thank you for the opportunity to respond and clarify.

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**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](mailto: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.

DRAFT

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"> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions.</li> <li>• 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</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Locate specific muscle groups, peripheral nerves and vascular structures through clinical palpation</li> <li>• Locate active myofascial trigger points in the muscles based on the work of Travel and Simons technique</li> </ul>	<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"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice.</li> <li>Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments.</li> </ul>	<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"> <li>• Demonstrate understanding of the underlying physiological, biomechanical and chemical mechanisms that can occur with the application of dry needling to the neuromusculoskeletal system.</li> <li>• 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.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Verbalize 3 indications and contraindications associated with dry needling of neuromusculoskeletal structures in the thorax, neck, shoulder, upper extremity, and craniofacial region.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice.</li> <li>• Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments.</li> </ul>	<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"> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist.</li> </ul>	<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
<p>Factors influencing safety and injury prevention</p>	<ul style="list-style-type: none"> <li>• 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</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Verbalize 3 indications and contraindications associated with dry needling of neuromusculoskeletal structures in the thorax, neck, shoulder, upper extremity, and craniofacial region.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions</li> <li>• Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice</li> </ul>	<ul style="list-style-type: none"> <li>• Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist.</li> <li>• Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments.</li> <li>• Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice.</li> <li>• Locate specific muscle groups, peripheral nerves and vascular structures through clinical palpation.</li> </ul>	<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"> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist..</li> <li>• Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice.</li> <li>• 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.</li> </ul>	<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"> <li>• Synthesize foundational and clinical sciences of myofascial pain, trigger points, pain patterns, movement dysfunction and functional dry needling to impact those findings clinical setting</li> <li>• Clearly define and describe dry needling for the treatment of neuromusculoskeletal dysfunction, movement impairments and pain associated with that dysfunction and impairment.</li> <li>• Demonstrate understanding of the underlying physiological, biomechanical and chemical mechanisms that can occur with the application of dry needling to the neuromusculoskeletal system.</li> </ul>	<ul style="list-style-type: none"> <li>• Verbalize 3 indications and contraindications associated with dry needling of neuromusculoskeletal structures in the thorax, neck, shoulder, upper extremity, and craniofacial region</li> <li>• 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</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions.</li> </ul>	<ul style="list-style-type: none"> <li>• Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments.</li> <li>• Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments.</li> <li>• Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice</li> </ul>	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"> <li>• Synthesize foundational and clinical sciences of myofascial pain, trigger points, pain patterns, movement dysfunction and functional dry needling to impact those findings clinical setting</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Verbalize how best to incorporate dry needling into conventional physical therapy practice</li> </ul>	<ul style="list-style-type: none"> <li>• Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions</li> <li>• 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</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments.</li> <li>• Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments.</li> <li>• Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice</li> </ul>	<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"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments.</li> <li>Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice.</li> <li>Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments.</li> </ul>	<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"> <li>• Synthesize foundational and clinical sciences of myofascial pain, trigger points, pain patterns, movement dysfunction and functional dry needling to impact those findings clinical setting</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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</li> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions</li> </ul>	<ul style="list-style-type: none"> <li>• Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments.</li> <li>• Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments.</li> </ul>	<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
<b>Contraindications and precautions related to dry needling (e.g., age, allergies, diseases/ conditions)</b>	<ul style="list-style-type: none"> <li>• 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</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Verbalize 3 indications and contraindications associated with dry needling of neuromusculoskeletal structures in the thorax, neck, shoulder, upper extremity, and craniofacial region</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions</li> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice</li> </ul>	<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"> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions</li> <li>• 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.</li> <li>• Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice</li> </ul>	<ul style="list-style-type: none"> <li>• Describe different type of myofascial trigger points and discuss their role in musculoskeletal pain and movement impairments.</li> <li>• Locate specific muscle groups, peripheral nerves and vascular structures through clinical palpation</li> <li>• Locate active myofascial trigger points in the muscles based on the work of Travel and Simons technique</li> </ul>	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"> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions</li> <li>• Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice</li> </ul>	<ul style="list-style-type: none"> <li>• Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist.</li> </ul>	<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
<b>Needle manipulation techniques</b>	<ul style="list-style-type: none"> <li>• 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</li> </ul>	<ul style="list-style-type: none"> <li>• 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</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions</li> <li>• Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice</li> </ul>	<ul style="list-style-type: none"> <li>• Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist.</li> </ul>	<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"> <li>• 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.</li> <li>• Demonstrate understanding of the underlying physiological, biomechanical and chemical mechanisms that can occur with the application of dry needling to the neuromusculoskeletal system.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Apply and synthesize the knowledge in the practical applications of the physiological mechanisms of needling during the case study discussions</li> </ul>	<ul style="list-style-type: none"> <li>• Explain the scientific basis of the effects of dry needling on reducing musculoskeletal pain and movement impairments.</li> <li>• Explain indications, adverse effects and safe practice of dry needling within the scope of physical therapy practice.</li> <li>• 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.</li> </ul>	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"> <li>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</li> </ul>	<ul style="list-style-type: none"> <li>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</li> </ul>	<ul style="list-style-type: none"> <li>Participant will develop the psychomotor skills necessary to safely and effectively deliver dry needling treatment during each practical lab sessions</li> <li>Participant will develop the necessary psychomotor skills and knowledge to enable them to apply integrative dry needling techniques into their professional practice</li> <li></li> </ul>	<ul style="list-style-type: none"> <li>Understand and demonstrate all safety precautions in regard to needle handling utilizing a sterile technique for safety of the patient and the therapist.</li> </ul>	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

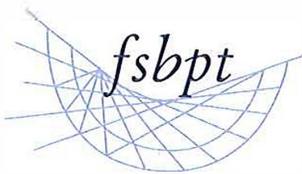
### Integrative Dry Needling:

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

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[www.fsbpt.org](http://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](mailto: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<sup>+</sup> (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 conditions<sup>1</sup>. When compared to diagnostic gold standard MRI, diagnostic accuracy of physical therapists was not significantly different than orthopedic surgeons for musculoskeletal diagnosis<sup>1</sup>. However, several studies have noted some variability in clinical and pattern diagnosis among allied<sup>1</sup> and alternative<sup>2</sup> 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 endplate<sup>3</sup>, that are not present in other tissue, including traditional acupoints.<sup>4</sup> Myofascial trigger points have been shown to respond favorably when treated by physical therapists using techniques such as dry needling<sup>5</sup>, instrument assisted and traditional myofascial techniques and joint mobilization<sup>6</sup>.

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 tissue<sup>7</sup>. 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 injury<sup>7</sup>. Static adhesions between muscle and fascial tissue leads to increased thickness and disorganization of connective tissue layers, increasing tissue stiffness and decreasing ROM<sup>8</sup>. Physical therapy techniques such as myofascial release<sup>9</sup>, instrumented assisted soft tissue mobilization<sup>10</sup>, and dry needling<sup>11</sup> have all been shown to stimulate the blood flow, nitrous oxide, and connective tissue remodeling effects described by Butts et al.<sup>12</sup>

Physical therapy treatment techniques have demonstrated efficacy in addressing pain and dysfunction via spinal cord mediated effects<sup>13</sup>, primarily through modulation of A-beta fiber activity, stimulation of non-opioid inhibitory

mechanisms<sup>14</sup>, and opioid-based mechanisms<sup>12</sup>. Common techniques in physical therapy practice, such as spinal manipulation<sup>15</sup>, spinal joint mobilization and dry needling<sup>16</sup> 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 points<sup>17</sup> 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 acupoints<sup>18</sup>. 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 effects<sup>19</sup>. According to recent literature, there seems to be a consistent physiological response to needle stimulation, regardless of the specifically defined points<sup>19</sup>. An alternative hypothesis to point specificity has been proposed<sup>12</sup>, 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 stimulation<sup>12</sup>.

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.

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- 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.
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- 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).
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- 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  
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- 10 Loghmani M & Warden S (2009) Instrument assisted cross fiber massage accelerates knee ligament healing.  
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- 11 Chou L, Hsieh YL, Kuan TS, Hong C (2014) Needling therapy for myofascial pain: recommended techniques  
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- 12 Butts R et al. (2016) Peripheral and spinal mechanisms of pain and dry needling mediated analgesia: a  
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- 13 Boal R & Gillette R (2004) Central neuronal plasticity, low back pain and spinal manipulative therapy. *Journal  
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- 14 Hegedus E, Goode A, Butler R, Slaven E (2011) The neurophysiological effects of a single session of spinal  
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### **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.

	Kinetacore	Integrative Dry Needling	IAMT	Myopain	Spinal Manipulation Institute
<b>Hours of actual needle handling</b>	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.
<b>Supervision in class</b>	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><b>Describe competency assessment</b></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 &amp; precautions, anatomy &amp; indications, history and models of treatment, definitions, OSHA &amp; 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 neuromuskuloskeletal 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, hypoaesthetic (central, segmental and peripheral), neurophysiologic, chemical, and hormonal effects of dry needling.</p>

What advanced training options do you have passed the 54 hours	Kineticore A course is available that can be offered before taking level 2 so that they get practice. They have a level 3 also.	Integrative Dry Needling In process of designing third course.	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.	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	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 Neuro-musculoskeletal 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.
Do you use acupuncture texts and if so, why	Only reference acupuncture texts to demonstrate that it is different.	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.	NO! Absolutely not.	We do not as we are not teaching acupuncture.	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.

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\\_FDN/Dry\\_needling\\_of\\_muscle\\_motor\\_points\\_for\\_chronic\\_low\\_back\\_pain.pdf](https://www.kinetacore.com/physical-therapy/assets/files/Prep_Materials/Level_1_FDN/Dry_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 ashi 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.

DRAFT

## 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"> <li>• Commission on Accreditation in Physical Therapy Education (CAPTE)</li> <li>• APTA</li> <li>• State chapters or specialty groups of the APTA</li> <li>• Federation of State Boards of Physical Therapy (FSBPT)</li> </ul> <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"> <li>- Sterile needle procedure to include one of the following standards:                     <ul style="list-style-type: none"> <li>• The U.S. Centers for Disease control and Prevention, OR</li> <li>• The U.S. Occupational Safety &amp; Health Administration</li> </ul> </li> <li>- Anatomical Review</li> <li>- Blood Borne Pathogens</li> <li>- Contraindication and Indication for Dry Needling.</li> </ul> <p>Dry Needling shall not be delegated to assistive personnel.</p>
Colorado	<ul style="list-style-type: none"> <li>• 2 years of clinical practice as a licensed PT.</li> <li>• 46 hours of in-person dry needling education &amp; training.</li> </ul>



	<ul style="list-style-type: none"> <li>• The course instructor of the dry needling course must also have met the same pre-requisites and have two years of experience.</li> </ul>
DC	<ul style="list-style-type: none"> <li>• Documented proof of sufficient education and training to ensure competent practice.</li> <li>• Self-study and online courses in dry needling are not acceptable.</li> </ul>
Delaware	<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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> </li> </ul>



	<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"> <li>• The dry needling program, including the required supervised training, shall be taught by a Physical Therapist who meets the qualifications of Regulation 15.4.</li> </ul>
Illinois	Board regulations in process – not yet adopted
Louisiana	<ul style="list-style-type: none"> <li>• 2 years of experience as a licensed PT.</li> <li>• 50 hours of education &amp; training in dry needling.</li> <li>• Online and distance learning are not acceptable.</li> <li>• Course instructor must be a licensed healthcare provider with minimum 2 years of experience in dry needling.</li> </ul>
Maryland	Board regulations in process – not yet adopted.
Montana	Board regulations in process – not yet adopted.
Mississippi	<ul style="list-style-type: none"> <li>• 3 years of experience as a licensed PT.</li> <li>• 50 hours of education &amp; training.</li> <li>• Online coursework not acceptable.</li> <li>• Course provide must meet same pre-requisites.</li> </ul>
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"> <li>• Musculoskeletal and neuromuscular systems;</li> </ul>



	<ul style="list-style-type: none"><li>• Anatomical basis of pain mechanism, chronic pain, and referred pain;</li><li>• Trigger points;</li><li>• Universal Precautions</li></ul> <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"><li>• Dry needling technique;</li><li>• Dry needling indications and contraindications;</li><li>• Document of dry needling;</li><li>• Management of adverse effects;</li><li>• Practical psychomotor competency, and</li><li>• Occupational Safety and Health Administration's Bloodborne Pathogen Protocols.</li></ul> <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>
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Utah	<ul style="list-style-type: none"> <li>• 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.</li> </ul>
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"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul> <p>Dry needling may not be performed by a PTA or a physical therapy aide.</p>



# Appendix C

## Public Hearing Summary

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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 needed 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% 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 refute 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, 1<sup>st</sup> 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 1<sup>st</sup> 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, 3<sup>rd</sup> 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 2<sup>nd</sup> 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 2<sup>nd</sup> 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 16<sup>th</sup> 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

<b>Name</b>	<b>Representing</b>	<b>Position</b>	<b>Testified</b>
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 Helming	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

DRAFT

# Appendix D

## Written Comments

DRAFT

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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

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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

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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

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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

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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

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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.

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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

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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 |

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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

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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

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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

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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.

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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

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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

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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

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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

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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

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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

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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.

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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.

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George Whiteside, MS, EAMP, President Emeritus, Washington East Medicine Association (2005-2010)  
Mindfulness Medicine Northwest, Licensed Acupuncturist, Certified Herbalist

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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

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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

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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

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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

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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

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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

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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

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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

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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 a practitioner with standard training and also routine use of needles in their practice, such as a licensed EAMP or acupuncturist or licensed medical physician. As I am in the process of receiving my license as an EAMP who has trained for more than 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 than 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

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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

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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

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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

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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

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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

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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

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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's and MDs.

Barbara Beale, LAc LLC

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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](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](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

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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

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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

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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 breached 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

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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 without 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

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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

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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 its 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 person's 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

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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

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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

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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

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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

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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

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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 bimolecular 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 bimolecular 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 bimolecular 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

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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

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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.”

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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

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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.

DRAFT

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.

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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."<sup>1</sup> 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."<sup>2</sup> 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.<sup>3</sup> 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**

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<sup>1</sup> Gunn IMS: Intramuscular Stimulation. <http://www.istop.org/ims.html>

<sup>2</sup> 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.

<sup>3</sup> [http://www.iamt.org/wp-content/uploads/2014/04/APTASTatement\\_DryNeedling-2014.pdf](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)***,<sup>4</sup> 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.<sup>5</sup>
- 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).<sup>6</sup>

### 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.”<sup>7</sup> 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:*

<sup>4</sup> 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>

<sup>5</sup> TITLE 43. PROFESSIONS AND BUSINESSES CHAPTER 33. PHYSICAL THERAPISTS.

[http://sos.ga.gov/plb/acrobat/Laws/15\\_Physical\\_Therapists\\_43-33.pdf](http://sos.ga.gov/plb/acrobat/Laws/15_Physical_Therapists_43-33.pdf)

<sup>6</sup> <http://news.nationalpost.com/news/canada/judo-acupuncture-needle>

<sup>7</sup> 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."<sup>8</sup>

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 needling<sup>9</sup>; 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,"

<sup>8</sup> Cummings. Safety Aspects of Electroacupuncture. *Acupuncture Med.* 2011;**29**:83-85

<sup>9</sup><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.”<sup>10</sup>

- As mentioned above, a Canadian Olympic athlete was similarly injured by dry needling.<sup>11</sup>

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.”<sup>12</sup>

#### 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%).**<sup>13</sup>

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

<sup>10</sup> 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

<sup>11</sup> <http://news.nationalpost.com/news/canada/judo-acupuncture-needle>

<sup>12</sup> <http://ubcgunnims.com/courses/prerequisites/>

<sup>13</sup> [https://www.physiotherapyalberta.ca/files/faq\\_dry\\_needling\\_adverse\\_events.pdf](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.<sup>14</sup>

*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,”<sup>15</sup> and clean needle technique is a requirement for licensure<sup>16</sup>. 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”<sup>17</sup> and is a technique commonly performed by acupuncturists treating myofascial pain.** The World Health Organization defines trigger points as a subset of acupuncture points.<sup>18</sup> 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.”<sup>19</sup> And Dommerholt himself insists, “Manual physical therapists must realize that dry needling is also within the scope of acupuncture practice.”<sup>20</sup>

It is well-represented in the literature that acupuncture has measurable effects on autonomic regulation,<sup>21</sup> neuroendocrine mechanisms,<sup>22</sup> the cardiovascular system,<sup>23</sup> tissue repair,<sup>24</sup> and so on.

**To say acupuncture only works to “restore energy flow” is a gross misrepresentation.**

<sup>14</sup> Bauer, M. Treating the Elderly. *Acupuncture Today*. September, 2002, Vol. 03, Issue 09

<sup>15</sup> <http://www.nccaom.org/about/history/>

<sup>16</sup> Washington Administrative Code.. East Asian Medicine Practitioner. WAC 246-803-240. Examinations

<sup>17</sup> Trigger point needling: techniques and outcome. Vulfsons et al. *Curr Pain Headache Rep*. 2012 Oct;16(5):407-12

<sup>18</sup> 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

<sup>19</sup> 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.

<sup>20</sup> Dommerholt, J. *J Man Manip Ther*. 2011 Nov; 19(4): 223–227.

<sup>21</sup> Li, Qian-Qian et al. “Acupuncture Effect and Central Autonomic Regulation.” *Evidence-based Complementary and Alternative Medicine : eCAM* 2013 (2013): 267959. PMC. Web.

<sup>22</sup> Liang, Fengxia, Rui Chen, and Edwin L. Cooper. “Neuroendocrine Mechanisms of Acupuncture.” *Evidence-based Complementary and Alternative Medicine : eCAM* 2012 (2012): 792793.

<sup>23</sup> 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.

<sup>24</sup> 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.<sup>25</sup> According to the company's website, the textbook for the course is, "Biomedical Acupuncture for Pain Management."<sup>26</sup> 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.<sup>27</sup> Other studies use this or similar protocols.<sup>28 29 30 31</sup>**

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.

<sup>25</sup> <http://dryneedlingcourse.com/dr-mas-textbooks/pain-management/table-of-contents>

<sup>26</sup> Ma, Yun-tao. Biomedical Acupuncture for Sports and Trauma Rehabilitation Dry Needling Techniques. New York: Elsevier; 2010.

<sup>27</sup> 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.

<sup>28</sup> 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

<sup>29</sup> 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

<sup>30</sup> 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.

<sup>31</sup> 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.”<sup>32</sup>

## ii. Trigger Points v. Ashi Points

Dry needling is also commonly called “trigger point needling”<sup>33</sup> and is a technique commonly performed by acupuncturists treating myofascial pain.<sup>34 35 36 37</sup> The technique of needling taut bands of tissue is described in the earliest acupuncture text<sup>38</sup> 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.<sup>39</sup>

**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.”<sup>40</sup>

**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**

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<sup>32</sup> 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

<sup>33</sup> Trigger point needling: techniques and outcome. Vulfsons et al. *Curr Pain Headache Rep*. 2012 Oct;16(5):407-12

<sup>34</sup> Callison, M. *Motor Point Index*. AcuSport Seminar Series LLC, San Diego, 2007, (p.9).

<sup>35</sup> Reeves, W. *The Acupuncture Handbook of Sports Injuries & Pain*. Hidden Needle Press, Boulder, CO, 2009, (p.360).

<sup>36</sup> Goddard, A. *J Chinese Medicine*. 2011 Oct. (97):25-28.

<sup>37</sup> Nugent-Head, A. *J chinese Medicine*. 2013. Feb. (101):5-12.

<sup>38</sup> Huang Di Nei Jing. *Ling Shu*, Ch13,

<sup>39</sup> Physical Therapy Association of Washington. *Sunset Review application*, June 2016

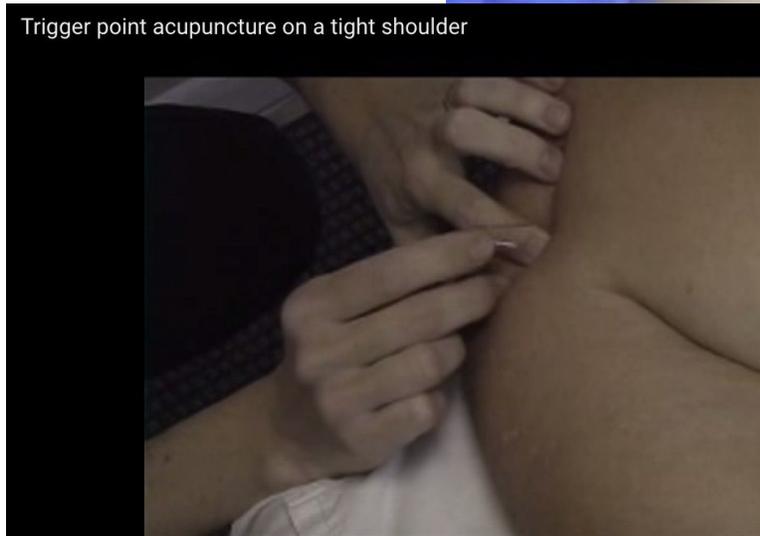
<sup>40</sup> Liu, Skinner, McDonough. “Traditional Chinese Medicine acupuncture and myofascial trigger needling: The same stimulation points?” *Complement Ther Med*. 2016. Jun;26:28-32.

described Birch’s conclusions as “conceptual opinions.”<sup>41</sup> 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.<sup>42</sup>

Visual comparison of dry needling and acupuncture:

A video<sup>43</sup> was cited in the application for sunrise review that showed trigger point dry needling. Compare this to a video of trigger point acupuncture<sup>44</sup>. 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:

<sup>41</sup> 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

<sup>42</sup> 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

<sup>43</sup> <https://www.youtube.com/watch?v=I75OAZr6V4&index=49&list=FLJZHGN5-n5P2nJEP2TeVcow>

<sup>44</sup> <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.<sup>45</sup>

**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..**

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<sup>45</sup> 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.

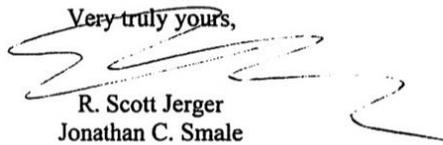
The purchase and receipt of acupuncture needles by individuals who are not qualified to practice acupuncture or for intended uses other than acupuncture make such needles legally “adulterated” and/or “misbranded” under the FDCA and is in direct violation of the FDCA and FDA’s implementing regulations. 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."<sup>46</sup>**

Killoren, a Washington physical therapist and owner of US Dry Needling, distributes Myotech needles.<sup>47</sup> 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

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<sup>46</sup> 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

<sup>47</sup> Killoren, Paul. LinkedIn profile. <https://www.linkedin.com/in/paul-killoren-410804a>

needle" category. Doing this to define #dryneedling v acupuncture."<sup>48</sup> 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.<sup>49</sup> **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.<sup>50</sup> 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.<sup>51</sup>

- 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.

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<sup>48</sup> <https://twitter.com/DrDunning/status/746471831654240256>

<sup>49</sup> [https://www.accessdata.fda.gov/cdrh\\_docs/pdf15/K150903.pdf](https://www.accessdata.fda.gov/cdrh_docs/pdf15/K150903.pdf)

<sup>50</sup> "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.

<sup>51</sup> "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.**



**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

**aaPM&R**  
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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](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  
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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.<sup>i</sup>

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...”<sup>ii</sup>

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.<sup>iii</sup>

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<sup>iv</sup>

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.”<sup>v</sup>

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."<sup>vi</sup>

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.”<sup>vii</sup>

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.”<sup>viii</sup>

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...”<sup>ix</sup>

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.**”<sup>x</sup>

### **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.<sup>xi</sup>

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.”<sup>xiii</sup> 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.

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<sup>i</sup> McGraw-Hill Concise Dictionary of Modern Medicine. © 2002 by The McGraw-Hill Companies, Inc.

<sup>ii</sup> <http://www.remedyspot.com/content/topic/4412122-re-how-are-you-charging-for-dry-needling/>

<sup>iii</sup> American Association of Acupuncture and Oriental Medicine (AAAOM) Position Statement on Trigger Point Dry Needling (TDN) and Intramuscular Manual Therapy (IMT), May 17 2011

<sup>iv</sup> <http://www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/MARFS/Chapter16/default.asp>

<sup>v</sup> Applicant Report: Dry Needling in PT Scope of Practice June 1, 2016

<sup>vi</sup> Medical Dictionary, © 2009 Farlex and Partners.

<sup>vii</sup> <http://www.remedyspot.com/content/topic/4412122-re-how-are-you-charging-for-dry-needling/>

<sup>viii</sup> <http://www.remedyspot.com/content/topic/4412122-re-how-are-you-charging-for-dry-needling/>

<sup>ix</sup> <http://www.remedyspot.com/content/topic/4412122-re-how-are-you-charging-for-dry-needling/>

<sup>x</sup> [http://www.iamt.org/wp-content/uploads/2014/04/APTASTatement\\_DryNeedling-2014.pdf](http://www.iamt.org/wp-content/uploads/2014/04/APTASTatement_DryNeedling-2014.pdf)

<sup>xi</sup> Chapter 14: Intra-Muscular Stimulation (IMS) pp209-228“Trigger-Point Dry-Needling” J. Dommerholt and C.F. Fernandez-de-las-Penas 2013 Elsevier Ltd.

<sup>xii</sup> 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.<sup>1</sup> Licensure requires attaining specific, quantitative levels of theory and clinical training in both western and Asian medicine.<sup>2</sup> Gaining a license requires passing a national, accredited examination.<sup>3</sup>

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.<sup>4</sup> 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<sup>5</sup> and in accredited schools.<sup>6</sup> 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.

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<sup>1</sup> 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.

<sup>2</sup> RCW 18.06.050 and WAC 246-803-100 through 240

<sup>3</sup> WAC 246-803-240

<sup>4</sup> RCW 18.06.050(2)

<sup>5</sup> RCW 18.06.060

<sup>6</sup> 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,<sup>7,8</sup> whose 2016 resolution states that dry needling should be performed only by licensed physicians and acupuncturists.<sup>9</sup>
- The American Academy of Physical Medicine and Rehabilitation,<sup>10</sup> 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,<sup>11</sup> 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.

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<sup>7</sup> 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.

<sup>8</sup> 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>

<sup>9</sup> Physicians wishing to be certified as "medical acupuncturists" undertake an additional 300 hours of training, including supervised clinical work.

<sup>10</sup> AAPM&R Position on Dry Needling, adopted June, 2012

<sup>11</sup> 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,<sup>12</sup> 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:<sup>13</sup>

- "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."<sup>14</sup>
- The authors [Ernst] observe that all deaths would likely be avoided with adequate acupuncture training.<sup>15</sup>
- [From a different literature review]: Adverse events would be avoided if all acupuncturists were trained to a high level of competency.<sup>16</sup>
- [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.<sup>17</sup>

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.

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<sup>12</sup> Physiotherapy Alberta is the organization responsible for regulating the practice of physiotherapy in the province.

<sup>13</sup> 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.

<sup>14</sup> Janz *ibid.*

<sup>15</sup> Ernst E. Deaths after acupuncture: A systematic review. *International Journal of Risk & Safety in Medicine* 2010;22:131–6.

<sup>16</sup> 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.

<sup>17</sup> 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.

DRAFT



## 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.<sup>14</sup>

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.<sup>8</sup>

Prior to 2014, only large scale studies examining adverse events related to acupuncture were available.<sup>4,5,10,12,18,19-22</sup> Brady et al are the first to publish a prospective study of adverse events related to trigger point/IMS dry needling.<sup>1</sup>

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.<sup>19,21</sup>

- 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"> <li>• Bruising</li> <li>• Bleeding</li> <li>• Pain during treatment</li> <li>• Pain following treatment</li> <li>• Aggravation of symptoms followed by improvement</li> <li>• Feeling relaxed/energized</li> <li>• Feeling tired/drowsy</li> <li>• Feeling faint</li> <li>• Dizzy</li> <li>• Nausea</li> <li>• Sweating</li> </ul>	<ul style="list-style-type: none"> <li>• Prolonged pain at site</li> <li>• Extensive bruising</li> <li>• Profuse sweating</li> <li>• Severe nausea</li> <li>• Vomiting</li> <li>• Fainting</li> <li>• Headache</li> <li>• Extreme fatigue</li> <li>• Severe emotional reaction</li> <li>• Gastrointestinal disturbance</li> <li>• Skin irritation</li> <li>• Slurred speech</li> <li>• Forgotten needle/patient</li> <li>• Seizure</li> </ul>	<ul style="list-style-type: none"> <li>• Pneumothorax</li> <li>• Puncture of other vital tissue</li> <li>• Systemic Infection</li> <li>• Broken needle</li> </ul>

<sup>#</sup> 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.<sup>5,10,12,18,23</sup> 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.<sup>1</sup> 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.<sup>4,20</sup> 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 products<sup>7</sup> has been used to discuss adverse events related to dry needling.<sup>1,22</sup>

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 studies<sup>8</sup> 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.<sup>4,5</sup>

#### 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%<sup>10</sup>, 0.14%<sup>23</sup>, 7%<sup>21</sup>, 8.6%<sup>22</sup>, 11.4%<sup>5</sup>).

- Acupuncture adverse event rates in 2.2 million acupuncture treatments performed by physicians.<sup>22</sup>
  - 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 Rates<sup>1</sup>

- 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,<sup>1,7,22</sup> 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 study<sup>1</sup> 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  
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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](mailto: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

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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

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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 5<sup>th</sup>—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 5<sup>th</sup>, 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 4<sup>th</sup>, 2012 at 6:30pm (who does not hold a medical degree).

Since October 4<sup>th</sup>, 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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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I am writing to in response to the Sunrise Review on Dry Needling 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 Columbia 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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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

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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!

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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

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I support the proposal to add dry needling to the PT scope of practice.

Deb Schaack

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I STRONGLY OPPOSE physical therapists having dry needling under the scope of their practice.

Sarah Collins

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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

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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

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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

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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

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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.

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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

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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

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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

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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

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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

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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

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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](#),<sup>a</sup> [Hongcai Shang](#),<sup>a</sup> [Xiumei Gao](#),<sup>a</sup> and [Edzard Ernst](#)<sup>b</sup>

## **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.<sup>1–4</sup> Prospective surveys to determine the frequency of acupuncture-related adverse events have been conducted in Germany,<sup>5,6</sup> Norway<sup>7</sup> and the United Kingdom of Great Britain and Northern Ireland.<sup>8,9</sup> 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%.<sup>5</sup> Another large-scale observational study showed a rate of adverse events requiring specific treatment of 2.2% (4963 incidents among 229 230 subjects).<sup>6</sup> 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.<sup>10,11</sup> 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 <sup>a</sup>	Adverse event (no. of cases <sup>b</sup> )	Acupoint (code <sup>c</sup> or site)	Outcome
<b>Spinal cord and neighbouring tissues</b>			
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.	Subarachnoid haemorrhage (35 cases)	GB20, GV16, GV14, BL10	3 deaths, 32 recoveries
Bao F, Zhang XL, Tian SP. Acupuncture at Fengchi point			

[Table 1](#)

### Traumatic events after acupuncture, as identified through a systematic review of the Chinese-language literature, 1980–2009

Reference <sup>a</sup>	Cases <sup>b</sup> (age in years and sex)	Reason for acupuncture	Acupoint (code <sup>c</sup> 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.	33, male	Toothache	Buccal region	Buccal space abscess	Recovery
Wang YJ. Acupuncture	52, male	Toothache	Buccal region	Temporal space	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 <sup>a</sup>	Cases <sup>b</sup> (age in years and sex, or no. of cases)	Reason for acupuncture	Acupoint (code <sup>c</sup> or site)	Adverse event	Outcome
Liu CB. Acupuncture-related syncope in 4 cases. <i>J Clin Acupunct</i> 2001;17:51	34, 45 & 50, females	Low back pain; shoulder pain		Fainting	Recovery
Li YZ. <i>Chin J Acupunct</i> 2001;17:51	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.<sup>12</sup>

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.<sup>2</sup> 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.<sup>13</sup> 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,<sup>14</sup> but very few were found in surveys<sup>7-9</sup> or prospective observational studies.<sup>5,6</sup> 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 literature<sup>1</sup> 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.<sup>15</sup> 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,<sup>1-9</sup> 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:](#)

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[Go to:](#)

### **Competing interests:**

None declared.

[Go to:](#)

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- 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**.<sup>[1][2]</sup> The word *medicine* is derived from **Latin** *medicus*, meaning "a physician".<sup>[3][4]</sup> 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.<sup>[5]</sup>

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,<sup>[6]</sup> but is generally safe when done by an appropriately trained practitioner.<sup>[7]</sup> 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