Manning, Judy [IDPH]

From: Valerie <vastall@centurylink.net>
Sent: Thursday, October 29, 2015 9:01 AM
To: Manning, Judy [IDPH]
Subject: Response for Acupuncture/ Dry Needling
Attachments: Dry Needling_Acupunctur1.docx

Dear Ms. Manning,

I think that the physical therapists who want to pierce the skin with needles, esp. the thin, filiform needles that are used for acupuncture, should be required to get the same training and be licensed as the acupuncturists are required to do in this state.

Attached is my "Response" document. I have mailed a similar document along with other printed documents for the consideration of the IPOT Board.

Thank you for all your efforts in coordinating the collection of these comments.
Sincerely,

Valerie Stallbaumer, L.Ac., M.S.O.M.
Ames, IA 50010

Acupuncture/ dry needling Response---p.1

By Valerie Stallbaumer, L. Ac., M.S.O.M.

First, I will comment on some of the statements made by physical therapists at the Sept. 11, 2015 IPOT Board meeting.

1) Pam Reynolds, P.T. of Johnston Physical Therapy and Sports Medicine, was misinformed to say that the federal government does not recognize acupuncture. *Also, she questioned, "Where would all these soldiers get treatments if I was not able to do acupuncture/DN?*
--Acupuncture is covered on all insurance policies for federal employees.
--Acupuncture is a valid medical expense for tax deductions and is covered on all FLEX plans.
--Acupuncture is used in several U.S. Army posttraumatic stress disorder treatment programs.
--Acupuncture is used in some V.A. hospitals for pain management and various health issues.
--Ms. Reynolds works next door to the most highly trained acupuncturists in Iowa, Yimin and Diana Xu of the Family Acupuncture Clinic. They are both former professors of the Southwest Acupuncture College and have been practicing extensively since 1983.

2) Shane McClinton, P.T. of Des Moines brought a client, Stephanie McFarland, to talk about her experiences with Shane's needling techniques. *She said that she would not be able to do her running if she had not had the acupuncture needles. She said that she would continue to go to Shane for those treatments.* RESPONSE: Here is an example where client loyalty is used inappropriately. Instead of referring his client to a fully-trained acupuncturist who could have made greater improvements for his client, Shane uses his insignificant training to make some difference but probably failed to make a long-lasting effect. If truly helping the client is the most important goal, then referring the patient to someone who specializes in the techniques of acupuncture should be the standard practice.

3) The argument is that there are not enough acupuncturists (L.Ac.'s) to treat all the people who need it.
--For all the locations where P.T.'s are doing needling, there are well-established, fully-trained acupuncturists in Iowa. L.Ac.'s are located all around the state. I know of clients who travel at least an hour for regular acupuncture treatments when they live in a location not near a fully trained acupuncturist. Travelling for these treatments is not an inconvenience for many people.

4) P.T.'s say that what we (L.Ac.'s) do is not scientific; but using the same techniques P.T.'s insist that they are using more scientific methods, based on more scientific research.
--Acupuncture and Oriental Medicine have evolved with science, are supported by the National Institute of Health, the World Health Organization and is researched around the world. Research on the efficacy, specific techniques and health issues are published in wide-spread journals annually. These cannot be ignored. P.T.'s did not invent scientific research on needling.

P. 2 --- Stallbaumer

Other Comments for the IPOT Board Consideration ---by Valerie Stallbaumer, L.Ac.

1) **People in the general public do not see any difference with acupuncture and the dry needling techniques.**

   --By only getting insignificant training and occasionally dabbling in acupuncture, P.T.'s are giving a bad reputation to our profession and to the well-established practice of this highly skilled approach to health care.

   --When people do not get the best results, they are going to assume that acupuncture does not work. Also, a number of people I have talked with who received needling from a P.T. commented that it was uncomfortable or even painful. This impression also gives a bad reputation to our profession and to the L.Ac.'s who really know what they are doing.

2) **No matter what you want to call this technique, it is ACUPUNCTURE.**

   --Re-naming the practice of using filiform needles to treat pain or various health issues does not take away from the fact that this is acupuncture. All the references that P.T's use to try to prove that they are doing something different or that they have learned from a different source, all these same references refer to the modern history of how acupuncture has evolved in this country and around the world.

3) **This is not a turf battle**.

   --We already own this "turf." Acupuncturists have already, for centuries, used all the possible point locations, needling methods and techniques. Because of how extensive the scope of knowledge is for this practice is why it takes 3 – 4 years minimum to learn the skills and practice them in a supervised, clinical setting for hundreds of hours as part of that training. Just as all practitioners have a scope of practice that they are extensively trained in, successfully past examinations in and fulfill annual continuing education in their field; this is what we specialize in. All people doing any style of needling should follow the laws to practice this specialty. If P.T.'s want to do acupuncture, they should get the college degree and become licensed or hire a licensed acupuncturist to join their clinic.

4) **It is all about the training.**

When any member of the general public is asked who they would seek for getting acupuncture, based on the number of hours of training, all people surveyed would seek the most highly trained practitioners, the licensed acupuncturists. P.T.'s assume that acupuncture is just a mechanical process—just put needles where there is pain. That is the least effective method and should not be chosen in most cases. That is where the extensive training comes in. Licensed acupuncturists (who receive 2700 – 3300 hours for their advanced college degrees) know that there is much more to treating pain. How to diagnose is much more than just how to find tight or inflamed muscles.

P.3 --- Stallbaumer

5) **P.T.'s have referred to a position paper published this year by the Federation of State Boards of P.T.** (fsbpt) that concluded that P.T.'s already have over 80% of the skills to do needling. But some of the skills listed are what anyone is capable of. They have listed: being able to stand up straight, hold your hand steady, communicate clearly with the patient, record accurate notes.... These statements assume that doing the needling is just a mechanical process. This is where the lack of sufficient knowledge causes inferior techniques and results and misguides the public.

6) **Filing insurance claims is committing fraud.**
Filing insurance claims using inaccurate codes is unethical and fraudulent. They are doing acupuncture and misrepresenting it with incorrect codes. Also, the U.S. attorney general has already ruled that this technique or any acupuncture cannot be filed as a claim with Medicare. --Many insurance companies now cover acupuncture when it is done by a licensed acupuncturist. All states on the west coast (CA, OR, WA), many states on the east coast and every year more insurance policies are covering acupuncture treatments in the Midwest.

Submitted by: Valerie Stallbaumer, L.Ac.
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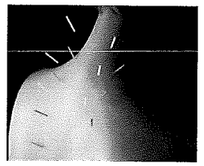
Practicing acupuncture and TCM Oriental medicine for 18 years in Iowa.
College degrees: B.S. in biology and chemistry
M.S in Integrated Sciences
M.S. in Oriental Medicine
Other careers: Taught sciences at the secondary level for 8 years.
Worked as a research associate in biochemistry and microbiology for 6 years.

Coalition for Safe Acupuncture Practice

When is Dry Needling Acupuncture?



The short answer is "Always."

Dry needling is a pseudonym for a brief course of study in myofascial acupuncture also known as *ashi* acupuncture and trigger point acupuncture.[7] Three important studies, Trigger Points and Classical Acupuncture Points, Parts 1,2,3 (P.T. Dorsher, J. Fleckenstein) explore the relationship of Ashi or Acupuncture points to myofascial trigger point regions. In the first part of the study, myofascial trigger point regions were demonstrated to have strong (93.3%) anatomic correspondences with classical acupuncture points.[1] The second portion of this study examined the clinical correspondences of trigger point regions and classical acupuncture points in the treatment of both pain and somatovisceral disorders, and found they had ~ 97 % correlation for treating pain conditions and over 93 % correlation in treating somatovisceral conditions.[2] The third portion of the study concluded that the strong (up to 91 %) consistency of the distributions of trigger point regions' referred pain patterns to acupuncture meridians provides a third line of evidence that trigger points most likely represent the same physiological phenomenon as acupuncture points in the treatment of pain disorders.[3]

Ashi Point Needling is Myofascial Trigger Point Needling is Acupuncture. Dry Needling is Acupuncture, too.

The National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), the certifying board for Acupuncture licensure, completed a job task analysis in 2003 and again in 2008. The analysis documented the prevalence of actual use of Dry Needling techniques, that is the treatment of trigger points, motor points and/or ashi points with acupuncture needles, by practicing acupuncturists. In 2003, 82% of acupuncturists surveyed used needling of trigger points in patients that presented with pain. Of the patients that present for acupuncture treatment, it is estimated that 56% present with trigger point pain.[4]

These findings document that acupuncturists are well trained to use and have consistent historical usage of trigger and motor point "dry needling" treatment. Dry needling represents a substantial daily practice among American acupuncturists.[5]

Medicare reinforces these findings by its use of ICD-9 (International Classification of Disease, 9th Ed.) and CPT (Current Procedural Terminology) coding in its claims reimbursement. While litigating a case involving coding for Dry Needling, Assistant U.S. Attorney Kevin Doyle said "The only code for Medicare that would cover something like Dry Needling would be an Acupuncture code." [6]

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The Coalition for Safe Acupuncture Practice seeks to bring public and media attention to this public health issue by education, petition and Public Demonstration.

Please visit us on Facebook at Coalition for Safe Acupuncture Practice, where you can also sign the CSAP Petition. Or write us at CSAP@Aardvarksfly.com. Thanks!

COALITION for SAFE ACUPUNCTURE PRACTICE

Coalition for Safe Acupuncture Practice

What is Dry Needling?

Recently, Physical Therapists have been seeking to incorporate what is being named "Dry Needling" into their patient treatment regimens. Dry Needling is indistinguishable from acupuncture, yet is often based on two or three day seminars, featuring only 16 to 24 hours of classroom education with no needle technique clinical internship training being included.

Is Dry Needling the same as Acupuncture?

"Yes," according to all major state and national organizations involved in the certification, professional representation and educational development of the field of Acupuncture and Oriental Medicine. The **Council of Colleges of Acupuncture and Oriental Medicine** (CCAOM) "It is the position of the CCAOM that any intervention utilizing dry needling is the practice of acupuncture, regardless of the language utilized in describing the technique." [1]

Medicare agrees. "The only code for Medicare that would cover something like dry-needling would be an acupuncture code," said Assistant U.S. Attorney Kevin Doyle ." [2]

Will Dry Needling practice affect Acupuncture practice?

Patients do not discern between types of needling treatments. When a patient receives a therapy involving needling, their perception is that they have received acupuncture. When acupuncture is performed by practitioners without adequate classroom and clinical education, the experience of acupuncture is not optimal. When acupuncture is performed by practitioners without needling technique education, without Clean Needle Technique certification, and without needle technique clinical internship, the experience of needling can be hazardous.

Adversely performed acupuncture negatively impacts all those practitioners who are licensed to practice acupuncture. Negative patient feedback especially affects the availability of new patients for Licensed Acupuncturists. It makes good business sense for practitioners of Traditional Chinese Medicine and acupuncture to safeguard, protect and regulate the teaching and practice of their chosen healing art, Acupuncture.

Coalition for Safe Acupuncture Practice seeks to inform and warn the public of the healthcare hazards and the potential for serious injury that exists in undergoing Dry Needling treatment by any healthcare practitioners, including Physical Therapists, who are not also fully trained and licensed as Acupuncturists.

Sources Cited: 1. "Council of Colleges of Acupuncture and Oriental Medicine Position Paper on Dry Needling." *Acupuncture Today Is a Leading Provider of Acupuncture News, Info and Research Information in the World.* Web. 28 Dec. 2011. <http://www.acupuncturetoday.com/mpacms/at/article.php?id=32377>.
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COALITION for SAFE ACUPUNCTURE PRACTICE

ACUPUNCTURE today

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Acupuncture Collaboration with the U.S. Navy and the U.S. Marines

By Joe C. Chang, MAOM, Dipl. OM, LAc

These past several months have been a true testament of passionate people who want to help soldiers. Previously, I've talked about studies that have shown clear cost in dollars of **treating our returning veterans**, as well as the value of using solid evidence-based research to treat them. Below, I've given just a few highlights of how integrating complementary and alternative therapies are helping heal our soldiers as they return from war.

Back in the spring of this year, representatives from the **Naval Medical Center at San Diego** and the **Naval Hospital at Camp Pendleton** in Oceanside, Calif., came to Ft. Hood for a site visit at the **Warrior Combat Stress Reset Program** at **Carl R. Darnall Army Medical Center**. The goal was to collaborate and share information on our integrative posttraumatic stress disorder (PTSD) program. The representatives were able to visit the Warrior Combat Stress Reset Program for two days, on our mental health protocols and aspects of the complementary and alternative medicine.

All of the representatives from the U.S. Army agreed while there is no single treatment program that has been proven to provide exactly what our service members need, everyone agreed that an integrative, holistic approach will enable our soldiers to heal from their trauma and provide the best service to our warriors that they deserve.

Advocates for an intensive PTSD program at the U.S. Army were convinced that the traditional methods of treating PTSD are not always long enough in duration, intense enough or comprehensive enough. The Traditional treatment programs are modeled after those utilized for survivors of civilian traumas and not for Soldiers who will be asked not only to face their traumas, but to redeploy into the same environment multiple times. Therefore, a PTSD treatment program that incorporates the integration of medical massage, meditation, yoga, acupuncture, marital/family therapy as well as reiki with standard treatment protocols of cognitive-behavioral therapy, cathartic psychotherapy and pharmacotherapy may turn out to be the most effective in addressing all aspects of PTSD.

On another front, I have been working to incorporate acupuncture into the **Evans Army Community Hospital** and am about to add acupuncture services as a pain-management modality for the department of surgery. Additionally, opportunities to add acupuncture into the **Cheyenne Veterans Affairs Medical Center** and the **Washington State Derpartment of Veterans Affairs** for the treatment of PTSD, in conjunction with standard mental health protocols, are ongoing and are likely to result in an integrative approach for our veterans in the near future.

Our veterans deserve the best possible health care. Complementary and alternative therapies, including acupuncture, will play an integral role in that.

Editor's Note: The representatives from the Navy came to visit the Warrior Combat Stress Reset Program to learn about it and see how similar programs might be implemented at Navy military treatment facilities.

Disclaimer:

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Marines, Department of Defense, or the U.S. Government. Opinions, interpretations, conclusions, and recommendations herein are those of the author and are not necessarily endorsed by the U.S. Army, the U.S. Marines, and the U.S. Navy."

Joe C. Chang has worked as an acupuncturist at two integrative PTSD programs for the military. Additionally, he has worked as a volunteer acupuncturist with the Austin Veterans and Family Advocacy Council in their Veterans Team Recovery Integrated Immersion Program.

ACUPUNCTURE today

Print this Document!

Comprehensive Military PTSD Treatment Programs

By Joe C. Chang, MAOM, Dipl. OM, LAc

So far, there are four comprehensive posttraumatic stress disorder (PTSD) and combat stress treatment programs in the U.S. Army that have incorporated different CAM approaches in their treatment programs. Many of these comprehensive programs started as a result of the **Ft. Bliss Restoration and Resilience Center**, near El Paso, Texas. This integrative approach treats many of the symptoms of PTSD that are not addressed through the standard mental health protocols that included cognitive-behavioral therapy and pharmacotherapy. The Ft. Bliss program incorporated medical massage, meditation, yoga, acupuncture, marital/family therapy and Reiki with standard treatment protocols . Additionally, soldiers go through a daily 45-minute "power walk" and play water polo three times a week.

Public relations exposure at Ft. Bliss has built support for the integration of CAM into standard treatment programs. This support has been generated through scheduled visits to the facility by top military personnel, including Secretary of Defense Robert Gates, and the Chairman of the Joint Chiefs of Staff, Admiral Michael Mullen.

At the **Warrior Combat Stress Reset Program** at Ft. Hood (near Killeen, Texas), their intensive, combat-stress three-week program focuses on the reduction of hyperarousal and reactivity. Reducing these core symptoms of combat stress and posttraumatic stress disorder allows other treatments to be more effective. The program includes group counseling, biofeedback, individual counseling and alternative therapies (massage, acupuncture, yoga and Reiki).

The Deployment Health Clinical Center at Walter Reed Army Medical Center (in Washington, D.C.) uses evidence-based therapies in a comprehensive three-week program. Soldiers learn coping skills to reduce intrusive symptoms such as hyperarousal and avoidance. The program also provides a therapeutic group process for mutual support and re-integration into family and community. Additionally, soldiers are taught stress management and practice various forms of relaxation (guided imagery, yoga, progressive muscle relaxation and deep abdominal breathing).

The **Landstuhl Regional Medical Center** (near Landstuhl, Germany) uses an intensive, eight-week, therapeutic day-treatment program that includes a holistic approach. During the eight-hour days, patients will participate in multiple disciplines and interests, including art therapy, yoga and meditation classes, substance-abuse groups, anger and grief management, tobacco cessation, pain management and multiple posttraumatic stress disorder treatment protocols. The evidence-based protocols include eye movement desensitization and reprocessing (EMDR), cognitive processing therapy, and prolonged-exposure therapy.

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Joe C. Chang has worked as an acupuncturist at two integrative PTSD programs for the military. Additionally, he has worked as a volunteer acupuncturist with the Austin Veterans and Family Advocacy Council in their Veterans Team Recovery Integrated Immersion Program.

Term and Title Protection

What APTA is doing to ensure term and title protection in all US jurisdictions, and what you can do to help.

Terms

- Physical therapy
- Physiotherapy

Titles

- Physical therapist or physiotherapist
- PT (state licensure designation for physical therapists)
- Educational degrees obtained by physical therapists that are used in conjunction with the state licensure designation of PT, such as the DPT or MPT

Introduction

A growing problem throughout the country is the misuse or inappropriate advertisement of physical therapy services. People who are not licensed physical therapists have held themselves out to the public as providing "physical therapy" or "physiotherapy," or use the initials "PT" to describe their services. This characterization is misleading to the public, illegal in some states, and a disservice to individuals who are in need of physical therapy and who think they are receiving it, but in reality are not.

When the public receives treatment such as physical therapy, people deserve to know what treatment they are receiving and that the person performing the treatment is a licensed physical therapist (PT) who has the requisite education and training to provide the treatment.

Massage therapists, chiropractors, personal trainers, or health care practitioners may share some of the same treatment modalities or techniques that also are used by physical therapists; however, an intervention should only be described or advertised as physical therapy or physiotherapy when provided or supervised by a licensed physical therapist.

In addition, some fitness personnel, specifically personal trainers, have mistakenly used the initials "PT" which is the recognized and protected state licensure designation for licensed physical therapists. The use of the licensure designation "PT" by licensed physical therapists is to ensure public protection; these specific initials denote to the consumer that the person is licensed by the state to practice physical therapy.

Physical Therapy – NOT a Generic Term

Physical therapy is not a generic term. It describes the care and services provided by or under the direction of a licensed physical therapist. Other health care providers have attempted to classify physical agents, mechanical modalities, and/or electrotherapy as "physical therapy" or "physiotherapy." The use of these modalities can be described as the practice of physical therapy only when a licensed physical therapist provides the modalities. Some professions may use some of the same physical agents and modalities as physical therapists, but only physical therapists and physical therapist assistants under the direction and supervision of physical therapists practice "physical therapy."

What makes the terms physical therapy and physiotherapy exclusive to the physical therapy profession is the distinct education of physical therapists, the special body of knowledge of the physical therapy profession, the regulatory standards and requirements for licensure as a physical therapist, and the unique perspective, specific skills, practice standards, and specialized care that are provided by licensed physical therapists.

As clinicians, physical therapists engage in an examination process that includes taking the patient/client history, conducting a systems review, and performing tests and measures to identify potential and existing problems. To establish diagnoses, prognoses, and plans of care, physical therapists perform evaluations, synthesizing the examination data and determining whether the problems to be addressed are within the scope of physical therapist practice. Based on their judgments about diagnoses and prognoses and based on patient/client goals, physical therapists provide interventions (the interactions and procedures used in managing and instructing patients/clients), conduct reexaminations, modify interventions as necessary to achieve anticipated goals and expected outcomes, and develop and implement discharge plans.

The patient/client management elements of examination, evaluation, diagnosis, and prognosis should be represented and reimbursed as physical therapy only when they are performed by a physical therapist. Physical therapists are the only professionals who provide physical therapy examinations, evaluations, diagnoses, prognoses, and interventions based on the physical therapist's examination and evaluative process. Intervention should be represented and reimbursed as physical therapy only when performed by a physical therapist or under the direction and supervision of a physical therapist.

Protecting the Public

The rationale behind term protection generally relates to the protection afforded to consumers and patients. Specifically, state regulatory bodies are often concerned that an individual or entity that is not properly qualified to provide physical therapy services may, for example, advertise or represent that physical therapy services are being provided, when in fact there is no physical therapist involved in the provision of services. A consumer also may mistakenly believe that someone using the initials "PT" is a licensed physical therapist, when in fact they are not.

In addition to consumer protection issues, term protection also seeks to address concerns relative to third party payers. For example, third party payers who bundle physical therapy benefits with those of other health care

professionals may, depending on the time a service is provided, offer a "physical therapy" benefit that is in fact exhausted before the patient ever sees a licensed physical therapist. Additionally, allowing nonphysical therapists to use terms such as "physical therapy" may result in a payer reimbursing for a service that it believes to be physical therapy when in fact there is no physical therapist involved in the provision of services.

The protection of the terms physical therapy and physiotherapy is not referring to protection against the use of various physical agents, modalities, or procedures by others, but rather is against the inappropriate labeling of those modalities and procedures as physical therapy.

Term Protection and State Laws

Violations and Complaints

Resources for Chapters

APTA Positions

Consumer Protection Through Licensure of Physical Therapists and Physical Therapist (.pdf)
(See Principle III – Appropriate Use of Protected Terms and Title by Licensees)

Communication Resources

Advertisement: Protecting the Use of 'PT' (.pdf)

Sample Letter: Misuse of the term 'PT' (.doc)

Last Updated: 1/13/2015
Contact: advocacy@apta.org

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WHAT
DOES
A FALL
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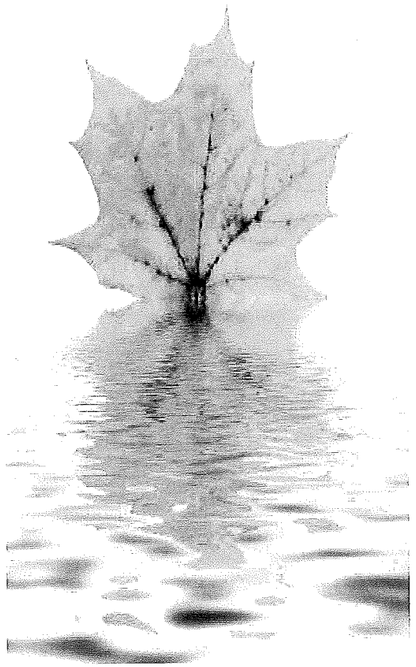


Recently, the terms Dry Needling and Intramuscular Manual Therapy have been introduced to patient populations as new treatment options.

Are they? This paper analyzes the origins of Acupuncture, Dry Needling and Intramuscular Manual Therapy, examines the advantages and implications of their present day practice, and arrives at suggestions for how to best incorporate these therapeutic options into America's health care future.

Acupuncture,
Dry Needling and
Intramuscular Manual Therapy:

Understanding Acupuncture's Therapeutic Role in America

J. Hoyt | Coalition for Safe Acupuncture Practice | Mary J. Rogel, PhD, LAc, Alan Uretz, PhD, LAc, Kris Justesen, LAc, OMD, Editors| 4/12 v2

"I look to the diffusion of light and education as the resource to be relied on for ameliorating the condition, promoting the virtue, and advancing the happiness of man." Thomas Jefferson

Preface

Acupuncture, Oriental Medicine and Traditional Chinese Medicine (TCM) inherits and develops the philosophies of Taoism and Confucianism and uses them to understand disease and health. The guiding concept of TCM is a correspondence between humankind and nature. We, as an organism in nature, reflect the world in which we live, thus making a balance between humankind and nature essential for wellbeing. Practice of Acupuncture with an understanding of the concepts of Traditional Chinese Medicine coupled by appropriate hours of clinical practice is essential to preserving the efficacy, the safety, the harmony and ultimately the power of Acupuncture to heal.

Dry Needling, as developed by Travell & Simons (Travell & Simons' *Myofascial Pain and Dysfunction: The Trigger Point Manual,* 1999[45]), C. Chan Gunn ("Acupuncture Loci: A Proposal for Their Classification According to Their Relationship to Known Neural Structures," *American Journal of Chinese Medicine,* 1976[123]) and Peter Baldry (*Acupuncture, Trigger Points and Musculoskeletal Pain: A Scientific Approach to Acupuncture for Use by Doctors and Physiotherapists in the Diagnosis and Management of Myofascial Trigger Point Pain,* 2005[113]), seeks to redefine Acupuncture by reframing its theoretical principles in a Western manner. This changing of Acupuncture's context is justified by a search for a biomedical principle by which Acupuncture affects its therapeutic properties. Attempting to provide new insight into a time honored healing model is laudable. Not respecting and preserving the methods by which that modality is practiced is dangerous.

Acupuncture, Dry Needling and Intramuscular Manual Therapy: Understanding Acupuncture's Therapeutic Role in America is organized in a question and answer or Socratic method format. Because completeness and entirety of each answer is the goal, some repetition of material occurs.

In the United States, both the American Association of Acupuncture and Oriental Medicine (AAAOM) and the Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) have examined the practice of Dry Needling and found it to be consistent with and synonymous with the practice of Acupuncture.[37,39]

This paper explains why.

What is Acupuncture? What is Dry Needling?

Until the last decade, the term "dry needling" was a generic concept, simply meaning the use of a needle, not carrying an injectable substance, to pierce soft tissue for therapeutic purposes.[1] Now, with the advent of Dry Needling and Intramuscular Manual Therapy techniques as promoted by the American Physical Therapy Association and the American Academy of Orthopaedic Physical Therapists,[2] a controversial new application has been created for the term "Dry Needling."
This white paper seeks to answer the following questions:

- What are the origins of Acupuncture?
- What are the origins of Dry Needling and Intramuscular Manual Therapy?
- What is the definition of Acupuncture?
- What are the definitions of Dry Needling and Intramuscular Manual Therapy?
- Is Dry Needling/Intramuscular Manual Therapy a subset of Acupuncture?
- What national clinical and classroom education guidelines exist for Dry Needling, Intramuscular Manual Therapy and Acupuncture?
- Is EMG needle testing a model for Dry Needling, Intramuscular Manual Therapy and/or Acupuncture?
- What is Scope of Practice? When does a need arise to expand Scopes of Practice?
- What role do Medicare/Medicaid billing codes play in defining Scope of Practice in regards to Acupuncture, Dry Needling and Intramuscular Manual Therapy?
- Are Physical Therapy national organizations, through promotion of Dry Needling/Intramuscular Manual Therapy, seeking to develop a parallel therapeutic system of Acupuncture?
- Is Dry Needling/Intramuscular Manual Therapy, when practiced by Physical Therapists, safe?
- Is Acupuncture, when practiced by Licensed Acupuncturists, safe?
- How do we, as a healthcare community, define quality health care?
- Summary Statement

Table of Contents

What are the origins of Acupuncture?

To have a vantage from which to view Acupuncture, Dry Needling and Intramuscular Manual Therapy, it is necessary to have a rudimentary understanding of the genesis of these health care methods.

Acupuncture originated in China many centuries ago and soon spread to Japan, the Korean peninsula and elsewhere in Asia. Acupuncture, today, is widely used in health care systems in the countries of this region; it is officially recognized by governments and well received by the general public.[3A]

Over its 2500 years of development, a wealth of experience has accumulated in the practice of Acupuncture, attesting to the wide range of diseases and conditions that can be treated effectively with this approach. Unlike many other traditional methods of treatment, which tend to be specific to their national or cultural context, Acupuncture has been used throughout the world, particularly since the 1970s.[4] Although Acupuncture was introduced to Europe as long ago as the early seventeenth century, skepticism about its effectiveness continues to exist in countries where modern Western medicine is the foundation of health care, especially in those where Acupuncture has not yet been widely practiced. People question whether Acupuncture has a true therapeutic effect, or whether it works merely through the placebo effect, the power of suggestion, or the enthusiasm with which patients wish for a cure.[5]

A large body of research exists in Acupuncture, covering virtually every symptom.[6] In the 1950's, the Central Committee in China was interested in this question; thousands of additional studies were performed. The results led the Committee to bestow equal recognition to Traditional Chinese Medicine (TCM) and Western Medicine.[7]

In 1991, a progress report on traditional medicine and modern health care was submitted by the Director-General of the World Health Organization to the Forty-fourth World Health Assembly.[8] The report pointed out that in countries where Acupuncture forms part of the cultural heritage, its use in an integrated approach to modern and traditional medicine presents no difficulty. However, in countries where modern Western medicine is the foundation of health care, the ethical use of Acupuncture requires objective evidence of its efficacy under controlled clinical conditions.[9]

In 2003, the World Health Organization reviewed selected studies on controlled clinical trials. Some of these studies provided incontrovertible scientific evidence that Acupuncture is more successful than placebo treatments in certain conditions. For example, the proportion of chronic pain relieved by Acupuncture is generally in the range 55-85%, which compares favorably with that of potent drugs (morphine helps in 70% of cases) and far outweighs the placebo effect (30-35%). In addition, the mechanisms of Acupuncture analgesia have been studied extensively since the late 1970s, revealing the role of neural and humoral factors.[10]

> *"Over its 2500 years of development, a wealth of experience has accumulated in the practice of Acupuncture, attesting to the wide range of diseases and conditions that can be effectively treated with this approach."*[4] *(World Health Organization)*

The 2003 World Health Organization Report, *Acupuncture: Review and Analysis of Reports on Controlled Clinical Trials* (2003) concluded that diseases, symptoms or conditions for which Acupuncture has been proved-through controlled trials-to be an effective treatment included: Adverse reactions to radiotherapy and/or chemotherapy; Allergic rhinitis (including hay fever); Biliary colic; Depression (including depressive neurosis and depression following stroke); Dysentery, acute bacillary; Dysmenorrhoea, primary; Epigastralgia, acute (in peptic ulcer, acute and chronic gastritis, and gastrospasm); Facial pain (including craniomandibular disorders); Headache; Hypertension, essential; Hypotension, primary; Induction of labour; Knee pain; Leukopenia; Low back pain; Malposition of fetus, correction of; Morning sickness; Nausea and vomiting; Neck pain; Pain in dentistry (including dental pain and temporomandibular dysfunction); Periarthritis of shoulder; Postoperative pain; Renal colic; Rheumatoid arthritis; Sciatica; Sprain; Stroke; Tennis elbow.[11]

The past two decades have seen extensive studies on Acupuncture, and great efforts have been made to conduct controlled clinical trials that include the use of "sham" Acupuncture or "placebo" Acupuncture controls. Although still limited in number because of the difficulties of carrying out such trials, convincing reports, based on sound research methodology, have been published. In addition, experimental investigations on the mechanism of Acupuncture have been carried out.[12]

What are the origins of Dry Needling and Intramuscular Manual Therapy?

The origins of Dry Needling and Intramuscular Manual Therapy are less clearly documented. Prior to 1986, there were few if any mentions of Dry Needling as a therapeutic modality in this country. Jan Dommerholt, PT, DPT, MPS, has emerged as one of the main proponents of Dry Needling. In the United States, Dommerholt was the first physical therapist to teach trigger point dry needling courses and injection techniques.[13] Dommerholt has published extensively on the Dry Needling technique and teaches Dry Needling to biomedicine trained health professionals, most specifically Physical Therapists. He argues that Dry Needling is a new emerging Western technique described in Western scientific terms.[14] Dommerholt attributes the foundation of Dry Needling to the works of Janet Travell, MD. Myopain Seminars, founded by Dommerholt, markets its instructional seminars on Dry Needling as the Janet G. Travell, MD Seminar Series.[sm15]

> *"Many practitioners of Acupuncture use several TrP [triggerpoint] criteria to locate pain Acupuncture points."*18 *(Travell & Simons'* The Trigger Point Manual*)*

The work of Janet Travell, MD, is often credited by proponents of Dry Needling as being the foundation of Dry Needling theory and practice. Travell pioneered the use of Manual Trigger Point (MTrP) injections. Her first paper describing MTrP injection techniques was published in 1942, followed by many others. Together with Dr. David Simons she wrote the 2-volume Trigger Point Manual, first published in 1983, with a second edition being published in 1999.[16,17] Travell/Simons acknowledge Acupuncture's role in the development of Dry Needling:

"Many practitioners of Acupuncture use several TrP [Trigger Point] criteria to locate pain Acupuncture points and, in fact, are successfully performing dry needling of TrPs that they speak of as Acupuncture therapy.[18]"

Dommerholt echoes this awareness of Trigger Points, as a subset of Acupuncture points, being used therapeutically:

"Although muscle needling techniques have been used for thousands of years in the practice of acupuncture, there is still much uncertainty about their underlying mechanisms. The acupuncture literature may provide some answers." [19]

The term Intramuscular Manual Therapy seems to be a later derivation of the terms "Manual Therapy" and Intramuscular Stimulation." The Centers for Medicare & Medicaid Services (CMS) define Manual Therapy, under Current Procedure Terminology code 97140, as "mobilization, manipulation, manual traction and manual lymphatic drainage.[20]" Dr. C. Chan Gunn, President of the Institute for the Study and Treatment of Pain, based in Vancouver, Canada, and Clinical Professor at the University of Washington, Seattle, US, takes credit for the development of Intramuscular Stimulation. In a 2002 interview Gunn stated:

"I have developed a technique called Intramuscular Stimulation (IMS), to stimulate the nerves within the muscles... The IMS technique began in 1973, and coincided with my growing interest in acupuncture from 1974, when I noticed that most acupuncture points related to nerve-muscle junctions.[21]"

Travell & Simons, in *Myofascial Pain and Dysfunction: The Trigger Point Manual,* Volume I (1999), acknowledged Gunn's work:

"Gunn recommends identifying TrPs [trigger points] by spot tenderness in a palpable taut band and then using acupuncture techniques. Gunn identifies this TrP injection technique as Intramuscular Stimulation.[22]"

In 1995, Jennifer Chu, M.D., Associate Professor and Director of Electrodiagnostic Medicine of the Department of Physical Medicine and Rehabilitation at the University of Pennsylvania School of Medicine, conducted a series of studies of what she termed "dry needling or non-electrical and non-chemical intramuscular stimulation (IMS)."[23] This study was published under the title "Dry needling (intramuscular stimulation) in myofascial pain related to lumbosacral radiculopathy" and is quoted extensively in support of Dry Needling/Intramuscular Stimulation for the treatment of myofascial pain. However, the National Institutes of Health, in their study entitled *Complementary and Alternative Therapies for Back Pain II:*

Evidence Reports/Technology Assessments, No. 194 (2010), excluded the Chu study and its clinical conclusions because of inadequate clinical trial design, specifically, "Observational (Comparative) Study not Reporting Harms."[24] (See Endnote A.)

In 2012, the use of the terms "Intramuscular Manual Therapy" to indicate the practice of Dry Needling was formalized by the American Physical Therapy Association:

"The issue of whether the performance of dry needling (sometimes referred to as trigger point dry needling or intramuscular manual therapy) is within the professional and legal scope of physical therapist practice continues to be a question posed to state regulatory boards and agencies."[25]

(A.): The NIH excluded the study with the explanation: "Observational (Comparative) Study not Reporting Harms." The Agency for Healthcare Research and Quality explains this exclusion: "Only systematic reviews that compare the relative benefits and **harms** [emphasis added] among a range of available treatments or interventions for a given condition should be included in Comparative Effectiveness Reviews."
When To Select Observational Studies as Evidence for Comparative Effectiveness Reviews Prepared for: The Agency for Healthcare Research and Quality (AHRQ) Training Modules for Systematic Reviews Methods Guide www.ahrq.gov[26]

What is the definition of Acupuncture?

"Acupuncture, in the strictest sense, refers to insertion of dry needles, at specially chosen sites for the treatment or prevention of symptoms and conditions,"[27] states the Alberta Heritage Foundation for Medical Research, Health Technology Assessment Unit. (Please see Appendix A for the Alberta Heritage Foundation's publication *Acupuncture: Evidence from Systematic Reviews and Meta-analyses.*)

The Agency for Healthcare Research and Quality (AHRQ), a division of the National Institutes of Health, in a Technology Assessment published by The U.S. Department of Health and Human Services, Public Health Service agrees: "Acupuncture refers to the insertion of dry needles at specially chosen sites for the treatment or prevention of symptoms and conditions."[26,27] (Please see Appendix B for AHRQ Technology Assessment published by CMS entitled *Acupuncture for Osteoarthritis*.)

> *"Acupuncture, in the strictest sense, refers to insertion of dry needles, at specially chosen sites for the treatment or prevention of symptoms and conditions."*[27] *(AHRQ Technology Assessment,* Acupuncture for Osteoarthritis)

Another way of viewing Acupuncture is to see the body as an energetic whole, comprised of energy pathways that are approached by and accessed through the insertion of solid, filiform acupuncture needles. Acupuncture literally means to puncture with a needle.[28] Acupuncture can be defined to include traditional body needling, electric acupuncture (electro-acupuncture), and microsystem acupuncture such as ear (auricular), face, hand and scalp acupuncture.[29] Thus, Acupuncture becomes a system of medicine that utilizes needles to achieve therapeutic effect.[30]

The Centers for Medicare and Medicaid Services describe Acupuncture in the following manner:

"Acupuncture involves the stimulation of the specific Acupuncture points on the skin, usually by the insertion of needles ranging in length from 1cm to 10cm. Between 5 and 15 needles are used in a typical treatment, with the point combinations varying during a course of sessions. The Acupuncture points can be chosen based on a standardized "formulary" involving a fixed menu of consistent points for each disease/condition or selected for each patient individually based on a patient's specific symptoms and Qi [energetic] balance. Depth of puncture can be up to 5cm." [31]

The World Health Organization (WHO) recognizes the need to establish standard and universal nomenclature for Traditional Chinese Medicine, i.e. herbal medicine, Acupuncture and other non-medication therapies. The WHO acknowledges that "owing to its unique paradigm and remarkable efficacy with fewer adverse effects, this system of medicine has been attracting more and more interest internationally."[32]

After 10 years of effort, a consensus on the proposed standard international Acupuncture nomenclature was reached by the Regional Office for the Western Pacific's Working Group and then by the WHO Scientific Group in Geneva.[33] 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.[34] Practical use has proven these WHO publications to be invaluable contributions to international information exchange on Acupuncture.[35] 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.[36]

Code	Term	Chinese	Definition/Description
5.1.0	**Acupuncture**	**鍼; 鍼法**	the insertion of needles into humans or animals for remedial purposes or its methods
5.1.6	filiform needle	毫鍼	a type of fine needle of varying length most commonly used in performing acupuncture at present
5.1.53	acupuncture point	穴; 腧穴; 穴位	the point where a needle is inserted and manipulated in acupuncture therapy
5.1.54	meridian point	經穴	acupuncture points of a main meridian or the governor or conception vessel
5.1.55	extra point	經外奇穴; 奇穴	acupuncture points not located on the meridians, also known as non-meridian point
5.1.56	specific point	特定穴	points on the fourteen meridians with specific therapeutic effects
5.1.225	trigger point	發痛点	a sensitive area of the body which produces a reaction elsewhere in the body when stimulated

The American Association of Acupuncture and Oriental Medicine, the national organization that represents both Licensed Acupuncturists and students of Acupuncture and Oriental Medicine by promoting excellence and integrity in the professional practice of Acupuncture and Oriental medicine, clarifies the concept of Acupuncture:

"1. Acupuncture is the stimulation of specific anatomical locations on the body, alone or in combination, to treat disease, pain, and dysfunction.
2. Acupuncture 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 Acupuncture can be applied to health and wellness."[37]

The Council of Colleges of Acupuncture and Oriental Medicine, whose mission 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, summarizes the practice and discipline of Acupuncture:

"Acupuncture is a system of medicine that utilizes needles to achieve therapeutic effect.
The language used to describe and understand this effect is not limited and is articulated in both traditional and modern scientific terms. The National Institutes of Health has recognized the efficacy of Acupuncture in its consensus of 1997[38] and continued funding of research."[39]
(Please see Appendix C for complete CCAOM Dry Needling Position Paper.)

What are the definitions of Dry Needling and Intramuscular Manual Therapy?

This definition, from the *Dry Needling Fact Sheet* provided by Jan Dommerholt and frequently quoted by other Physical Therapists, might serve as a starting point:

"Dry needling is an invasive procedure in which a solid filament needle is inserted into the skin and muscle directly at a myofascial trigger point."[40]

The North Carolina Board of Physical Therapy defines Dry Needling/Intramuscular Manual Therapy thusly:

"Intramuscular manual therapy, which is sometimes referred to as **dry needling** [emphasis added], is defined as a technique to treat **myofascial pain** [emphasis added] using a dry needle *(without medication)* that is inserted into a trigger point with the goal of releasing / inactivating the trigger points and relieving pain.[41]"

As defined by the American Physical Therapy Association's Educational Resource Paper, *Physical Therapists & the Performance of Dry Needling* (2012), Dry Needling is an invasive technique used by physical therapists (where allowed by state law) to treat myofascial pain that uses a dry needle, without medication or injection, which is inserted into areas of the muscle known as trigger points.[42]

> *"Dry Needling is an invasive procedure in which a solid filament needle is inserted into the skin and muscle directly at a myofascial trigger point."* 40 *(Dommerholt,* Dry Needling Fact Sheet*)*

In his article, *Trigger Point Dry Needling* (2006), Jan Dommerholt acknowledges Gunn's work in the field of Dry Needling/Intramuscular Stimulation while helping to define both terms and their usage:

"A review of TrP-DN [trigger point-Dry Needling] would be incomplete without including a brief summary of Gunn's needling approach... Gunn introduced the term Intramuscular Stimulation or "IMS" to distinguish his approach from other needling and injection approaches, but the term is frequently used to describe any dry needling technique."[43]

Is Dry Needling/Intramuscular Manual Therapy a subset of Acupuncture?

A subset is a group of things, people, etc., that is part of a larger group.[44] In order to determine whether Dry Needling is a subset of Acupuncture, it is necessary to clarify the diagnostic and therapeutic usage of the term "Trigger Points." Travell and Simons' *Myofascial Pain and Dysfunction, the Trigger Point Manual*, describes the relationship between Trigger Points, Acupuncture and Dry Needling:

"The distinction between TrPs [Trigger Points] and Acupuncture points *for the relief of pain* is blurred for a number of good reasons... There is a high degree of correspondence (71% based on their analysis) between published locations of TrPs and classical acupuncture points *for the relief of pain.*[45]

"Classical acupuncture points are identified as prescribed points along meridians defined by ancient Chinese documents. As Melzack, *et al.*[46] showed, the ancient Chinese clinicians were astute enough to recognize the importance of many common TrP locations and to include them in their charts of acupuncture points for pain. Currently, there are a number of practitioners of acupuncture who use a modified definition of acupuncture points which would selectively identify TrP locations. Belgrade[47] states that "tender points are acupuncture points and can often be chosen for therapy." If one defines an acupuncture point for treatment of pain as a tender spot, one is using a cardinal definition of TrPs as a criterion for an acupuncture point, which would increase the likelihood of treating a TrP and calling it an acupuncture point.[48]

"It is now well-established that pain relief experienced from classical acupuncture points is associated with an endorphin response in the central nervous system.[49,50]

"One student of Acupuncture, Pomeranz,[51] emphasized the importance of the Deqi phenomenon for identifying an acupuncture point. The Deqi phenomenon is described as a sensation of fullness, distension, and pins and needles when the inserted needle encounters the acupuncture point. However, essentially the same sensory phenomenon is frequently observed when injecting a TrP and the local twitch response is observed.[52]"

Travell/Simons summarize this discussion:

"In conclusion, frequently the acupuncture point selected for the treatment of pain is actually a TrP."[53]

Since the use of Acupuncture predates Dry Needling, it is appropriate to state that frequently the trigger point selected for the treatment of pain is actually an Acupuncture point. In fact, Dry Needling is a pseudonym for a brief course of study in myofascial acupuncture also known as Ashi Acupuncture and Trigger Point Acupuncture.[54] Three important studies, Trigger Points and Classical Acupuncture Points, Parts 1,2,3 (P.T. Dorsher, J. Fleckenstein) explore the relationship of Ashi or Acupuncture points to myofascial trigger point regions. In the first part of the study, myofascial trigger point regions were demonstrated to have strong (93.3%) anatomic correspondences with classical acupuncture points. [55] The second portion of this study examined the clinical correspondences of trigger point regions and classical acupuncture points in the treatment of both pain and somatovisceral disorders, and found they had ~ 97 % correlation for treating pain conditions and over 93 % correlation in treating somatovisceral conditions.[56] The third portion of the study concluded that the strong (up to 91%) consistency of the distributions of trigger point regions' referred pain patterns to Acupuncture meridians provides a third line of evidence that trigger points most likely represent the same physiological phenomenon as Acupuncture points in the treatment of pain disorders.[57] (Please see Appendix D for text of three studies "Trigger Points and Classical Acupuncture Points Parts 1-3," by P.T. Dorsher, et al.)

The World Health Organization agrees. WHO defines trigger point as a subset of Acupuncture points. Therefore, Dry Needling of trigger points is also a subset of Acupuncture. In 1981, the World Health Organization (WHO) Regional Office for the Western Pacific organized a Working Group for the Standardization of Acupuncture Nomenclature. After 10 years of effort, a consensus on the proposed standard international Acupuncture nomenclature was reached by the Regional Office for the Western Pacific's Working Group and then by the WHO Scientific Group in Geneva. In 1991, *A Proposed Standard International Acupuncture Nomenclature* was published by WHO in Geneva and a revised edition of *Standard Acupuncture Nomenclature* (Part 1 and 2) was published by the Regional Office for the Western Pacific in Manila. Below is an excerpt from *A Proposed Standard International Acupuncture Nomenclature* as pertains to trigger points. Again, please note the hierarchy of coding numbers used. All terms beginning with a code of 5.1 have been determined by the World Health Organization to be a subset of Acupuncture.[58] (For a chart presentation of the WHO's classifications used in this paper, please see Appendix E.)

5.1.225	trigger point	殘痛点	a sensitive area of the body which produces a reaction elsewhere in the body when stimulated
5.1.226	trigger point needling	殘痛点刺鍼	a type of acupuncture in which the trigger points are needled for therapeutic purposes
5.1.227	tender point needling	壓痛点刺鍼	a type of acupuncture in which the tender points are needled for therapeutic purposes
5.1.228	intramuscular stimulation needling	筋肉刺鍼	a needle stimulating treatment for muscle shortening in deep muscles, especially effective for chronic pain of neuropathic origin, also known as needling myofascial trigger points
5.1.68	ouch point	阿是穴；天應穴	an acupuncture point with no specific name nor definite location, the site of which is determined by tenderness or other pathological responses, also known as the ashi point
5.1.127	lifting-thrusting method	提插法	a needle manipulation involving lifting and thrusting the needle
5.1.168	intermuscular needling	分刺	an ancient needling method by puncturing directly into the muscle

Licensed Acupuncturists use Ashi/Trigger Point Acupuncture/Dry Needling in their healthcare practices.

The National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM), the certifying board for Acupuncture licensure, supports this conclusion. The NCCAOM completed a job task analysis in 2003 and again in 2008. The analysis documented the prevalence of actual use of Dry Needling practices, that is the treatment of trigger points, motor points and/or ashi points with Acupuncture needles, by practicing acupuncturists. In 2003, 82% of acupuncturists surveyed used needling of trigger points in patients who presented with pain. Of the patients who present for Acupuncture treatment, it is estimated that 56% present with trigger point pain.[59]

> *"Acupuncturists are well trained to use and have consistent historical usage of trigger and motor point "dry needling" treatment. Dry needling represents a substantial daily practice among American acupuncturists."*[59] *(Council of Colleges of Acupuncture and Oriental Medicine*, Dry Needling Position Paper)

These findings from the 1981 convened WHO Working Group for the Standardization of Acupuncture Nomenclature document that acupuncturists are well trained to use and have consistent historical usage of trigger and motor point "dry needling" treatment that pre-dates the 1986 introduction of the term "dry needling." Dry Needling represents a substantial daily practice among American acupuncturists.[60]

C. Chan Gunn goes one step farther as he explores the relationship between Acupuncture and Dry Needling/Intramuscular Stimulation. In his article Neuropathic Pain: A New Theory for Chronic Pain of Intrinsic Origin (1989), he concludes that all three are injection techniques and therefore one and the same:

"Why is Acupuncture accepted in the East, specifically for the treatment of chronic pain, but not in the West? One reason is that the modus operandi of Acupuncture is not fully understood... Injection techniques, including Acupuncture, are more effective and long lasting because the tissue injury that they produce can unleash the body's healing source of bio-energy through the current of injury.[61]"

What national clinical and classroom education guidelines exist for Dry Needling, Intramuscular Manual Therapy and Acupuncture?

In their resource paper, "Physical Therapists and the Practice of Dry Needling" (2012), the American Physical Therapy Association describes the current educational standards for entry level Physical Therapists:

"The education of physical therapists includes anatomy, histology, physiology, biomechanics, kinesiology, neuroscience, pharmacology, pathology, clinical sciences, clinical interventions, clinical applications, 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** [emphasis added] to that knowledge. Currently dry needling is not specifically included in entry-level education for physical therapists; however some physical therapist education programs have begun including it in their curriculum."[62]

Jan Dommerholt (PT, DPT, MPS and the first Physical Therapist in the United States to teach trigger point dry needling courses[63]) also acknowledges that Physical Therapy education is not designed to teach Physical Therapists how to insert a needle into patients: "In the United States, dry needling is not included in physical therapy educational curricula.[64]" He adds, "Accurate needling requires clinical familiarity with Myofascial Trigger Points and excellent palpation skills.[65]"

Licensed Acupuncturists, however, are receiving education in Acupuncture/ashi/myofascial trigger point location through palpation skills and needling technique. Individuals who attain national Acupuncture certification through the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) undergo a rigorous training program at a minimum standard of three academic years, 1490 hours in Acupuncture, including point location and needle technique. Of the 1490 hours in Acupuncture, 660 hours must be clinical hours, in other words, hours spent practicing Acupuncture under the supervision of a LAc. In addition, NCCAOM-certified Acupuncturists are required to be certified in Clean Needle Technique and must complete Continuing Education Units in order to maintain their certification.[66]

The World Health Organization's publication, *Guidelines on Basic Training and Safety in Acupuncture* (2010), presents Needle Technique Safety guidelines that are meant for hospitals, clinics and practitioners, and that provide standards for safety in the clinical practice of Acupuncture.[67] The purpose of these Guidelines is to minimize the risk of infection and accidents, to alert acupuncturists to contraindications, and to advise on the management of complications occurring during needle insertion.[68] Since both Acupuncture and Dry Needling/Intramuscular Manual Therapy involve the insertion of dry needles into the

human body for therapeutic purposes, the WHO recommendations are particularly germane for both Acupuncturists and Physical Therapists employing Dry Needling/Intramuscular Manual Therapy. They are also the basis for Clean Needle Certification that is required of all Licensed Acupuncturists in the United States. These basic safety standards for needling a human body, as delineated by WHO, include training in:

Guidelines on Basic Training and Safety in Acupuncture

1. Prevention of infection
   Clean working environment
   Clean hands
   Preparation of needling sites
   Sterilization and storage of needles and equipment
   Aseptic technique
2. Contraindications
   Pregnancy
   Medical emergencies and surgical conditions
   Malignant tumors
   Bleeding disorders
3. Accidents and untoward reactions
   Needle Quality
   Position of patient
   Fainting
   Convulsions
   Pain
   Stuck needle
   Broken needle
   Local infection
4. Electrical stimulation and laser therapy
5. Injury to important organs
   Areas not to be punctured
   Precautions to be taken

Source:
"Guidelines on Basic Training and Safety in Acupuncture." *World Health Organization.* Web. 13 Feb. 2012. <http://apps.who.int/medicinedocs/en/d/Jwhozip56e/>.

Is EMG needle testing a model for Dry Needling, Intramuscular Manual Therapy and/or Acupuncture?

Needle insertion for EMG by Physical Therapists is not sanctioned by the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM). Based on AANEM's recommendations, BlueCross BlueShield does not reimburse Physical Therapists performing EMG in North Carolina or nationally.

> *"Non-physician providers, including physical therapists, chiropractors, physician assistants, and others, do not have the appropriate training and knowledge to perform and interpret EMG studies."*[69] *(American Association of Neuromuscular and Electrodiagnostic Medicine)*

It is the position of the North Carolina Board of Physical Therapy Examiners that "the question of whether the insertion of a needle would be 'an invasive procedure that is not allowed for physical therapists' is not an issue in North Carolina as physical therapists have used needle insertion for EMG studies for more than forty years.' "[70] The American Association of Neuromuscular and Electrodiagnostic Medicine (AANEM) disagrees. The AANEM is a regulatory agency that provides Electrodiagnostic policy guidelines, which include EMG testing. Their white paper, "Model Policy for Needle Electromyography and Nerve Conduction Studies" (2010), defines electrodiagnostic (EDX) evaluation as an extension of the neuromuscular portion of a physical examination.[71] During EDX evaluation, physicians typically perform needle electromyography (EMG) and nerve conduction studies (NCSs).[72] It is the recommendation of the American Association of Neuromuscular and Electrodiagnostic Medicine that:

"Non-physician providers, including **physical therapists** [emphasis added], chiropractors, physician assistants, and others, **do not have the appropriate training and knowledge to perform and interpret EMG studies** [emphasis added] and interpret NCSs."[73] (Please see Appendix F for AANEM Model Policy for Needle Electromyography and Nerve Conduction Studies.)

BlueCross BlueShield of North Carolina (and nationally) supports this policy, adopting as their own standards the ones set forth by AANEM. BlueCross BlueShield North Carolina (BCBSNC) Corporate Medical Policy Guidelines for Electrodiagnostic Studies, including Needle EMG Studies, are as follows:

"Needle insertion for an EMG requires detailed knowledge of anatomy to prevent injury to anatomical structures, nerves, and arteries. A qualified physician in electrodiagnostic studies must be knowledgeable regarding the pathology of muscle and nerve, neuromuscular physiology, electrophysiology, and clinical understanding of neurological and musculoskeletal conditions in order to formulate an accurate diagnosis. Electrodiagnostic studies are performed by physicians that have extensive knowledge of neurological and musculoskeletal disorders. BCBSNC reinforces their EMG guidelines by further stating that "Electrodiagnostic Studies are not covered by BCBSNC when performed by non-physicians or physicians without appropriate training."[74] (Please see Appendix G for BCBSNC Corporate Medical Policy on Electrodiagnostic Studies.)

"The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) has indicated in their position statements that needle EMG must be performed by a physician with special training in electrodiagnostic medicine (typically neurologists or physiatrists). The physician must complete at least 200 electrodiagnostic consultations during his/her training program. Full competency is achieved through the experience of completing an additional 200 complete Electrodiagnostic consultations. It is also recommended that the physician be credentialed through the American Board of Electrodiagnostic Medicine or other equivalent examining board."[75]

It seems reasonable to conclude that Physical Therapists performing Needle EMG studies in North Carolina and /or nationwide are neither sanctioned by the American Association of Neuromuscular and Electrodiagnostic Medicine nor are their EMG studies covered for insurance reimbursement by BlueCross BlueShield.

What is Scope of Practice?
When does a need arise to expand Scopes of Practice?

Scope of Practice has been described as:

1. "Defined spheres of activity within which various types of health care providers are authorized to practice"[76]
2. "Those health care services a ...health care practitioner is authorized to perform by virtue of professional license, registration, or certification"[77]
3. The "definition of the rules, the regulations, and the boundaries within which a fully qualified practitioner with substantial and appropriate training, knowledge, and experience may practice in a field"[78]
4. "Establish[ing] which professionals may provide which health care services, in which settings, and under which guidelines or parameters" [79]

The Federation of State Medical Boards, in their 2005 Report, "Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety" establishes this specific set of guidelines to be considered when evaluating the merit/need of a particular healthcare profession to expand its scope of practice to include modalities of another health care profession. These "Guidelines" recommend that State regulators and legislators review the following factors when considering scope of practice initiatives in the interest of public health and patient safety:[80]

FSMB Guidelines for evaluating merit/need of scope of practice expansion change

- Existence of a verifiable need for the proposed scope of practice change;
- Existing scopes of practice and the effect of requested changes on public health and safety;
- Formal education and training purported to support scope of practice changes and the existence of a formal process for accreditation;
- Existing or proposed regulatory mechanisms such as licensure, certification and registration;
- The advisability of allowing independent practice or requiring collaboration or supervision;
- The advisability of interaction and cooperation between affected regulatory boards in evaluating issues that involve multiple practitioners, in investigating complaints, and in recommending appropriate discipline;
- Requirements for full and accurate disclosure by all health care practitioners as to their qualifications to provide health care services;
- Accountability and liability issues relating to scope of practice changes;
- Details, rationale, and ethics of any proposals to bypass licensing or regulatory requirements in allowing scope of practice changes, the implications for other practitioners, and the effect on patient safety; and
- Financial impact and incentives related to and affecting the scope of practice changes.[80]

Space here does not permit a state by state examination of whether the needs identified in these guidelines have been met by each state's regulatory agencies in which Physical Therapists have expanded their scope of practice to include Dry Needling. However, one state's regulatory agency's ruling could serve as a test case. (Please see Appendix H for FSMB Scope Expansion Needs Worksheet Rubric Form to be used for additional state Scope of Expansion Needs Analyses.)

Following is the most recent ruling (1/2012) by the Illinois Department of Financial and Professional Regulation in the matter of Physical Therapists being allowed to Dry Needle in Illinois:

"The Department has received a number of inquiries regarding the practice of 'Intramuscular Manual Therapy' or 'dry needling' by licensed physical therapists.

"Following a review of the Illinois Physical Therapy Practice Act, it appears that 'dry needling' falls within the scope of practice of physical therapy when used to provide physical therapy to a physical therapy patient. This is pursuant to the definition of physical therapy as set forth in 225 ILCS 90/1(b), which states in part that physical therapy includes "(a)lleviating impairments, functional limitations, or disabilities by designing, implementing ... therapeutic interventions that may include ... treatment of a person ... with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental impairment, functional limitation, or disability." The Department has conducted research to verify that 'dry needling' has been found to be in the scope of practice for physical therapists in a number of other states including Texas, Virginia, Colorado, Ohio and Kentucky.

"The Department notes that physical therapists that wish to incorporate 'dry needling' in their practice must comply with all other provisions of the Illinois Physical Therapy Act including the requirement that the patient have a documented current and relevant diagnosis and/or referral for physical therapy services. In addition, the decision to use this therapy must follow an evaluation by a licensed physical therapist and should only be performed by those licensed physical therapists that have sufficient skill and training. Physical therapists that injure or harm a patient by improperly performing 'dry needling' may be subject to discipline of their physical therapy license up to and including revocation.

"The Department further notes that the practice of 'dry needling' would also fall under the scope of practice of acupuncture. Unless they are also licensed as an acupuncturist, physical therapists that wish to incorporate 'dry needling' in their physical therapy practice should not advertise or hold themselves out as an acupuncturist.[81]"

Following is scope of expansion needs analysis using the FSMB Scope of Practice Expansion Needs Worksheet Rubric for the State of Illinois:

Scope of Practice Expansion Needs Worksheet Rubric

These bulleted guidelines are from the Federation of State Medical Board's 2005 Report: Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access & Safety.[77] Please use as a rubric for determining if Physical Therapy Expansion of Scope of Practice needs have been met in your state. (Please see Appendix H.)

- **FSMB Guideline**

Was guideline satisfied and need met?

- **Existence of a verifiable need for the proposed scope of practice change**

  No evidence given of a need for the proposed scope of practice change

- **Existing scopes of practice and the effect of requested changes on public health and safety**

  IDFPR is repository of Physical Therapy and Acupuncture Practice Acts.

  No mention made of the effect of requested changes on public health and safety.

- **Formal education and training purported to support scope of practice changes and the existence of a formal process for accreditation**

  "...only be performed by those licensed physical therapists that have sufficient skill and training."

  No quantitative mention made of formal education and training purposed to support scope of practice changes. No mention made of a formal process for accreditation.

- **Existing or proposed regulatory mechanisms such as licensure, certification and registration**

  "The Department notes that physical therapists that wish to incorporate 'dry needling' in their practice must comply with all other provisions of the Illinois Physical Therapy Act including the requirement that the patient have a documented current and relevant diagnosis and/or referral for physical therapy services. In addition, the decision to use this therapy must follow an evaluation by a licensed physical therapist and should only be performed by those licensed physical therapists that have sufficient skill and training. Physical therapists that injure or harm a patient by improperly performing 'dry needling' may be subject to discipline of their physical therapy license up to and including revocation."

  Mention made of existing or proposed regulatory mechanisms such as licensure, certification and registration.

- **The advisability of allowing independent practice or requiring collaboration or supervision**

  "The Department further notes that the practice of 'dry needling' would also fall under the scope of practice of acupuncture. Unless they are also licensed as acupuncturist, physical therapists that wish to incorporate 'dry needling' in their physical therapy practice should not advertise or hold themselves out as an acupuncturist."

  No evaluation of independent practice versus collaborative or supervised practice provided.

- **The advisability of interaction and cooperation between affected regulatory boards in evaluating issues that involve multiple practitioners, in investigating complaints, and in recommending appropriate discipline**

  No mechanisms put in place to allow Physical Therapy Board and Acupuncture Board to interact.

  No mention made of need for such collaboration.

Scope of Practice Expansion Needs Worksheet Rubric continued

- **FSMB Guideline**

Was guideline satisfied and need met?

- **Requirements for full and accurate disclosure by all health care practitioners as to their qualifications to provide health care services**

No mention made of mechanism by which Physical Therapists practicing Dry Needling would be required to provide evidence of training in said area of expertise. No mention made of mechanism by which Physical Therapists piercing skin would be required to provide evidence of training in Acupuncture needle technique and safety guidelines as recommended by the World Health Organization for practitioners utilizing Acupuncture needles to effect therapeutic treatments.[#]

Licensed Acupuncturists in the state of Illinois, by virtue of their practice act, are required to have completed 1360 hours in Needle Technique classroom and clinical training/internship.

Licensed Acupuncturists in the state of Illinois are required to pass the Clean Needle Technique course regulated by ACAOM.

Licensed Acupuncturists in the state of Illinois are required to complete Continuing Education Units in Acupuncture in order to maintain their license.

- **Details, rationale, and ethics of any proposals to bypass licensing or regulatory requirements in allowing scope of practice changes, the implications for other practitioners, and the effect on patient safety**

IDFPR is repository of Physical Therapy and Acupuncture Practice Acts.

No mention made of the effect of requested changes on public health and safety.

No mention made of how an acupuncture needle qualifies as an assistive device.

No mention made of justifications for PT scope of practice expansion to include penetration of the derma.

The only mention made of the implications for other practitioners is to acknowledge that Dry Needling is also within the scope of practice of Acupuncturists. No mention is made of the scope of practice of physicians licensed to practice medicine in all its branches.

- **Financial impact and incentives related to and affecting the scope of practice changes.**

No study made of financial impacts.

However, patient populations receiving Dry Needling will equate such treatment as being Acupuncture, since both are delivered via needle insertion and the practice of Acupuncture considerably predates that of Dry Needling. ".....The Department further notes that the practice of 'dry needling' would also fall under the scope of practice of acupuncture....."

With lack of state mandated and regulated Dry Needling education and clinical training hours, poorly performed Dry Needling will be perceived as poorly performed Acupuncture.

No mention made of financial incentives resulting from expansion of scope of practice by Physical Therapists to include Dry Needling. In terms of public access, generally Acupuncture treatments, since they are not reimbursed by Medicare/Medicaid, are less expensive than Physical Therapy treatments.

What role does Medicare/Medicaid billing codes play in defining Scope of Practice in regards to Acupuncture, Dry Needling and Intramuscular Manual Therapy?

The Centers for Medicare & Medicaid Services define Dry Needling as Acupuncture.[82] The Agency for Healthcare Research and Quality (AHRQ), a division of the National Institute of Health, in a Technology Assessment published by The U.S. Department of Health and Human Services, Public Health Service also corroborates that "Acupuncture, in the strictest sense, refers to the insertion of dry needles, at specially chosen sites for the treatment or prevention of symptoms and conditions."[83]

In their Medical Policy Reference Manual dated 3/2012, BlueCross BlueShield writes "Dry needling for musculoskeletal conditions is considered experimental / investigative and it does not meet TEC criteria #2-5."[84] (Please see Appendix I for BlueCross BlueShield Medical Policy Reference Manual 8.01.018 – Dry Needling.) The policy goes on to state:

"This procedure [Dry Needling] should be reported with the unlisted physical medicine code. Do not report dry needling with the CPT® codes used to report trigger point injection(s)." [85]

Medicare, while investigating a case involving a doctor who was billing for "Dry Needling" therapy, ruled that "to bill Medicare, doctors need to make an actual injection."[86] Assistant U.S. Attorney Kevin Doyle explains: "There is a claim code for trigger point injections. The only code for Medicare that would cover something like dry-needling would be an acupuncture code."[87] Acupuncture is a non-covered procedure federally. (Please see Appendix J for text of Rutland Herald news article.)

> *"The only code for Medicare that would approve for something like dry-needling would be an acupuncture code."* [88] *(Assistant U.S. Attorney Kevin Doyle)*

Medicare billing procedures for Dry Needling are as follows:

"'Dry needling' of ganglion cysts, ligaments, neuromas, tendon sheaths and their origins/insertions are non-covered procedures. Medical necessity for injections of more than **two** sites at **one** session or for **frequent** or **repeated injections** [emphasis added] is questionable. Such injections are likely to result in a request for medical records which must evidence careful justification of necessity."[89]

Neither the Center for Medicare & Medicaid Services nor Trailblazer Health Enterprises recognize the American Physical Therapists Association/American Association of Orthpaedic Physical Therapists use of term Intramuscular Manual Therapy as a terminology for describing the insertion of Dry Needles/Acupuncture for therapeutic purposes. As stated previously, the Centers for Medicare & Medicaid Services does not reimburse for Dry Needling or Acupuncture services.[90]

The Centers for Medicare & Medicaid Services (CMS), as administered by Trailblazer Health Enterprises, has specific medical definitions attached to Physical Therapy treatment nomenclature. Manual Therapy is a specific treatment modality that is compensated for under Current Procedural Terminology coding used for Physical Medicine and Rehabilitation Services, as administered by Physical Therapists. (Please see Appendix K for Centers for Medicare & Medicaid Services: Physical Services.) Those definitions are as follows:

"97140 © Manual therapy

Manual therapy such as mobilization, manipulation, manual traction and manual lymphatic drainage.

"Myofascial Release/Soft Tissue Mobilization: This procedure may be medically necessary for the treatment of restricted motion of soft tissues involving the extremities, neck and/or trunk. Skilled manual techniques (active and/or passive) are applied to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples include: Facilitation of fluid exchange. Restoration of movement in acutely edematous; muscles. Stretching of shortened connective tissue.

"Manipulation: CPT description for code 97140 includes manual therapy and techniques such as manipulation, soft tissue mobilization or joint mobilization. Individual techniques should not be separately coded or billed since it is a time-based code. All techniques applied on the same date of service should be totaled into the time calculated for the code. This procedure may be medically necessary as an adjunct to other therapeutic procedures such as those represented by code 97110, 97112 or 97530.

"Joint Mobilization: This procedure may be medically necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure. CPT description for code 97140 includes manual therapy and techniques such as manipulation, soft tissue mobilization or joint mobilization.[91]

**Are Physical Therapy national organizations,
through promotion of Dry Needling/Intramuscular Manual Therapy,
seeking to develop a parallel therapeutic system of Acupuncture?**

Nationally, Physical Therapists are represented by several organizations: the Federation of State Boards of Physical Therapy, the American Academy of Orthopaedic and Manual Physical Therapists and the American Physical Therapy Association. Together and separately, each of these organizations have issued statements either in support of Dry Needling, in support of scope of Physical Therapy practice expansion to include Dry Needling or both.

On March 8, 2010, the Federation of State Boards of Physical Therapy (FSBPT) published the "Intramuscular Manual Therapy (Dry Needling) Resource Paper."(Please see Appendix L for the FSBPT "Intramuscular Manual Therapy/Dry Needling Resource Paper.") The opening statement of this paper asserts:

"It is not unusual for a state licensing board to be asked for an opinion as to whether or not an evaluative technique, treatment, or procedure is within the scope of practice for that given profession. It is as important to base regulation on evidence, when possible, as it is to base practice on evidence."[92]

However, the Federation of State Medical Boards (FSMB) does *not* recommend promoting scope of practice expansion solely through state licensing boards. In their often cited report, *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*, the FSMB advocates a process by which state regulatory boards *and* state *l*egislatures work together in tandem when exploring requests to create, change, or expand scope of practice, supported by verifiable needs for those proposed changes in scope of practice:

"The Federation has formulated a set of Guidelines to be used by State regulatory boards **and legislatures** when considering requests for creation or expansion of scopes of practice. The Guidelines are designed to assist policy makers in assuring that all practitioners are prepared, by virtue of **education** and **training**, to provide services authorized in their scopes of practice in a safe, effective and cost efficient manner." [93][emphasis added] (Please see Appendix M for FSMB's *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety.)*

The American Academy of Orthopaedic Manual Physical Therapists (AAOMPT) Position Statement (2010) on Dry Needling is as follows: "*It is the Position of the AAOMPT Executive Committee that dry needling is within the scope of physical therapist practice. "*[94] The Supporting Statement immediately following this statement reads:

"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." [emphasis added].[95]
(Please see Appendix N for text of AAOMPT webpage Position Statement.)

However, in contrast to the AAOMPT Statement asserting that "Physical therapists are well trained to utilize dry needling in conjunction with manual physical therapy interventions,[96]" the American Physical Therapists Association's (APTA) 2012 Resource Paper entitled *Physical Therapists and the Performance of Dry Needling* notes that:

"The education of physical therapists includes anatomy, histology, physiology, biomechanics, kinesiology, neuroscience, pharmacology, pathology, clinical sciences, clinical interventions, clinical applications, 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. "Currently dry needling is not specifically included in entry-level education for physical therapists; however some physical therapist education programs have begun including it in their curriculum"** [emphasis added].[97] (Please see Appendix O for APTA *Resource Paper, Physical Therapists and the Performance of Dry Needling*.)

Licensed Acupuncturists, however, are receiving education in Acupuncture/ashi/myofascial trigger point location and needling technique classroom and clinical education. Individuals who attain a LAc certification undergo a rigorous training program at a minimum standard of three academic years, 1490hours in Acupuncture, including point location and needle technique. Of the 1490 hours in Acupuncture, 660 hours must be clinical hours, in other words, hours spent practicing Acupuncture under the supervision of a LAc. In addition, LAcs are nationally required to be certified in Clean Needle Technique and must complete Continuing Education Units in order to maintain their licensure.[98]

The AAOMPT Support Statement for the inclusion of Dry Needling into Physical Therapist practice notes positive clinical Dry Needling research as a second determining factor in finding for Dry Needling to be a justified expansion of Physical Therapy scope of practice: "**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.[99]" However, the AAOMPT Support Statement omits further mention of any such research. On the other hand, the APTA Dry Needling Resource Paper summarizes Research Review to date:

"The remaining 46 individual studies were reviewed by a member expert in research analysis using a standardized review form. The results of the review included 10 case reports (n<10), 1 case series (n>, 10), 12 observational studies, and 23 randomized controlled trials (RCT). These 46 studies were reviewed using a rating scale from 0-5, with 5 indicating the highest level of quality and highest level of support for dry needling. **The median quality of the research was 3; the median support of dry needling was 2.**
Of the 23 RCTs, again using a rating scale from 0-5, with 5 indicating the highest level of quality and highest level of support for dry needling, the median quality of the research was 4; **the median support of dry needling was 3.** One case study of the 10 noted above was not included in the rating of the evidence. This case addressed an adverse event of a cervical epidural hematoma from dry needling performed by a physician.[100]"

This is hardly conclusive evidence for the efficacy and usefulness of Dry Needling by Physical Therapists. In contrast, the therapeutic effect of Acupuncture has been recognized as significant and worthy of continued research by both the National Institutes of Health[101] and the World Health Organization.[102] The World Health Organization reports that diseases, symptoms or conditions for which Acupuncture has been proved - through controlled trial - to be an effective treatment include: "Adverse reactions to radiotherapy and/or chemotherapy; Allergic rhinitis (including hay fever); Biliary colic; Depression (including depressive neurosis and depression following stroke); Dysentery, acute bacillary; Dysmenorrhoea, primary; Epigastralgia, acute (in peptic ulcer, acute and chronic gastritis, and gastrospasm); Facial pain (including craniomandibular disorders); Headache; Hypertension, essential; Hypotension, primary; Induction of labour; Knee pain; Leukopenia; Low back pain; Malposition of fetus, correction of; Morning sickness; Nausea and vomiting; Neck pain; Pain in dentistry (including dental pain and temporomandibular dysfunction); Periarthritis of shoulder; Postoperative pain; Renal colic; Rheumatoid arthritis; Sciatica; Sprain; Stroke; Tennis elbow.[103] One much studied result of Acupuncture is its analgesic properties. The WHO reports that the proportion of chronic pain relieved by Acupuncture is generally in the range 55-85%, which compares favorably with that of potent drugs (morphine helps in 70% of cases) and far outweighs the placebo effect (30-35%).[104]

The previous section explored the definition of scope of practice and scope of practice expansion and examined guidelines for establishing both. To summarize, the FSMB emphasizes: "Requests to create, change, or expand scope of practice should be supported by a verifiable **need** [emphasis added] for the proposed change."[105]

Conversely, the APTA Dry Needling/Intramuscular Manual Therapy paper based its case for Dry Needling/Intramuscular Manual Therapy being included into Physical Therapy scope of practice by investigating the answers to the following two questions:

"1) Have you adopted a formal or established an information statement on the use of dry needling? and,
2) Do you have a formal or informal process for including dry needling, or other "new" tests, measures, or interventions into your scope of practice for physical therapists/physiotherapists?"[106]

Responses to these questions establish recent publications, internal processes and procedures. They do not establish verifiable needs supported by patient safety and public protection objectives.

The FSMB expands upon the course of action necessary to pursue when assessing the need for scope of practice expansion:

"All discussions about changes in scope of practice should begin with a basic understanding of the definition of the practice of medicine and recognition that the education received by physicians differs in scope and duration from other health care professionals. Non-physician practitioners may seek authorization to provide services that are included in the definition of the practice of medicine under existing state law. In evaluating these requests, policy makers should examine a variety of issues, including: economic impact on health care delivery; standards for education, training and examination; practice parameters; and regulatory mechanisms. Patient safety and accountability should be the most important factors in establishing expectations and limitations associated with scope of practice changes."[107]

The national organizations involved in the promotion of Dry Needling/Intramuscular Manual Therapy practice for Physical Therapists

1. Have not followed FSMB recommended guidelines to pursue scope of practice creation or expansion through both regulatory and legislative means
2. Have not demonstrated that national Dry Needling/Intramuscular Manual Therapy education and/or educational guidelines exist
3. Have not demonstrated a verifiable research driven need for Dry Needling/Intramuscular Manual Therapy as performed by Physical Therapists
4. Have not demonstrated a verifiable public health care need for the expansion of Physical Therapy Scope of Practice to include Dry Needling/Intramuscular Manual Therapy

The *White House Commission on Complementary and Alternative Medicine Policy Final Report* (2002) expresses additional concerns when considering scope of practice expansion:

"In some states, acupuncture can be practiced by professional acupuncturists who have spent several years in training or by practitioners of another health modality (e.g., a physician, dentist, podiatrist, physical therapist, or chiropractor) with less, limited, or no additional training or experience in acupuncture. The situation is further complicated by state variations in licensing requirements and scope-of-practice regulations."[108]

This same Commission then goes on to state that four important issues of access and delivery concern both the public and practitioners when considering issues of scope of practice expansion within the Complementary and Alternative Medicine fields:

- "Determining the extent of the public's choice among health care modalities.
- Preserving Complementary and Alternative Medicine (CAM) styles and traditions that have been valued by both practitioners and consumers
- Maintaining competition in the provision of CAM and other health services
- Providing opportunities for appropriately trained and qualified health practitioners to offer the full range of services in which they are trained and competent"[109]

If verifiable public need and safety are not the propelling forces behind Physical Therapy's desire to appropriate Acupuncture by renaming it Dry Needling, are there other contributing theoretical justifications?

The APTA's *Dry Needling Resource Paper* states: "There are several Dry Needling conceptual and practical models including, but not limited, to:

1. Superficial Dry Needling (SDN) - Baldry Model
2. Deep Dry Needling (TrP-DN) - Travell Model
3. Radiculopathy Model – Intramuscular Stimulation (IMS) Gunn Model"[111]

Dommerholt writes: "Although muscle needling techniques have been used for thousands of years in the practice of acupuncture, there is still much uncertainty about their underlying mechanisms. The acupuncture literature may provide some answers, however, due to its metaphysical and philosophical nature, it is difficult to apply traditional acupuncture principles to the practice of using acupuncture needles in the treatment of MPS [multiple pain syndromes]." [112]

Though perhaps difficult, it is possible for Acupuncturists, with an education spanning both Western biomedical and Eastern medical concepts, to compare the three APTA sanctioned Dry Needling Models with corresponding and pre-existing Acupuncture practical medical theory.

1. BALDRY MODEL – Superficial Dry Needling

In the third edition of his book, *Acupuncture, Trigger Points and Musculoskeletal Pain,* Baldry discourses:

"It is because traditional Chinese acupuncture is perforce inextricably bound up with archaic concepts concerning the structure and function of the body that most members of the medical profession in the Western world view it with suspicion and skepticism.

"My reason for writing this book is to bring to the attention of doctors and physiotherapists a 20thcentury-evolved scientific approach to acupuncture for the relief of pain emanating from trigger points in the myofascial pain syndrome and from tender and trigger points in the fibromyalgia syndrome, and to take acupuncture (so far as the alleviation of nociceptive pain of this type is concerned) out of the category of alternative or complementary medicine by describing a method of employing it that has been developed as a result of observations made by physicians during recent years and is now fast becoming incorporated within the framework of present-day orthodox medical practice."[113]

In Travell & Simons' *Myofascial Pain and Dysfunction: The Trigger Point Manual Volume I* (1999), mention is made of Baldy's model of Acupuncture and evidence given as to its and by default, Acupuncture's, therapeutic mechanism:

"Another version of "acupuncture" used for the treatment of TrPs involved insertion of the needle to only a depth of approximately 4 mm into the skin and subcutaneous tissue overlying the TrP.[113a] Compared to needle penetration of the TrP, this insertion technique must involve an entirely different mechanism that depends on nervous system modulation of TrP activity. This technique requires a controlled clinical study to confirm its efficacy for TrPs and, if effective, needs further research to identify its mechanism. Ward[114] examined 12 acupuncture sites that were also common TrP sites in either a trapezius or infraspinatus muscle for the electrical activity characteristic of an active locus in a TrP. Characteristic [meaning that the acupuncture point sites selected evidenced identifying characteristics of trigger points and therefore were one and the same] endplate spike activity was observed in every case."[115]

Not wishing to acknowledge the historical origins of Acupuncture, nor wanting to acknowledge the basis of its differential diagnostic theory does not serve to eradicate Acupuncture's medical discipline nor nullify its beneficial validity. Baldry's search for a meaningful method for relieving musculoskeletal pain appears to have taken him knowingly to the practice of Acupuncture. Clearly, Baldry was founding his methods and research on Acupuncture.

2. TRAVELL MODEL – Deep Dry Needling

In *Travell & Simons' Myofascial Pain and Dysfunction: The Trigger Point Manual Volume I* (1999), the relationships between Acupuncture and Dry Needling are explored:

"Classical acupuncture points are identified as prescribed points along meridians defined by ancient Chinese documents. As Melzack, *et al.*[116] showed, the ancient Chinese clinicians were astute enough to recognize the importance of many common TrP (trigger point) locations and to include them in their charts of acupuncture points for pain.

"Currently, there are a number of practitioners of acupuncture who use a modified definition of acupuncture points which would selectively identify TrP locations. Belgrade[117] states that "tender points are acupuncture points and can often be chosen for therapy."

"As reported by Melzack, *et al.*,[118] there is a high degree of correspondence (71% based on their analysis) between published locations of TrPs and classical acupuncture points *for the relief of pain.*

"If one defines an acupuncture point for treatment of pain as a tender spot, one is using a cardinal definition of TrPs as a criterion for an acupuncture point, which would increase the likelihood of treating a TrP and calling it an acupuncture point.... Central myofascial TrPs occur in the midfiber region of a muscle belly.

"One student of acupuncture, Pomeranz,[119] emphasized the importance of the Deqi phenomenon for identifying an acupuncture point. The Deqi phenomenon is described as a sensation of fullness, distension, and pins and needles when the inserted needle encounters the acupuncture point. However, essentially the same sensory phenomenon is frequently observed when injecting a TrP and the local twitch response is observed.[120]

"In conclusion, frequently the acupuncture point selected for the treatment of pain is actually a TrP."[121]

> *"The acupuncture point selected for the treatment of pain is actually a Trigger Point."*[121] *(Travell & Simons'* The Trigger Point Manual)

Mark Seems, PhD, LAc, and founding director of Tri-State College of Acupuncture, in *A New American Acupuncture* concurs and cites the creation of de qi/local muscle twitch response as evidence of acupuncture point stimulation:

"Acupuncture needles are inserted into muscular and connective soft tissue, not simply into spaces between bones and tendons. When a needle succeeds in creating the celebrated de qi response indicating the "arrival of qi," the needle has actually caused a myofascial response, whereby the muscle underlying the needle begins to contract and "grasp" the needle." [122]

3. GUNN MODEL – Intramuscular Stimulation (IMS)

In the article "Acupuncture Loci: A Proposal for Their Classification According to Their Relationship to Known Neural Structures" (1976), Chan Gunn, PhD, suggests:

"As a first step toward acceptance of acupuncture by the medical profession, it is suggested that a new system of acupuncture locus nomenclature be introduced, relating them [acupuncture points] to known neural structures." [123]

Gunn, as corroboration to this proposal, quotes:

"Dr. P.D. Wall commenting on acupuncture for pain therapy in the 1974 International Symposium on Pain, divides acupuncture into two categories:

1. The classical theory and its application based on the ancient concept which depends on the rebalancing of the Yin and Yang and insertion of needles into classical loci situated on meridians

2. The contemporary version which constitutes a gradual extension of the ancient theories – classical loci, for instance, are moving closer and closer to the dermatones of the injury and needles with or without electrical stimulation are being used."[124]

Gunn gives details of his study's attempt to classify Acupuncture points:

"It was noted that many of these [acupuncture] loci (35) were located at known sites of muscle motor points. These were classified as Type I.

"In this study, Type I loci were demonstrated to be muscle motor points by evoking muscle twitches in response to minimum electrical stimulation using a standard calibration-stable stimulator with variable control of output."[125]

Gunn then concludes:

"Many workers in acupuncture also feel that a new system for the classification of acupuncture loci based on their relationship to known neural structures is overdue."[126] (Please see Appendix P for full text of Gunn's article, "Acupuncture Loci: A Proposal for Their Classification According to Their Relationship to Known Neural Structures.")

However, in a Peterhouse Profile (2002), Gunn seemingly abandons his earlier interest in Acupuncture.

When asked for an explanation of the relationship between IMS and Acupuncture, Gunn replies:

"IMS borrows its needle technique from traditional Chinese acupuncture, but updates and enhances it with anatomy and neurophysiology. I like to think that it brings Western and Eastern medicine together. But whereas medical diagnosis and examination, and a knowledge of anatomy, are not applicable in acupuncture, they are crucial to IMS. It follows that prompt objective results can be anticipated from IMS, which is not always true of acupuncture. But my research does provide the theoretical underpinning that explains why the ancient technique of acupuncture often does work."[127]

Gunn's assessment of Acupuncture education is inaccurate. Today, in the United States, over 50 accredited[128] professional colleges teach a diversity of styles of health care utilizing Acupuncture, Chinese herbology, manual techniques such as tuina (Chinese therapeutic massage), nutrition, and exercise/breathing therapy. Individuals who attain this degree undergo a rigorous training program at a minimum standard of three academic years that contains 450 hours in biomedical science (biology, anatomy, physiology, western pathology, and pharmacology), 90 hours in patient counseling and practice management, and 1365 hours in Acupuncture. Of the 1490 hours in Acupuncture, 660 hours must be clinical hours. [129]

In *Myofascial Pain and Dysfunction: The Trigger Point Manual Volume I (*1999), Travell & Simons' give this explanation of the IMS technique:

"Gunn recommends identifying TrPs by spot tenderness in a palpable taut band and then using **acupuncture techniques**. He first identifies the TrP as a spot of localized tenderness in a taut band and then identifies the precise skin location through which to insert the acupuncture needle using a dermometer (point finder or skin resistance detector). He then inserts the needle through this location to the TrP where he feels a **"grabbing" sensation** at the needle tip, which is often associated with aching pain, as the needle enters the TrP. An LTR [local twitch response] is often observed. Gunn identifies this TrP injection technique as **Intramuscular Stimulation**. [emphasis added] [130, 131]

As previously noted, the de qi sensation, local muscle twitch response and "grabbing sensation" achieved upon needle insertion are all descriptions of the same desired therapeutic and healing phenomenon accessed through Acupuncture needle insertion by Acupuncturists.

Kiiko Matsumoto, LAc (Licensed Acupuncturist), a collaborator with Gunn in his original 1976 study (please see Endnote B), and Stephen Birch, LAc, summarize the interaction of Acupuncture and western medicine:

"The human body is an intricate set of systems that interact with each other as a functional whole. The nervous, muscular, skeletal, digestive, respiratory, reproductive, excretory, hormonal, and vascular systesm each have distinct characteristics and properties. Yet none of these systems are separate entities. When working synchronously they constitute what we call, in a gross sense, "life." All parts of the body are to some degree innervated and vascularized. These systems provide a medium that connects the parts through a series of complex interactions and feedback mechanisms. Incorporated within the nervous and vascular systems are various sub-systems such as the hormonal messengers. Each sub-system is itself a categorization that represents another set of specific interactions.

"Within the body one system is amazingly pervasive and versatile: the connective tissue. In effect, the connective tissue is a system that totally interconnects all parts of the body at each level from the anatomical to the microscopic. Connective tissues can be found within every single organelle, within every cell, and within every tissue of the body. Most significant for Oriental medical theory and practice are the properties such energy generation and conduction that these tissues demonstrate.

"The various membranes and fasciae discussed in Oriental Medical literature are composed of connective tissues. Although modern anatomical, physiological, and embryological knowledge is much more detailed than the discussions in early Chinese medical texts, the essential anatomical details are the same... It is thus possible and intriguing, and in fact necessary to propose and examine models by which we may explain classical Chinese medical concepts using the data of Western science."[132]

The Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) Position Paper on Dry Needling succinctly brings this discussion to a close:

"It is clear that other professions such as physical therapy and others also recognize the efficacy of Acupuncture and its various representations such as Dry Needling due to the fact that they are attempting to use Acupuncture and rename it as a physical therapy technique."[133]

> *"It is clear that other professions such as physical therapy also recognize the efficacy of Acupuncture and its various representations such as Dry Needling due to the fact that they are attempting to use Acupuncture and rename it as a physical therapy technique."* 133 *CCAOM* Position Paper on Dry Needling

Endnote B: "Matsumoto, drawing from various sources, including recent Chinese texts, selected for description 70 commonly used and reportedly effective acupuncture loci. This study analyzes their locations on the body in relationship to known neural structures. Loci were determined according to Matsumoto's descriptions and other references."[134] [Gunn, C. Chan. "Acupuncture Loci: A Proposal for Their Classification According to Their Relationship to Known Neural Structures." *American Journal of Chinese Medicine* 4.No. 2 (1976): 183+. Print]

Is Dry Needling/Intramuscular Manual Therapy, when practiced by Physical Therapists, safe?

The Federation of State Boards of Physical Therapy, in their Fall 2011 Federation Forum newsletter writes: "Dry needling is a topic that most physical therapy boards had not even discussed a few short years ago. However, now, it is a significant issue in a number of states." [135] Because of the newness of the this recent expansion of scope of practice by Physical Therapists to include Dry Needling as a therapeutic option, there are few clinical research trials evaluating the safety of Dry Needling *as performed by Physical Therapists*. However, some possible adverse event situations are addressed by programs promoting Dry Needling education for Physical Therapists. One such class is called *Dry Needling, Orthopedic Approach™* and is taught by Yun-tao Ma, LAc, Phd:

"Integrative Dry Needling, Orthopedic Approach™ is a contemporary dry needling therapy developed by Yun-tao Ma, Phd, and based on the works of Dr Janet Travell (1982, 1992), Dr Chan Gunn (1978), clinical evidence, evidence-based research and Dr Ma's own 40 years of clinical and research experience and neuroscience training." [136]

In his companion book to Integrative Dry Needling, Orthopedic Approach™ entitled *Biomedical Acupuncture for Sports and Trauma Rehabilitation: Dry Needling Techniques*,[137] Ma addresses "Safety Issues in Dry Needling Acupuncture Practice:"

> **"PREVENTION OF NEEDLING ACCIDENTS: Understanding the Anatomy of Acu-Reflex Points**
> Each acu-reflex point (ARP) has specific anatomic features. ARPs on the limbs are relatively safe, but prolonged infection and swelling leading to muscular atrophy—mostly results of wet needling procedures—have been recorded. ARPs on the torso close to the internal viscera merit special caution for safe needling. The following areas must also be needled with caution:
> 1. Cervical area (posterior) from C1 to C2: This area contains vertebral arteries and the medulla oblongata.
> 2. Thoracic area from T1 to T12: The surface tissue is very close to the pleura and the lungs.
> 3. Lumbar area from L2 to L3: This area is near the lower part of the kidney.
> 4. Neck (lateral and front): This area is near big blood vessels and organs.
> 5. Chest: This area is near the lungs and heart.
> 6. Abdomen: This area is near the liver, spleen, and intestines."[138]

It should be noted that the Dry Needling, Orthopedic Approach™ class covers three days:

- *"Time and cost-effective preparation*: the Dry Needling Course includes preparatory home study using Dr Ma's two textbooks and updated course manual, so that we don't waste much time on introducing background theory and we are ready to roll from the first day. When the course ends on a Sunday, chiropractors and physical therapists are excited to get into the clinic on Monday and start using what they have learned.
- *Learning by immersion*: ALL THREE DAYS physical therapists and chiropractors are using needles under Dr Ma's close supervision and meticulous instructions." [139]

In contrast, according to the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM) Examination Study Guide for the Diplomate of Acupuncture Certification (Lac), all candidates for Licensed Acupuncturist certification have completed a minimum number of hours, 1490 classroom hours of academic course work, to qualify to take each required examination (see chart below). Completion of these hours of course work qualifies the applicant to sit for the following Acupuncture Certification Examinations as a "pre-graduate". Additional hours are required for final certification. In addition to passing the below certification exams all candidates for NCCAOM Certification in Acupuncture must document successful completion of a clean needle technique (CNT) course. In regards to Clean Needle Technique (CNT), the Biomedicine module focuses on universal precautions and emergency situations in comparison to the Acupuncture with Point Location module which focuses on actual needling and its emergencies (e.g., needle angle and depth).[140]

Following are actual excerpts of the **Study Guide for the Diplomate of Acupuncture Certification** from NCCAOM pertaining to needling technique topics for board examination.[141]

Examinations	Matriculation Date	Completed Hours
*Acupuncture with Point Location *Biomedicine *Foundations of Oriental Medicine	Matriculating Prior to July 1, 2004	1,350
	Matriculating on or after July 1, 2004	1,490

*Required for the Acupuncture Certification Program

***NCCAOM® Examination Study Guide for the Diplomate of Acupuncture Certification (2012):* Excerpts**

Sub Domain A6: Point location (images only)

A 1 (c): Five Phase/Element points
A 1 (d): Antique points (Jing Well, Ying Spring, Shu Stream, Jing River, He Sea)
A 1 (j): Extraordinary meridian
A 2 (a): Distal/local, adjacent points
A 2 (b): Based on TCM muscular channel theory
A 2 (d): Front-Mu (Alarm) points, Back-Shu (Associated) points, and their combination(s)
A 2 (e): Lower He-Sea (Uniting) points
A 2 (g): Eight Influential points
A 2 (h): Four Sea points
A 2 (j): Five Shu (Transporting) points according to TCM
A 2 (k): 5 Luo-Connecting points, Yuan-Source (Primary) points, and their combinations
A 2 (j): Five Shu (Transporting) points according to TCM
A 2 (k): 5 Luo-Connecting points, Yuan-Source (Primary) points, and their combinations
A 2 (o): Extra Points
A 2 (p): Auricular points
A 2 (q): Scalp points
A 2 (r): Coalescent points
A 2 (s): Crossing points
A 2 (u): Confluent points
A 2 (v): Command points
For all:

- Ability to recognize (e.g., locate) and administer needling to points contained in above listed points category

A 2 (c): Points along corresponding channels to affected cutaneous regions

- Knowledge of the cutaneous regions
- Knowledge of acupuncture/points along the cutaneous regions
- Ability to identify points to affect the cutaneous regions

A 2 (i): Based upon causative factor

- Skills to administer points to treat causative factor(s) according to TCM

NCCAOM® Examination Study Guide for the Diplomate of Acupuncture Certification (2012): Excerpts

Subdomain A4: Needle selection (e.g., filiform, three-edges, plum-blossom, press and intradermal needles)

- Knowledge of acupuncture needles
- Knowledge of acupuncture needle use
- Knowledge of acupuncture needle applications, precautions
- Ability to utilize appropriate acupuncture needles
- Skills to administer appropriate acupuncture needles

Sub Domain A5: Identification of correct point location

- Knowledge of acupuncture points
- Knowledge of acupuncture point location theories and concepts
- Knowledge to identify correct point location
- Ability to identify correct point location
- Skills to identify correct point location

Domain B: Treatment Techniques and Mode of Administration (20% of total exam)

Sub Domain B1: Patient position

- Knowledge of correct positioning of the patient
- Knowledge of positioning techniques and concepts
- Ability to correctly position the patient
- Skills to decide and execute correct positioning of patient

Sub Domain B2: Needle insertion

- Knowledge of needle insertions with appropriate angle and depth
- Knowledge of safety rules and regulations concerning needle insertion
- Ability to insert needles to the appropriate angle and depth
- Skills to insert needles at correct angle and depth

B 2 (a): Angle / B 2 (b): Depth / B 2 (c): Needle insertion technique

B 3 (a): Lifting & thrusting / B 3 (b): Twirling or rotating

Sub Domain B5: Precautions based upon anatomy

- Knowledge of human anatomy
- Knowledge to consider anatomy to determine depth, precautions, and contraindications
- Ability to apply knowledge of human anatomy to safely administer acupuncture treatment techniques
- Skills to apply knowledge of human anatomy to safely administer acupuncture treatment techniques

Sub Domain B6: Removal of needles

- Knowledge of safe and correct removal of acupuncture needle(s)
- Ability & Skills to remove needles with correct techniques

Domain C: Use of Modalities or Agents (25% of total exam) / Sub Domain C4: Intradermal needles

- Knowledge of techniques, cautions and contraindications of intradermal needles
- Knowledge of different types of intradermal needles

Sub Domain C6: Electro acupuncture / Sub Domain C7: Electricity

C 7 (a): Micro current

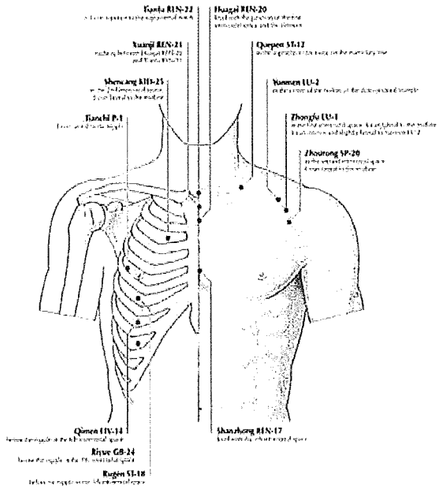
- Knowledge of theories and purposes of micro current
- Knowledge of techniques, cautions and contraindications of micro current
- Knowledge of applying electricity using micro current
- Knowledge to treat the patient by applying electricity using micro current
- Ability & Skills to administer micro current

The Department of Physical Therapy, Ben-Gurion University of the Negev, when advocating the practice of Dry Needling by Physical Therapists, offers the following caveat:

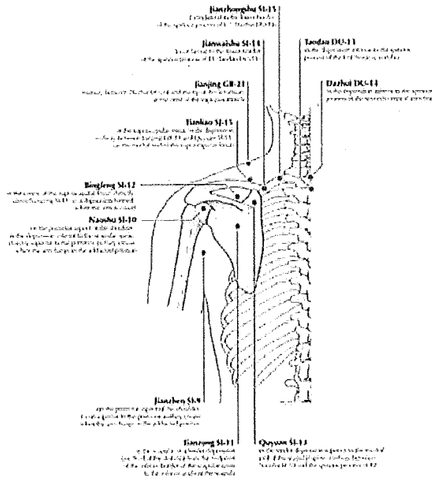
"The deep method of dry needling has been shown to be more effective than the superficial one for the treatment of pain associated with myofascial trigger points. Over areas with potential risk of significant adverse events, such as lungs and large blood vessels, we suggest using the superficial technique, which has also been shown to be effective, albeit to a lesser extent."[142]

In contrast, students of ACAOM, the Accreditation Commission for Acupuncture and Oriental Medicine, accredited schools study the location, insertion depth, and angle of insertion for minimally 361 Acupuncture points, not including special point locations. In Deadman's Manual of Acupuncture, an ACAOM accepted text for the study of Acupuncture in the United States, locations for Acupuncture points are described both in terms of anatomical site, insertion depth and angle of insertion.[143]

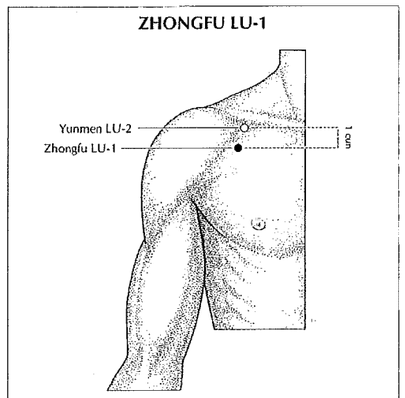
MAJOR POINTS OF THE CHEST



MAJOR POINTS OF THE UPPER BACK

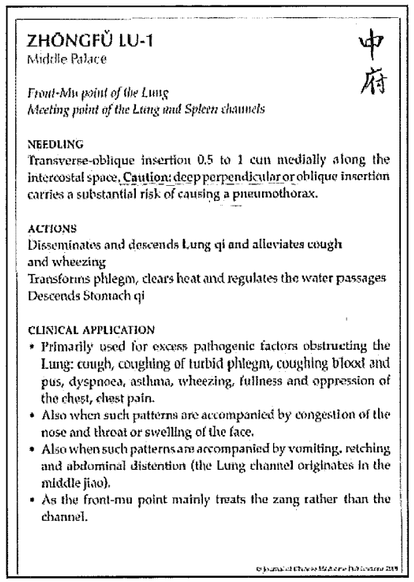


The Deadman charts above only show major points located in the area of the lungs and pleural cavity and are unilateral in presentation. The actual points on these areas include LU1, LU2, ST12, ST13, ST14, ST15, ST16,ST18, ST19, SP17, SP18, SP19, SP20, SP21, HT1, SI9, SI10, SI11, SI12, SI13, SI14, SI15, UB11, UB12, UB13, UB14, UB15, UB16, UB17, UB18, UB19, UB20, UB41, UB42, UB43, UB44, UB45, UB46, UB47, UB48, KD21, KD22, KD23, KD24, KD25, KD26, KD27, PC1, SJ14, SJ15, GB21, GB22, GB23, GB24 and LV14 and total 57 Acupuncture point locations (please see End Note C for explanation of meridian abbreviations).
In order to have an understanding of the completeness with which Licensed Acupuncturists have studied the human body, Acupuncture point location, and needle technique, that is angle and depth of insertion, please see Deadman flashcard of one point needled in this anatomical region, Lung Meridian, point number 1 (LU1).[144]



LOCATION
On the lateral aspect of the chest, in the first intercostal space, 6 cun lateral to the midline, 1 cun inferior to Yunmen LU-2.

LOCATION NOTE
i. Ask the patient to extend their hand forwards against resistance, in order to emphasise the delto-pectoral triangle. Locate Yunmen LU-2 in the centre of the triangle, then locate Zhongfu LU-1 in the intercostal space approximately one cun inferior and slightly lateral to it.



ZHŌNGFǓ LU-1 中府
Middle Palace

Front-Mu point of the Lung
Meeting point of the Lung and Spleen channels

NEEDLING
Transverse-oblique insertion 0.5 to 1 cun medially along the intercostal space. Caution: deep perpendicular or oblique insertion carries a substantial risk of causing a pneumothorax.

ACTIONS
Disseminates and descends Lung qi and alleviates cough and wheezing
Transforms phlegm, clears heat and regulates the water passages
Descends Stomach qi

CLINICAL APPLICATION
- Primarily used for excess pathogenic factors obstructing the Lung: cough, coughing of turbid phlegm, coughing blood and pus, dyspnoea, asthma, wheezing, fullness and oppression of the chest, chest pain.
- Also when such patterns are accompanied by congestion of the nose and throat or swelling of the face.
- Also when such patterns are accompanied by vomiting, retching and abdominal distention (the Lung channel originates in the middle jiao).
- As the front-mu point mainly treats the zang rather than the channel.

In the above drawings, the accompanying text indicates recommended needle location, needle angle and needle depth information, patient positioning instructions and contraindications to needling instructions.

Endnote C: LU denotes Lung meridian, ST denotes Stomach meridian, SP denotes Spleen meridian, SI denotes Small Intestine meridian, UB denotes Urinary Bladder meridian, KD denotes Kidney meridian, GB denotes Gall Bladder meridian, PC denotes Pericardium meridian, SJ denotes San Jiao meridian, LV denotes Liver meridian. These are standard designations.

This is a more complete, and therefore safe, process of locating and needling points than the methods suggested by Dry Needling as used by Physical Therapy educators and advocates. Learning how to needle as a practitioner of Acupuncture requires significantly more classroom and clinical educational hours to complete than learning how to needle as a Physical Therapist. Realistic parity is not achieved when Physical Therapy advocates quote Acupuncture malpractice statistics as proof of the safety of Dry Needling by Physical Therapists. Although the process is similar, the preparation and training to perform Dry Needling by Physical Therapists is of vastly shorter duration and thereby rendered incomplete when compared with the needling education received by Licensed Acupuncturists performing Acupuncture. It is to be assumed that the Dry Needling patient safety will be similarly vastly incomplete and thereby rendered inadequate.

The National Chiropractic Council (NCC), a federal risk purchasing group which purchases Physical Therapy malpractice insurance on a group basis for its members, has similar misgivings regarding the safety of Dry Needling as performed by Physical Therapists:

"Proponents of the addition of dry needling to the scope of physical therapy maintain that trigger point dry needling does not have any similarities to acupuncture other than using the same tool. These same proponents of the technique **re-define** [emphasis added] traditional Chinese medicine as being based on a traditional system of energetic pathways and the goal of acupuncture to balance energy in the body. They emphasize the channel relationship of acupuncture points, de-emphasize or completely exclude the use of ASHI points, and emphasize that acupuncture is based on the energetic concepts of Oriental medicine diagnosis. They therefore define dry needling as different and distinct from acupuncture because it is based on Western anatomy.[145]

> *"To allow physical therapists to use needles on patients without sufficient training constitutes a public health hazard."*[146] *(National Chiropractic Council)*

"However, these proponents fail to recognize that acupuncture schools teach both 'western' neurophysiological concepts along with 'traditional' meridian concepts. As such, acupuncturists are highly trained within both fields of medicine. In fact, the profession of Chinese medicine utilizes neurophysiological principles. As such, there is no such distinction between 'eastern' and 'western' [Dry Needling] acupuncture.[147]"

"To allow physical therapists to use needles on patients without sufficient training constitutes a public health hazard. Based on the foregoing, the North Chiropractic Council will not provide malpractice insurance for any physical therapist who inserts needles and/or utilizes the technique of dry needling."[148] (Please see Appendix Q for complete NCC letter.)

In 2005, CNA/HPSO (CNA/Health Care Providers Service Organization), a national company that insured 5,691 Physical Therapists that year, completed a landmark malpractice claims study for the field of Physical Therapy. Although CNA/HPSO does insure Acupuncturists, that company has not completed a similar malpractice study for the field of Acupuncture. However, two large prospective studies in the U.K. provided estimates of the rates of adverse events in regards to Acupuncture being performed by Acupuncturists. White et al. conducted a prospective survey of 32000 treatments and found that the rate of "significant" events were 14 per 10,000 Acupuncture visits.[149] None of these were deemed to be serious. MacPherson et al. conducted a prospective survey of 34000 Acupuncture treatments and found that there were **no** [emphasis added] reports of serious adverse events that required hospital admission or led to permanent disability or death.[150]

Inserted, below is the Primary Injury Chart gathered from Physical Therapy malpractice statistics, 12/1/93 through 33/1/2006. This chart is from CNA Insurance PT Claims Study 1993-2006.[151]

6A Frequency by Primary Injury

Primary injury	Number of open and closed claims	Percentage of open and closed claims
Trauma including fractures	390	27%
Burns	263	18%
Delay in recovery	166	11%
Additional procedure required	132	9%
Injury not specified	85	6%
Loss of limb or use of limb	84	6%
Abrasion/irritation/laceration	78	5%
Emotional distress (as primary injury)	56	4%
Unknown	42	3%
Bruise or contusion	34	2%
Sprain/strain	29	2%
Neurological related	27	2%
Cracked/broken teeth	17	1%
Death from disease	15	1%
Infection	9	1%
Brain damage and/or paralysis	8	1%
Death from trauma	6	<1%
No injury	6	<1%
Personal injury – e.g., slip and fall, hit by object, etc.	5	<1%
Death not otherwise classified	3	<1%
Loss of organ or organ function	3	<1%
Suicide	3	<1%
Addiction	2	<1%
Cardiopulmonary arrest	1	<1%
Total	1,464	100%

Empirically, Physical Therapy, as a mode of healthcare delivery and by contrast to Acupuncture, presents with more numerous and more severe health care risks to its intended recipient.

Is Acupuncture, when practiced by Licensed Acupuncturists, safe?

In The Prospective Survey of Adverse Events and Treatment Reactions, a survey of members of the British Acupuncture Council involving 1848 **professional Acupuncturists** [emphasis added] providing 34,407 treatments, practitioners reported no serious adverse events:

"A total of 574 practitioner responded, 31% of the total population [of members of the British Acupuncture Council and practicing in the UK]. No serious adverse events were reported, where these were defined as requiring hospital admission, prolonging hospital stays, permanently disabling or resulting in death (95% CI; 0 to 1.1 per 10,000 treatments). This conclusion was based on data collected from one in three members of the British Acupuncture Council. Given that the whole membership delivers between one and a half and two million treatments a year, this is important evidence on public health and safety. When compared with medication routinely prescribed in primary care, the results suggest that acupuncture is a relatively safe treatment modality."[152]

"The most important finding from this survey is that there were no serious adverse events associated with 34,407 treatments provided by **professional acupuncturists** [emphasis added]. We estimate that, with 95% confidence, the underlying serious adverse event lies between 0 and 1.1 per 10,000 treatment episodes. Interestingly, the prospective survey of Yamasita et al reported 94 minor adverse events associated with 65,482 treatments,[153] a rate of 1.4 per 1,000 treatments, very similar to the 1.3 (95% CI: 0.9 to 1.7) of this survey."[154]

> *"The most important finding from this survey is that there no serious adverse events associated with 34,407 treatments provided by professional acupuncturists."*154 (*MacPherson et al:* A Prospective Survey of Adverse Events and Treatment Reactions)

The National Center for Complementary and Alternative Medicine and the Agency for Health Research and Quality, divisions of the National Institutes of Health, agrees with this assessment of risks and adverse events associated with Acupuncture:

"Acupuncture is generally considered safe when performed by an **experienced practitioner** [emphasis added] using sterile needles. Relatively few complications from acupuncture have been reported. Serious adverse events related to acupuncture are rare, but include infections and punctured organs. Additionally, there are fewer adverse effects associated with acupuncture than with many standard drug treatments (such as anti-inflammatory medication and steroid injections) used to manage painful musculoskeletal conditions like fibromyalgia, myofascial pain, osteoarthritis, and tennis elbow."[155] (Please see Appendix R for NCCAM/AHRQ publication "Get the Facts: Acupuncture for Pain.")

A useful method of analysis is comparison. specifically the safety of Acupuncture when performed by Acupuncturists versus the incidence of adverse events occurring from a frequently prescribed class of medications for pain, non-steroidal anti-inflammatory drugs (NSAIDs). A "Prospective Survey of Adverse Events and Treatment Reactions" makes a safety comparison between Acupuncture treatments versus the use of NSAIDs:

"In comparing acupuncture's safety to the record of drug-related adverse events, a comparison can be made with non-steroidal anti-inflammatory drugs (NSAIDs), which, when taken for at least two months, cause 1 in 1,200 patients to die from gastrointestinal complications.[156] Some 20 million prescriptions for this group of drugs are taken in the UK every year, resulting in between 3,500 and 12,000 hospital admissions.[17] Estimates of non-steroidal drug related deaths range from 2000 to 2,500 a year in the UK[157,158] If one acupuncture treatment is equated with one prescription of this group of drugs, then the evidence from this survey of acupuncture practitioners suggests that the adverse event rate associated with acupuncture may be orders of magnitude lower than that associated with NSAIDs." [159]

> *"If one acupuncture treatment is equated with one prescription of this group of drugs, then the evidence from this survey of acupuncture practitioners suggests that the adverse event rate associated with acupuncture may be orders of magnitude lower than that associated with NSAIDs."*[159] *(MacPherson et al:* A Prospective Survey of Adverse Events and Treatment Reactions)

The key correlating factor in both of these assessments of minimal adverse events being associated with Acupuncture treatments is the caveat that such Acupuncture treatment be given by a professional or qualified Acupuncturist. The National Center for Biotechnology Information supports that conclusion:

"Declines in adverse reports may suggest that recent practices, such as clean needle techniques and more rigorous acupuncturist training requirements, have reduced the risks associated with the procedure. Therefore, acupuncture performed by trained practitioners using clean needle techniques is a generally safe procedure."[160]

> *"Generally speaking, Acupuncture treatment is safe if it is performed properly by a well-trained practitioner. Unlike many drugs, it is non-toxic, and adverse reactions are minimal. This is probably one of the chief reasons why Acupuncture is so popular in the treatment of chronic pain in many countries."*[161] *(World Health Organization:* Guidelines on Training and Basic Safety in Acupuncture*)*

The World Health Organization, in their *Guidelines on Basic Training and Safety in Acupuncture*, elucidates comprehensive standards as to appropriate Acupuncture clinical and classroom safety education:

"In competent hands, acupuncture is generally a safe procedure with few contraindications or complications. Its most commonly used form involves needle penetration of the skin and may be compared to a subcutaneous or intramuscular injection. Nevertheless, there is always a potential risk, however slight, of transmitting infection from one patient to another (e.g. HIV or hepatitis) or of introducing pathogenic organisms. Safety in acupuncture therefore requires constant vigilance in maintaining high standards of cleanliness, sterilization and aseptic technique. There are, in addition, other risks which may not be foreseen or prevented but for which the acupuncturist must be prepared. These include: broken needles, untoward reactions, pain or discomfort, inadvertent injury to important organs and, of course, certain risks associated with the other forms of therapy classified under the heading of "acupuncture".

"Finally, there are the risks due to inadequate training of the acupuncturist. These include inappropriate selection of patients, errors of technique, and failure to recognize contraindications and complications, or to deal with emergencies when they arise."[162]

"Generally speaking, Acupuncture treatment is safe if it is performed properly by a well-trained practitioner. Unlike many drugs, it is non-toxic, and adverse reactions are minimal. This is probably one of the chief reasons why Acupuncture is so popular in the treatment of chronic pain in many countries."[163]

The World Health *Guidelines on Basic Training and Safety in Acupuncture* forms the basis for the Licensed Acupuncturist designation in the United States. All candidates for Licensed Acupuncturist certification have completed a minimum number of hours, 1490 classroom hours of academic course work, to qualify to take each required examination (see chart below). Completion of these hours of course work qualifies the applicant to sit for the following Acupuncture Certification Examinations as a "pre-graduate".

Additional hours are required for final certification. In addition to passing the below certification exams all candidates for NCCAOM Certification in Acupuncture must document successful completion of a clean needle technique (CNT) course. In regards to Clean Needle Technique (CNT), the Biomedicine module focuses on universal precautions and emergency situations in comparison to the Acupuncture with Point Location module which focuses on actual needling and its emergencies (e.g., needle angle and depth).[164]

The Alberta Heritage Foundation for Medical Research in their study *Acupuncture: Evidence from Systematic Reviews and Meta-analyses* confirms that the rate or incidence of serious adverse events due to acupuncture treatment is low.[32] Furthermore, the adverse event rate, when compared with primary care drugs, suggests that acupuncture is a relatively safe treatment.[165]

How do we, as a health care community, define quality health care?

The Institute of Medicine stated that "quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"[166] This definition has been widely accepted and has proven to be a robust and useful reference in the formulation of practical approaches to quality assessment and improvement. The terms *health services* refer to a wide array of services that affect health, including those for physical and mental illnesses. Furthermore, this definition applies to many types of health care practitioners and to all settings of care. The definition emphasizes that high quality care *increases the likelihood* of good outcomes.[167]

> *"High quality care increases* the likelihood *of good outcomes."*[167] *(Institute of Medicine)*

How is quality of health care attained? In a classic formulation of the dimensions of quality of care almost 40 years ago, Avedis Donabedian described quality as including: "structure (viewed as the capacity to provide high quality care), process (now often termed performance), and outcomes:"[168]

Donabedian's classic formulation of dimensions of quality is presented in the following four text boxes with correlating evidence of its application and/or misapplication in the context of Dry Needling/Intramuscular Manual Therapy and Acupuncture.

I. STRUCTURAL: **Structural Measures of Quality**
Structural measures of quality typically include the characteristics of the resources in the health care system... They are measures of the presumed capacity of the practitioner or provider to deliver quality health care. For health care professionals, this may include licensure, specialty board certification, and type of training.[169]

In assessing Acupuncture training and licensing, the State of California sponsored Little Hoover Commission report entitled *Regulation of Acupuncture: A Complementary Framework* (2004) writes:

"According to a UCSF [University of California, San Francisco] analysis, the acupuncture curriculum is far more detailed and prescriptive than the educational requirements for other health professions."[170]

In assessing the training and subsequent aptitudes of therapists engaging in Trigger Point Dry Needling, Dommerholt, et al in a 2006 OPTP Award for Excellence in a Published Review of the Literature recognized article entitled "Myofascial Trigger Points: An Evidence-Informed Review" writes:

"Until very recently, the current scientific knowledge and clinical implications of Myofascial Trigger Points [MTrPs] were rarely included. It appears that orthopedic manual therapists have not paid much attention to the pathophysiology and clinical manifestations of MTrPs. Manual therapy educational programs in the US seem to reflect this orientation and tend to place a strong emphasis on joint dysfunction, mobilizations, and manipulations with only about 10%-15% of classroom education devoted to muscle pain and muscle dysfunction."[171]

II. PROCESS: **Quality-of-care literature is full of discussions about *performance measurement***
Technical aspects of performance measure of care include the timeliness and accuracy of diagnosis, the appropriateness of therapy, complications, and mishaps during treatment, and coordination of care across delivery settings, episodes of care, and professional disciplines.[172]

In a randomized, double blind, sham-controlled crossover trial comparing Dry Needling, Acupuncture and sham treatment of motion related neck pain, Irnich et al (2002) assessed relative quality of care:

"Acupuncture is superior to Sham [treatment] in improving motion-related pain and ROM [range of motion] following a single session of treatment in chronic neck pain patients. Acupuncture at distant points improves ROM more than DN [Dry Needling]; DN was ineffective for motion-related pain."[173]

> *"Acupuncture is superior to Sham in improving motion-related pain and ROM following a single session of treatment in chronic neck pain patients. Acupuncture at distant points improves ROM more than Dry Needling; Dry Needling was ineffective for motion-related pain."* [173] *(Irnich et al)*

III. **Outcomes Measurement**:
Health outcomes include the traditional measures of survival (now commonly expressed as *risk-adjusted mortality*), unintended effects of treatment (e.g., infection), and the relief of symptoms."[174]

BlueCross BlueShield, when assessing the probability of relief of symptoms as demonstrated by a survey of available clinical research trials investigating the use of Dry Needling by Physical Therapists, concluded:

"Despite the fact that dry needling has been known for years, there have been few published studies measuring the effect on patient outcomes published in the peer reviewed literature. Those studies that are available have design flaws or comprise small study samples so that it is not possible to draw conclusions regarding patient outcomes."[175]

Donabedian summarizes in the following Conclusion that quality health care is possible if health care organizations and their clinicians are accountable for its formation:

CONCLUSION: (1) that the quality of health care can be measured and improved and
(2) that quality of care should be measured with continued and increased vigor.
Pursuing this objective means indentifying and assessing the risks and opportunities posed by the changes in health care in the United States. **It also means describing how health care organizations and clinicians should be accountable to patients and society** [emphasis added].[176]

In "Measuring the Quality of Health Care" (2012), the Institute of Medicine outlines a range of fundamental desirable objectives that result from the measurement of health care quality:

"• providing data to inform quality improvement efforts;
• inspecting and certifying that a facility or individual meets previously established standards;
• comparing groups for a variety of purposes, including selective contracting by purchasers and choice of providers and practitioners by individuals;
• informing patients, families, and employees about the health care decisions and choices they face;
• identifying and possibly eliminating substandard performers—those whose performance is so far below an acceptable level that immediate actions are needed;
• highlighting, rewarding, and disseminating best practices;
• monitoring and reporting information about changes in quality over time; and
• addressing the health needs of communities"[177]

It is the last objective that should concern us most, as purveyors of quality health care.

Three proposals would improve the likelihood of the health needs of communities being met:

1. Clear classification and explanation of health care options and their respective providers

The Little Hoover Commission, *Regulation of Acupuncture: A Complementary Framewor*, notes:

"An important underlying tension [in health care delivery] is the trend toward blending traditional Oriental Medicine with Western biomedicine. While both healing paradigms can benefit the public, those benefits will be jeopardized if the two regulatory schemes are not kept separate and distinct."[178]

The White House Commission on Complementary and Alternative Medicine Policy describes the current circumstances potential health care consumers are confronted with when searching for care:

"Navigating the maze of titles and certificates among the various types of practitioners is a challenge for consumers, most of whom are unfamiliar with the nuances of these professions. Information on a practitioner's qualifications should be readily available to help consumers make informed choices in their selection and use of a practitioner. Information on state regulations, requirements, and disciplinary actions should be readily available to help ensure consumers' safety. CAM [Complementary and Alternative Medicine which includes Acupuncture according to the National Center for Complementary and Alternative Medicine, a division of the National Institutes of Health[179]] practitioners without any formal training may be reluctant to make that fact known.

"Moreover, **consumers may not be able to distinguish between a degree or certificate obtained from an accredited organization and a degree or certificate purchased from an organization with no requirement that students meet appropriate educational standards** [emphasis added]. However, disclosure of such information will help consumers evaluate the qualifications of practitioners and make informed choices."[180]

2. More and improved communications between health care providers

Communication barriers between health care providers, especially between those theoretically trained in Eastern and Western modalities, are blocking a necessary free course of exchange. The Institute of Medicine, in *Complementary and Alternative Medicine in the United States* (2005), writes:

"Studies of the use of CAM [Complementary and Alternative Medicine] for the treatment of specific illnesses have documented the popularity of CAM for the treatment of health problems that lack definitive cures; that have an unpredictable course and prognosis; and that are associated with substantial pain, discomfort, or side effects from prescription drug medicine.

"The investigators commented on the observation that CAM providers typically did not discuss with the conventional doctors the care that they were providing to patients who were concurrently seeking care from conventional doctors. This finding, they argue, in conjunction with the fact that patients rarely discussed their CAM care with their conventional physicians raises concerns about the coordination and safety of concurrent care. "[181]

3. Promotion of interdisciplinary health care teams

The Federation of State Medical Boards, *Assessing Scope of Practice in Health Care Delivery: Critical Questions in Assuring Public Access and Safety*(2005)[186] concurs:

"The Institute of Medicine (IOM) reports from 2001[182] and 2003[182] recognize the complexity of scope of practice issues across disciplines and urge state regulators to allow for innovation in the use of all types of clinicians in meeting patient needs in the most effective and efficient way possible. Further, the IOM encouraged use of interdisciplinary teams to optimize patient care. The Pew Health Commission Taskforce on Health Care Workforce Regulation[184] called for States to explore pathways to allow all professionals to provide services to the full extent of their current knowledge, training, experience and skills. The American Medical Association adopted a report on physician and non-physician licensure and scope of practice."[185,186]

> *"The Institute of Medicine encouraged use of interdisciplinary teams to optimize patient care."*186 *(Institute of Medicine,* Assessing Scope of Practice in Health Care Delivery*)*

Practitioners, working within their area of expertise and working with each other, can accomplish unsurpassed integrative health care. Following is a clinical study from the UCLA Center for East-West Medicine, Department of Internal Medicine, UCLA David Geffen School of Medicine, Los Angeles, CA, USA:

"An 87-year-old female with a history of osteoarthritis and spinal stenosis presented with a five month history of severe right hip pain. She had been seen by multiple specialists and hospitalized many times. During these encounters, she was prescribed a long list of pain medications. However, these medications did not improve her pain and added to her risk of adverse drug events. After exhausting traditional Western medical therapies, she received a referral to the UCLA Center for East-West Medicine. There, clinicians treated her with a nonpharmacological integrative East-West medicine approach that included acupuncture, dry needling of trigger points, and education on self-acupressure. Her pain began improving and she was able to cut back on analgesic use under physician supervision. Ultimately, she improved to the point where she was able to discontinue all of her pain medications. Symptomatic relief was evidenced by improvement in health-related quality of life."[187]

> *"This case study suggests that integrative East-West medicine may have the potential to reduce the incidence of polypharmacy in elderly patients presenting with pain conditions and improve their quality of life.."*[188] *(Tu et al, Case Study, UCLA Center for East-West Medicine)*

This paper recommends:

1. **Formation of national guidelines** as to what constitutes desirable education, certification & licensure, both classroom and clinical, in the full spectrum of health care modalities, including complementary and alternative medicine.

2. **Full disclosure at health care treatment sites** of specific national guidelines *and* specific training, certification and licensure of all practitioners involved in practicing health care at that location so that consumers can make informed, intelligent decisions regarding their therapeutic options.

3. **Promotion of interdisciplinary teams** of health care providers to increase the range of therapeutic options available to patients. Rather than unwarranted expansions of scope of practice as Western practitioners recognize the value of Eastern health paradigms, interdisciplinary teams working together would better serve the public's health care needs.

The following recommendations are presented in the spirit of achieving the standards of quality health care provided by the Committee on Quality of Health Care in America, Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century (2012):*

1. *Care is based on continuous healing relationships*.
2. *Care is customized according to patient needs and values*.
3. *The patient is the source of control*.
4. *Knowledge is shared and information flows freely*.
5. *Decision making is evidence-based*.
6. *Safety is a system property*.
7. *Transparency is necessary*.
8. *Needs are anticipated*.
9. *Waste is continuously decreased*.
10. *Cooperation among clinicians is a priority*.[188]

Summary Statement

The Federation of State Board of Physical Therapy in *Changes in Healthcare Professions Scope of Practice: Legislative Considerations* (2006) wrote: "The only factors relevant to scope of practice decision making are those designed to ensure that *all licensed practitioners be capable of providing competent care*."[190]
We agree. Dry Needling is synonymous with Acupuncture and is, in fact, a subset of Acupuncture.
Dry Needling is an Acupuncture practice. Licensed Acupuncturists are the best equipped, prepared and qualified and therefore the best choice to provide competent care in the fields of Dry Needling, Intramuscular Manual Therapy and Acupuncture.

Footnotes

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Written Statement to the Iowa Board of Physical and Occupational Therapy

This statement will address the following points:

1. **"Dry Needling" is exactly the same technique based on the same biomedical concepts as are integrated into acupuncture courses taught at accredited colleges.**
2. **Not all acupuncture points are located on meridians. A significant part of acupuncture is at non-meridian points AKA trigger points.**
3. **Accredited colleges of acupuncture have been integrating trigger point therapy into curriculums for over 20 years.**

Southwest Acupuncture College Boulder Campus submits this statement in opposition to allowing an expansion of scope for physical therapy by rule to include "dry needling," a treatment domain that is equivalent to acupuncture practice. We oppose this action by the Physical Therapy Board in Iowa because dry needling education providers have no set standards, and the training is offered at a fraction of the hours necessary to use filiform needles safely. This statement will provide testimony that trigger point acupuncture is an integral part of accredited coursework in acupuncture colleges in the Untied States.

We are a college offering Masters degrees in Acupuncture and Acupuncture and Oriental Medicine. Our two colleges, one in Boulder and one in Santa Fe, are institutionally accredited and our degrees are programmatically accredited by the Accreditation Commission for Acupuncture and Oriental Medicine, the national accrediting agency recognized by the U.S. Department of Education for the accreditation of Master's and post-graduate doctoral programs in acupuncture and in Oriental medicine.

Since opening in 1997, the Boulder Campus of Southwest Acupuncture College has employed techniques that are now labeled as "Dry Needling". I personally learned these techniques as part of my program at another acupuncture college in 1992-95 and I have treated Olympic athletes in the Olympic village in Atlanta in 1996. Along with acupuncture texts, I used Janet Travell's textbooks as the basis for learning trigger point therapy.

One of the Boulder campus's founding instructors, Whitfield Reaves, is an internationally recognized expert in Sports Acupuncture, a field that began in the United States in the 1980s. He has taught bioscience-based needling therapies for musculo-skeletal injuries in our needling technique courses consistently within our program since we opened. In 2000, he began to offer a Sports Acupuncture series, which included instruction in trigger point acupuncture, using techniques identical to what is now known as dry needling. Whitfield Reaves developed the Sports Acupuncture specialty courses at our college that became the basis for courses developed in 2009-2010, as evidenced by the course taught here by Chad Bong in 2009. In addition, specialized courses in Trigger point therapy offered by Michael Young began in 2009 and continue to the present. Our Sports Acupuncture class is now being taught by Amy

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Dickinson, who has also developed our integrated clinic offered through the University of Colorado for their NCAA athletes. Syllabi for their coursework are attached.

The PT lobby maintains that acupuncture points have fixed locations on meridians. This is a misleading statement. Our curriculums are based on not one but three locations of acupuncture points:

1. Meridian points
2. Extra points
3. "ASHI" points

This third classification of acupuncture points, ASHI points, have a long history in medical literature from China. A 1st century textbook says, "[The point of] pain indicates a [clinically relevant] acupuncture point." Sun Si Miao, a famous physician during the Tang Dynasty, named these points "ASHI" points. These points have been utilized as effective points for the treatment of pain, and are fundamental in learning to treat pain. These points are trigger points.

In 1976, Chan Gunn, the Canadian developer of intramuscular stimulation (an early term for dry needling) and from whom Kinetacore founder Edo Zylstra received his initial training, published:

> "It is suggested that, as a first step towards the understanding and acceptance of acupuncture by the medical profession, the present anachronic systems of acupuncture locus nomenclature be dispensed with in favour of a modern, scientific one using neuro-anatomic descriptions."

Dr. Yuntao Ma, L. Ac., a provider of dry needling education courses, has taken this strategy further by renaming meridian acupuncture points as "homeostatic points". Thus you can see that the re-naming of acupuncture points was and remains a strategy to use the same techniques and anatomical locations of acupuncture treatment for the identical therapeutic effect.

I have personally been involved in the issue of dry needling and how the PT lobby has been attempting to redefine the acupuncture education and description of our medicine since 2005. I have noted that while originally only applied to trigger point therapy, the PT lobby now wishes to extend the definition of dry needling to any neurological affect of inserting a filiform needle. Recently a Physical Therapist in Colorado began offering Cosmetic Dry Needling treatment, even though the definition of dry needling in Colorado is specifically defined as needling trigger points. The PT lobby has been very effective in claiming that acupuncturists use an energetic medicine and dry needling is based on biomedical concepts. However our major modern textbooks, printed in 1953, use biomedical, neurological and anatomical language. Our graduates must become board certified in a Biomedicine module of the National Commission for the Certification of Acupuncture and Oriental Medicine (NCCAOM) in order to attain Diplomat status, which is used as the basis of acupuncture licensure. My college requires over 500 hours of education just in bioscience courses as part of our Masters in Science in Oriental Medicine program. Biomedical concepts are taught from Semester 1 and imbedded throughout our programs.

Southwest Acupuncture has been in operation in New Mexico since 1983, and in

Colorado since 1997. We are a fully accredited college incorporating bioscience into our curriculums. Trigger point needling and dry needling are indistinguishable from content taught in our acupuncture college. As leading experts in the training of health care providers in therapeutic needling, we know that what the physical therapy profession is promoting is an insufficient and misleading standard.

Sincerely,

Valerie Hobbs

Valerie Hobbs, Dipl. O.M., L. Ac.
Director of Program Development
Southwest Acupuncture College
October 29, 2015

Southwest Acupuncture College

Campus: Boulder **Term:** Spring 2000

Name and Number of Course: Sports Acupuncture 405

Instructor: Whit Reaves, OMD, Dipl.Ac., R.Ac.
Assistant: None
Semester Hours: 45.0
Course Hours: 3.00
Credit Hours: 3.00
Class Time: Monday, 5:45 pm – 8:45 pm
Prerequisites: All first year courses.

Required Books:

Close to the Bone…Legge

Course Description:

This course covers the use of acupuncture, electro-acupuncture, and related modalities in the treatment of athletic injury and the enhancement of athletic performance. Special techniques, including tendino-muscle meridians, opposite side and opposite extremity, and auricular will be included. This class will encompass specific injuries, including plantar fascitis, Achilles tendonitis and tennis elbow. The class will use lecture and student practice of techniques.

Learning Objectives:

On completion of this course, the student is expected to:

1. Be able to apply 3 special techniques to the treatment of pain;
2. Know 6 points and procedures in the enhancement of athletic performance;
3. Be able to diagnose and treat 3 trigger point conditions;
4. Know the diagnosis and treatment of 5 specific musculo-skeletal injuries.

Expectations:

Course grade and satisfactory passing of the class are dependent upon the following criteria:

1. Attendance at all classes is mandatory. Any absence may result in lowering of your grade. Students are expected to arrive on time and remain in class/clinic until it is over. Arriving late or leaving early may be considered an absence and may result in the lowering of the student's grade. At the discretion of the teacher, missed class/clinic time may result in an incomplete, academic warning or dismissal from class. Absence does not excuse students from any material covered that day, homework assignments, or exams missed. At the discretion of the Academic Dean, and on the advice of the Instructor, excessive absences may need to be made up at an additional cost to the student. Also, in accordance with college policy, students who miss fourteen consecutive days of classes, without having made arrangements with the Academic Dean, will be automatically withdrawn from the program.
2. Prompt arrival at class, room set-up, take-down.
3. Cooperative participation in the creation of a classroom environment conducive to learning, inquiry, academic freedom, and to the instructor achieving the objectives of this course.
4. Grading:

Class participation	=	20%
Project	=	20%
Mid-term exam	=	20%
Final practical exam	=	40%

Evaluations will be administered in the 10th week of class for Fall and Spring semester classes. Evaluations will be administered in the 5th week of class for Summer semester classes. They will take approximately the first 15 minutes of class.

WEEK	TOPIC
1	Introduction Flow chart for treating sports injuries Tendino-muscle meridian – theory and practice
2	Special techniques – Shu-stream points, opposite side, opposite extremity
3	Special techniques – Richard Tan's work, other empirical points
4	Auricular therapy
5	Trigger points – upper extremity, neck and shoulder
6	Trigger points – lower extremity, low back and hip
7	**Mid-term** Clinical demonstrations
8	Five Element Theory and the Athlete Korean Constitutional Acupuncture
9	Enhancement of athletic performance
10	Homeopathy for musculo-skeletal injuries
11	Nutrition, herbal medicine, and topicals for musculo-skeletal injuries
12	Treatment of injuries to the lower extremity
13	Treatment of injuries to the upper extremity
14	Treatment of injuries to the neck, back and shoulder
15	**Final Exam** Presentation of projects

Mid-term Break: March 4 – 19, 2000

Southwest Acupuncture College

Campus: Boulder **Term:** Summer 2009

Name and Number of Course: Trigger Point 600

Instructor: Michael Young, Dipl. Ac., L.Ac.; Full Professor
Assistant: Keith Economidis, Dipl.Ac., L.Ac.

Semester Hours: 3
Course Hours: 24
Credit Hours: 1.60
Class Time: Thursday 9:00 am – 12:00 pm, Weeks 1-8
Prerequisites: Techniques of Acupuncture and Moxibustion 112

Required Books:
Myofascial Pain and Dysfunction – Travell & Simons - Both Volumes

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Recommended Books:
None

Required Supplies: **A variety of needle lengths and gauges for working on trigger points in a variety of patients and locations.**

Course Description: This class will explore the most common trigger points of the body and their Chinese medical treatment. Topics included will be the pathophysiology of trigger points, apropos of all muscles, perpetuating factors, as well as integrated treatment utilizing cupping, bodywork, and acupuncture protocols.

Learning Objectives:
Given lecture, demonstration, discussion, and self-study, the student will be able to perform the following items in the listed domains with 75% accuracy:

Knowledge

1. Describe the mechanism by which trigger points develop.
2. Identify perpetuating factors that affect formation of Trigger points

3. Identify location of Trigger points and referral pain in major muscle groups
4. Develop and describe trigger point treatment using acupuncture techniques.

Skill:

1. Palpate and demonstrate the common location of trigger points in the major muscle groups covered in class.
2. Demonstrate acupuncture treatment of trigger points utilizing needles, cupping and bodywork.

Attitude/Behavior

1. Participate in classroom practice;
2. Demonstrate concern for patient safety by practicing CNT; and
3. Demonstrate flexibility, gentleness, and compassion by adapting technique to the patient's condition when working with patients.

Expectations:

Course grade and satisfactory passing of the class are dependent upon the following criteria:

1. Attendance at all classes is mandatory. Any absence may result in the lowering of your grade. Students are expected to arrive on time and remain in class until it is over. Arriving late or leaving early may be considered an absence and may result in the lowering of your grade. Absence does not excuse students from any material covered that date, homework assignments, or quizzes/exams missed. Please consult the current Student Policy and Procedure Manual.
2. Cooperative participation in the creation of a classroom environment conducive to learning, inquiry, academic freedom, and to the instructor achieving the objectives of this course.
3. Grading criteria – 75% or better grade overall.

Refund Policy:

Because elective classes have a minimum and maximum enrollment, no refunds are offered once the college has determined that an elective class has sufficient enrollment and will be offered. Once a student has registered for an elective, s/he will be billed for the class and no refund or credit is given. In the event that the class is cancelled due to insufficient enrollment, all monies will be refunded in full. The date of registration is the effective date of billing for ALL electives, regardless of start date.

WEEK	TOPIC
1	Introduction to Trigger Points. Pathophysiology of trigger points. Apropos of all muscles.
2	Perpetuating Factors. Overview of the head and neck region. Trapezius, Sternocleidomastoid.
3	Masseter, Pterygoids. Splenii, Posterior cervical, Overview of the upper back, shoulder, and arm region.
4	Levator Scapulae, Scalene, Supraspinatus, Infraspinatus, Teres Minor & Major.
5	Rhomboids, other shoulder and arm. Overview of Torso region. Pectoralis Major & Minor, Paraspinals
6	Abdominal muscles, General Issues, Overview of Lower Torso, Quadratus lumborum, Iliopsoas,
7	Glutei muscles, Piriformi, Quadriceps, Adductors, Hamstrings, leg, ankle and foot muscles.
8	Final Exam

Southwest Acupuncture College

Campus: Boulder **Term: Spring 2011**

Name and Number of Course:	**Sports Medicine 625**
	acusport@gmail.com
Instructor:	Chad Bong, MS, L.Ac., CSCS
Assistant:	None
Semester Hours:	45
Course Hours:	3
Credit Hours:	3
Class Time:	Wednesday 5:00 – 8:00 PM
Prerequisites:	Sports Medicine

Required Books:

The Acupuncture Handbook of Sports Injuries & Pain: A Four Step Approach to Treatment. Whitfield Reaves

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Recommended Books:

MUSCLES: Testing and Function ... Kendall, Mcreary & Provance

Myofascial Pain and Dysfunction: The Trigger Point Manual Janet G Travell & David Simons

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Required Supplies:

Gua Sha Tools, Cups, 90% isopropyl alcohol, and Acupuncture needles

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Course Description:

This course is the second of a two-semester sequence on orthopedics, and the acupuncture treatment of pain and injury. This course covers the acupuncture treatment of approximately 25 common injuries seen in the clinic. In addition, techniques common to all acupuncture sports medicine treatments will be covered. Also included in this course will be the general treatment of trauma to the body due to accident and acute injury. Students will learn how to create treatment protocols based upon the western diagnosis and assessment, the interview, and the physical exam. Orthopedic testing, including manual muscle testing, active and passive range of motion, and neurological testing will be

considered in these treatment protocols. Western orthopedic treatment will be reviewed, including procedures such as injection (cortisone, anesthetics, PRP, synvisc, etc), bracing and taping, and surgical options.

Learning Objectives:

Student can list 3 common signs and symptoms of at least 10 conditions covered in the course.

Student demonstrates the ability to palpate the tissues involved in the at least 10 pain or injury syndromes.

Student can perform 1 to 2 common orthopedic tests used to confirm at least 5 specific conditions covered in this course.

Student is able to state a general summary of the cause according to traditional Chinese medicine as well as western orthopedic medicine of at least 20 common pain and injury syndromes.

Student can list 3 western medical treatment options (physical therapy, physiatry, surgery, etc) of pain and injury syndromes, when they are important.

Student can summarize in written form the anatomy of the tissue(s) involved in 10 injury or conditions.

Student can design treatment protocols that include at least 3 modalities, including acupuncture, electrical acupuncture, moxibustion, manual therapies, cupping, and gua sha, for at least 10 common injury and pain syndromes.

Student can describe and treat 5 motor points.

Student can describe and treat 8 trigger points.

Student can describe and treat 3 "belly of muscle" treatments.

Student can describe and treat 3 "muscle-tendon junction" treatments.

Student can describe and treat 3 tendon and tendon sheath treatments.

Expectations:

Course grade and satisfactory passing of the class are dependent upon the following criteria:

Attendance at all classes is mandatory. Any absence may result in the lowering of your grade. Students are expected to arrive on time and remain in class until it is over. Arriving late or leaving early may be considered an absence and may result in the lowering of your grade. Absence does not excuse students from any material covered that date, homework assignments, or quizzes/exams missed. Please consult the current Student Policy and Procedure Manual.

Cooperative participation in the creation of a classroom environment conducive to learning, inquiry, academic freedom, and to the instructor achieving the objectives of this course.

Passing grade of 75% or better:

Midterm Exam	=	30%
Final Exam	=	35%
5 Quizzes (drop lowest)	=	15%
Project/presentation	=	10%
Class participation	=	10%

Evaluations will be available online the 11th week of the semester. Students will be given the last 15 minutes of class to complete.

WEEK	TOPIC
1	**Introduction to injury:** 1. Review of the Sites of injury: Anatomical tissues (Muscles, Tendon, Tendon Sheath, Ligament, Bone, etc) 3. Introduction to muscle testing
2	**Shoulder** 1. Supraspinatous 2. Infraspinatous
3	**Shoulder** 1. AC joint 2. Frozen shoulder 3. Biceps muscle group
4	**Finish Shoulder Neck** 1. Neurology and Anatomy 2. Levator Scapula
5	**Low Back and Hip** 1. Neurology and Anatomy 2. Quadratus Lumborum (QL)
6	**Low Back and Hip** 1. Trochanteric Bursitis 2. Arthritis of hip
7	**Low Back and Hip** 1. Glute Medius/Minimus 2. IT Band 3. Review for Midterm
8	**Midterm** 1. Practical 2. Written
9	**Anterior and Posterior Thigh Anterior Knee** 1. Patello-Femoral Joint Syndrome 2.

	Patellar Tendonitis
10	**Knee** 1. Lateral Knee 2. Medial Knee PRESENTATIONS
11	**Elbow** 1. Medial Epicondylitis (tennis elbow) 2. Lateral Epicondylitis (golfer elbow) PRESENTATIONS
12	Evaluations the last 15 minutes of class **Lower Leg** 1. Anterior Tibial Stress Syndrome 2. Medial Tibial Stress Syndrome 3. Lateral Ankle Sprain PRESENTATIONS
13	**HEEL** 1. Achilles Tendonitis 2. Plantar Fasciitis PRESENTATIONS
14	Complete any uncovered Material Review for Final
15	Final Exam Written exam Practical exam

Southwest Acupuncture College

SYLLABUS
Summer 2015
Campus: Boulder

MISSION STATEMENT

Southwest Acupuncture College is a classical school of Oriental Medicine offering an accredited professional degree program leading to a Masters of Science in Acupuncture or a Master of Science in Oriental Medicine. With the primary responsibility of educating students to become independent healthcare providers, our foremost goal is to provide excellence in the education of those prospective practitioners. A concomitant goal of the college, to cultivate service to the community in this emerging field of effective medical care, is fostered in the curriculum and the educational format as well as the life of the college community through our on-site low-cost public clinic and numerous off campus extern clinics that offer free service. In order to accomplish these Goals of promoting the greatest caliber and realization of professional performance, the staff and faculty are continually re-evaluating the program and supporting areas of institutional activity, seeking ways to enhance and maintain the college's standard of excellence.

Course Name/Number	Sports Medicine 625
Class Time	Wednesday 9:00am - 12:00pm
Format	Didactic/Practicum
Faculty Member	Amy Dickinson, BA, L.Ac., MTCM dickinson.acuamy@gmail.com
Assistant	None
Semester Hours	45
Course Hours	3
Credit Hours	2.25
Estimated Out of Classroom Hours	67.5 per semester. 4.5 per week
Prerequisites	Orthopedic Anatomy 620 and completion of Clinical Internships 250, 251 and 252
Required Books	The Acupuncture Handbook of Sports Injuries & Pain: A Four Step Approach to Treatment. Whitfield Reaves ISBN 978-0615274409
Recommended Books	MUSCLES: Testing and Function ... Kendall, Mcreary & Provance ISBN: 9780781747806
	Motor Point Index- An Acupuncturist's Guide to Locating and Treating Motor Points. Matt Callison
Required Supplies	Clean Needle Kit, Needles, Gua Sha Tools, Cups, 90% isopropyl alcohol, goniometer, measuring tape, Dr. Bob's Medicated oil or Po Sum On

Course Description	This course is the second of a two-semester sequence on orthopedics, and the acupuncture treatment of pain and injury. This course covers the acupuncture treatment of approximately 25 common injuries seen in the clinic. In addition, techniques common to all acupuncture sports medicine treatments are covered. Also included in this course are the general treatment of trauma to the body due to accident and acute injury. Students learn how to create treatment protocols based upon the western diagnosis and assessment, the interview, and the physical exam. Orthopedic testing, including manual muscle testing, active and passive range of motion, and neurological testing are considered in these treatment protocols. Western orthopedic treatment is reviewed, including procedures such as injection (cortisone and anesthetics), bracing/taping, and surgical options.
Student Assessment of Learning	This course requires a passing grade of 75% or better for the course overall: 6 Quizzes (drop lowest) = 30% Midterm Exam = 30% Written Final Exam = 20% Practical Final Exam = 20%

Final letter grades are assigned according to the Grading Policy (see the *Student Policy and Procedure Manual*). Adherence to Technical Standards, Student Conduct Standards, Attendance policy and submission of a course evaluation are required to receive a course grade.

Learning Objectives	
Knowledge	1. Student can list 3 common signs and symptoms of at least 10 conditions covered in the course. 2. Student is able to state a general summary of the cause according to traditional Chinese medicine as well as western orthopedic medicine of at least 20 common pain and injury syndromes. 3. Student can list 3 western medical treatment options (physical therapy, physiatry, surgery, etc) of pain and injury syndromes, when they are important. 4. Student can summarize in written form the anatomy of the tissue(s) involved in 10 injury or conditions. 5. Student can design treatment protocols that include at least 3 modalities, including acupuncture, electrical acupuncture, moxibustion, manual therapies, cupping, and gua sha, for at least 10

	common injury and pain syndromes. 6. Student can describe and treat 5 motor points. 7. Student can describe and treat 8 trigger points. 8. Student can describe and treat 3 "belly of muscle" treatments. 9. Student can describe and treat 3 "muscle-tendon junction" treatments. 10. Student demonstrates the ability to think conceptually about treatment of injury by assessing Mechanism of Injury and affected tissues.
Skill	1. Student demonstrates the ability to palpate the tissues involved in at least 10 pain or injury syndromes. 2. Student can perform 1 to 2 common orthopedic tests used to confirm at least 5 specific conditions covered in this course.

Week/Date	Topic	Required Reading
1	Introduction to injury: General Orthopedic Concepts Review of the Sites of injury: Anatomical tissues (Muscles, Tendon, Tendon Sheath, Ligament, Bone, etc) Review of treatment modalities used in acupuncture sports medicine A. Acupuncture B. Electrical stimulation C. Manual therapies D. Gua sha E. Cupping F. Other	Reaves, Introduction Look up and be able to define: Trigger point, motor point
2	Review of the Inflammatory Response and Direct Trauma **Quiz 1** Treatment Protocols for Direct Trauma Treatment of Pain and Injury to the Foot and Ankle	How does inflammation help healing? What are the consequences of long term inflammation and long term NSAID use?
3	Treatment of Pain and Injury to the Foot and Ankle Treatment of Pain and Injury to the Leg	Reaves
4	Treatment of Pain and Injury to the Knee	Reaves
5	Treatment of Pain and Injury to the Knee	Reaves

	Quiz 2	
6	Treatment of Pain and Injury to the Thigh, Introduce Hip and Pelvis	Reaves
7	Treatment of Pain and Injury to the Hip and Pelvis, **End class w Quiz 3**	Reaves
8	**Midterm Exam (1.5 Hours)** Start Pain and Injury to Lumbar-Sacral Region	Reaves
9	Treatment of Pain and Injury to the Lumbosacral Region	Reaves
10	Treatment of Pain and Injury to the Torso and Trunk **Quiz 4**	Reaves
11	Treatment of Pain and Injury to the Neck and Shoulder	Reaves
12	Treatment of Pain and Injury to the Neck and Shoulder (con'd) **Quiz 5**	Reaves
13	Treatment of Pain and Injury to the Upper Extremity	Reaves
14	Treatment of Pain and Injury to the Upper Extremity (con'd) **Quiz 6**	Reaves
15	Final Exam 90% Written exam 10% practical exam (on orthopedic testing and other material from the physical exam)	

Technical Standards: The *Technical Standards for Admission, Promotion and Graduation* comprise an academic standard for all classes and meeting these standards is required to receive a passing grade. (*See the* Student Policy and Procedure Manual *for full description of the Technical Standards*).

Course Evaluations: Consistent with our Mission, Southwest Acupuncture College engages in continual evaluation of the program. Learning to provide consistent and constructive feedback is an essential skill of the professional, and is therefore required to receive a grade for a course. **On-line evaluations open before the semester ends and close a week after class ends. All feedback on the class evaluation is confidential. No grade can be accessed after the final exam (or in absence of a final, the Monday of finals week) until a course evaluation is received.**

Attendance Policy
Attendance at all classes is mandatory. Any absence may result in the lowering of your grade. Students are expected to arrive on time and remain in class until it is over. Arriving late or leaving early may be considered an absence and may result in the lowering of your grade. Absence does not excuse students from any material covered that date, homework assignments, or quizzes/exams missed. Please consult the current *Student Policy and Procedure Manual.*

Student Conduct Standards

1. Cooperative participation is required in the creation of a classroom environment conducive to learning, inquiry, academic freedom, and to the instructor achieving the objectives of this course. All policies in the *Student Policy & Procedure Manual* apply.
2. There is no eating in any classroom.
3. Students are responsible for course materials from assigned texts and reading, lecture, labs, practicums, and other assignments as required.
4. Adherence to Honor Code is strictly enforced. (See the *Student Policy & Procedure Manual*)
5. Personal use of cell phones during class is prohibited.
6. Unless part of an accommodations plan, no electronic devices of any kind may be used during tests or test review.

Syllabus Changes
With the permission of the Academic Dean, the instructor may alter any, or all, of this syllabus during the semester as the learning environment requires. Students will be notified in writing of changes.

Disability Support Services:
The college provides accommodations for students with disabilities and does not discriminate on the basis of disability in the admission and retention of students. Under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, qualified persons with disabilities are entitled to reasonable accommodations to achieve nondiscriminatory access to programs, services, and activities. In order to receive accommodations, the student must begin the process by filing out an *Accommodation Application and Request for Accommodations Form* (see "Accommodations" in the *Student Policy & Procedure Manual)*. For more information or to discuss your specific needs, please schedule an appointment with the Academic Dean and/or Disability Coordinator.

Southwest Acupuncture College

SYLLABUS
Fall 2015
Campus: Boulder

MISSION STATEMENT

Southwest Acupuncture College is a classical school of Oriental Medicine offering an accredited professional degree program leading to a Masters of Science in Acupuncture or a Master of Science in Oriental Medicine. With the primary responsibility of educating students to become independent healthcare providers, our foremost goal is to provide excellence in the education of those prospective practitioners. A concomitant goal of the college, to cultivate service to the community in this emerging field of effective medical care, is fostered in the curriculum and the educational format as well as the life of the college community through our on-site low-cost public clinic and numerous off campus extern clinics that offer free service. In order to accomplish these Goals of promoting the greatest caliber and realization of professional performance, the staff and faculty are continually re-evaluating the program and supporting areas of institutional activity, seeking ways to enhance and maintain the college's standard of excellence.

Course Name/Number	Trigger Points 600
Class Time	Friday 1:30-4:30pm
Format	Lecture with practicum
Faculty Member	Michael Young, B.A., Dipl. Ac., L.Ac.; Full Professor youngacupuncture@earthlink.net
Assistant	None
Semester Hours	45
Course Hours	3
Credit Hours	2.25
Estimated Out of Classroom Hours	67.5 hours per semester, 4.5 hours weekly
Prerequisites	112, 231, 232, Concurrent Clinic 254 or higher or 300-level clinic
Required Books	1. Myofacial Pain & Dysfunction, Vol. 1: The Trigger Point Manual, The Upper Extremities – Travell/Simons. ISBN-13: 978-0683083668
	2. Myofacial Pain & Dysfunction, Vol. 2: The Trigger Point Manual, The Lower Extremities – Travell/Simons. ISBN-13: 978-0683083675
Recommended Books	None
Required Supplies	A variety of needle lengths and gauges for working on trigger points in a variety of patients and locations.

Course Description	This class explores the most common trigger points of the body and their Chinese medical treatment. Topics include the pathophysiology of trigger points, perpetuating factors, as well as integrated treatment utilizing cupping, bodywork, and acupuncture protocols.
Student Assessment of Learning	This course requires a passing grade of 75% or better for the course overall: Midterm written = 25% Midterm practical = 25% Final written = 25% Final practical = 25%

Final letter grades are assigned according to the Grading Policy (see the *Student Policy and Procedure Manual*). Adherence to Technical Standards, Student Conduct Standards, Attendance policy and submission of a course evaluation are required to receive a course grade.

Learning Objectives	
Knowledge	1. Describe the mechanism by which trigger points develop. 2. Identify perpetuating factors that affect formation of Trigger points 3. Identify location of Trigger points and referral pain in major muscle groups 4. Develop and describe trigger point treatment using acupuncture techniques.
Skill	1. Palpate and demonstrate the common location of trigger points in the major muscle groups covered in class. 2. Demonstrate acupuncture treatment of trigger points utilizing needles, cupping and bodywork.
Attitude	1. Participate in classroom practice; 2. Demonstrate concern for patient safety by practicing CNT. 3. Demonstrate flexibility, gentleness, and compassion by adapting technique to the patient's condition when working with patients.

See the final page of this syllabus for detail on how the mastery of the learning objectives will be tested.

Week/Date	Topic	Required Reading
1	Introduction to Trigger Points. Pathophysiology of trigger points. Apropos of all muscles.	pp. 1 – 11, 11-93, 94-177
2	Perpetuating Factors. Overview of the head and neck region. Trapezius, Sternocleidomastoid.	pp. 178-236, 237-277, 278-307, 308-328
3	Masseter, Pterygoids. Splenii, Posterior cervical.	pp. 329-348, 365-396,

4	Overview of the upper back, shoulder, and arm region. Levator Scapulae Scalene	pp. 485-490 pp. 491-503 pp. 504-538
5	Supraspinatur, Infraspinatus, Teres Minor & Major. Rhomboids, other shoulder and arm. Overview of Torso region.	pp. 495-503, 538-551, 552-536, 564-571, 587-595, 613-622, 485-490
6	Abdominal muscles, General Issues, Overview of Lower Torso, Quadratus lumborum, Iliopsoas	pp. 940-970, 801-818
7	Glutei muscles, Piriformi, Quadriceps, Adductors, Hamstrings, leg, ankle and foot muscles.	pp. 132-185, 315-338, 351-534
8	Midterm	
9	Pectoralis Major & Minor, Paraspinals	pp. 819-856, 913-939
10	Abdominal muscles	pp. 940-970
11	Overview of Lower Torso, Quadratus lumborum, Iliopsoas	pp. 23-27, 28-88, 89-109
12	**Holiday (No Class)**	
13	Glutei muscles	pp. 248-288, 289-314
14	Piriformi, Quadriceps, Adductors	pp. 186-214, pp. 351-354
15	Final Exam	

Technical Standards: The *Technical Standards for Admission, Promotion and Graduation* comprise an academic standard for all classes and meeting these standards is required to receive a passing grade. (*See the* Student Policy and Procedure Manual *for full description of the Technical Standards*).

Course Evaluations: Consistent with our Mission, Southwest Acupuncture College engages in continual evaluation of the program. Learning to provide consistent and constructive feedback is an essential skill of the professional, and is therefore required to receive a grade for a course. ***On-line evaluations open on Monday of the 15th week of the semester and close 10 days after the semester ends. All feedback on the class evaluations is confidential. No grade can be accessed on Populi system after the final exam (or in absence of a final, the Monday of finals week) until a course evaluation is received.***

Attendance Policy

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2. There is no eating in any classroom.
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4. Adherence to Honor Code is strictly enforced. (See the *Student Policy & Procedure Manual*)
5. Personal use of cell phones during class is prohibited.
6. Unless part of an accommodations plan, no electronic devices of any kind may be used during tests or test review.

Syllabus Changes

With the permission of the Academic Dean, the instructor may alter any, or all, of this syllabus during the semester as the learning environment requires. Students will be notified in writing of changes.

Disability Support Services:

The college provides accommodations for students with disabilities and does not discriminate on the basis of disability in the admission and retention of students. Under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, qualified persons with disabilities are entitled to reasonable accommodations to achieve nondiscriminatory access to programs, services, and activities. In order to receive accommodations, the student must begin the process by filing out an *Accommodation Application and Request for Accommodations Form* (see "Accommodations" in the *Student Policy & Procedure Manual)*. For more information or to discuss your specific needs, please schedule an appointment with the Academic Dean and/or Disability Coordinator.

Appendix A: States and Specific Dry Needling

State	Y: Allows N: Does not allow	Other Information
AK	Y	April 24, 2012 letter to Alex Kay, PT regarding performance of dry needling. *Paraphrase:* The board will not address specific treatment approaches by licensure; however, expect the professionalism of the clinician to determine if they are qualified to provide the type of treatment in question or whether referral is more appropriate. The PT will be held accountable for demonstrating this competence if there is ever a complaint.
AL	Y	Board minutes October 23, 2007: Acupuncture & Dry Needling does fall within the scope of practice for physical therapy.
AZ	-	Claimed by some resources to have approved dry needling for PTs, discussion with the board reports no official position is taken as the board is unable to provide advisory opinions.
CA	N	
CO	Y	In rules
DC	Y	In rules
FL	N	Florida physical therapy practice act contains language which specifically excludes penetrating the skin in the performance of acupuncture: **"Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human beings, or the prevention of such disability, injury, disease, or other condition of health, and rehabilitation as related thereto by the use of the physical, chemical, and other properties of air; electricity; exercise; massage; the performance of acupuncture only upon compliance with the criteria set forth by the Board of Medicine, when no penetration of the skin occurs;**[30] The board has not yet taken up the issue of whether or not dry needling is acupuncture. For now, this statute prohibits dry needling in Florida.
GA	Y	2011 Dry needling added to GA PT practice act; only state to have in statute

[30] Florida Statute. Chapter 468. Physical Therapy Practice.

State	Y: Allows N: Does not allow	Other Information
HI	N	Physical therapists, by statute, are not allowed to puncture the skin of a patient for any purpose
IA	Y	From 9/2010 Board of PT meeting minutes: In answer to a licensee's question regarding whether PTs may perform dry needling. Board determines that it does not appear to be prohibited.
ID	N	
IL	Y	Aug 2010 verbal opinion from the Il Dept. of professional regulation legal counsel that dry needling was not prohibited by the IL physical therapy practice act
IN	-	Claimed by some resources to have approved dry needling for PTs, minutes from Board meeting August 2012 state that "Indiana does not take a position on needling...The current statute is open and does not specifically state whether or not it is appropriate." Not prohibited, but not endorsed either.
KS	N	**Kansas Board of Healing Arts Board Minutes** **C. Dry Needling:** Mr. Anshutz and Mr. Riley (disciplinary attorneys of the Board of Healing Arts) stated that they believe Dry Needling is another name for acupuncture and the board only regulates acupuncture in the ND practice act. Several acupuncturists came before the board at the August 8, 2010, meeting and it is expected they will go the legislature to become regulated. Dry needling does not fit any of the modalities that are included in the PT practice act and could only be included as an experimental treatment if done through one of the teaching universities and based on research
KY	Y	March 18, 2010 Opinion and Declaratory ruling regarding state law governing dry needling therapy by the Kentucky Board of Physical Therapy. The board is of the opinion dry needling is within the scope of the practice of "physical therapy" as defined in Kentucky law by the General Assembly at KRS 327.010(1). Dry needling is a treatment used to improve neuromuscular function. As such it falls within the definition of physical therapy as defined under KRS 327:010 (1) "Physical therapy" means the use of selected knowledge and skills ...invasive or noninvasive procedures with emphasis on the skeletal system, neuromuscular, and cardiopulmonary function, as it relates to physical therapy. There is nothing in KRS Chapter 327 to prohibit a licensed physical therapist from performing dry needling so long as the physical therapist is competent in performing this intervention. While dry needling is within the scope of practice of physical therapy, a physical therapist must practice only those procedures that the physical therapist is competent to perform. The board can discipline a physical therapist for "engaging or permitting the performance of substandard patient care by himself or by persons working under their supervision due to a deliberate or negligent act or failure to act, regardless of whether

State	Y: Allows N: Does not allow	Other Information
		actual injury to the patient is established." KRS 327.070(2).
LA	Y	Within the Scope of Practice of PT; board regulations
MD	Y	In January 2011, the board of physical therapy began the rule making process for dry needling specifics in the state of Maryland. Regulations are still in proposed stage. Aug 27, 2010 MD Attorney General's opinion was that dry needling could fall within the scope of physical therapy as use of a mechanical device, however, the "Maryland Physical Therapy Board's informal statement that dry needling is consistent with the practice of physical therapy does not carry the force of law, as it is not a regulation adopted pursuant to the State Administrative Procedure Act." Currently rules to regulate dry needling are going through promulgation.
MS	Y	Board Minutes 2/2012: The Mississippi State Board of Physical Therapy considers that intramuscular manual therapy techniques are within the physical therapist scope of practice and is in the process of developing more specific competence requirements. The Attorney General has affirmed that the MS Board of PT was acting within its power to determine that dry needling was within scope of practice of PT.
MT	Y	The Montana Board of Physical Therapy has determined that trigger point dry needling is within the scope of practice for physical therapists. The board has formed a committee to begin the process of setting rules for trigger point dry needling which met for the first time June 30, 2011 and their work continues presently.
NH	Y	**PT Board MINUTES of October 19, 2011:** PTs can do dry needling if they have been trained to do so.
NJ	Y	Sept 2009, Board of PT determined dry needling is within the scope of practice of PTs. Currently being looked at by the Division of Consumer Affairs which may alter the opinion. No written documentation
NM	Y	March 2000, In a letter dated March 21, 2000, the PT board determined that the PT Act does not prohibit dry needling and that Section 61-12D-3, Paragraph I, Number 2 describing the practice of physical therapy supports that decision.
NC	Y	In 2010, NC PT Board voted to reverse previous policy which did not allow dry needling by PTs. Dec 9, 2010 Board Position Statement. **Position:** Based on currently available resource information, it is the position of the North Carolina Board of Physical Therapy Examiners that intramuscular manual therapy is within the scope of practice of physical therapists.
ND	Y	Board meeting May 13, 2013: The board voted to state that "Dry Needling" is within the scope of practice for PT in North Dakota.
NE	Y	Within the Scope of Practice of PT June 2011 board meeting minutes
NV	Y	Dry needling is within the SOP of PTs as ruled by NV Board of PT on March 20, 2012. As of April 19, 2012, the PT board legal counsel is writing up the new board Policy on dry needling and once signed by Chairman, Kathy Sidener, dry needling will be permissible by PTs in NV.

State	Y: Allows N: Does not allow	Other Information
NY	N	Early 1990s (1992?) and affirmed in 2007 NY State Board issued an opinion at the time that it was not an entry level skill and therefore could not be done.
OH	Y	In a letter dated January 5, 2007, the OH OT, PT, and ATC Board affirms the position of the PT Section of the board that nothing in the OH PT practice act prohibits a PT from performing dry needling. The letter goes on to read that the PT must demonstrate competency in the modality.
OR	Y	November 2009: Upon further discussions the Physical Therapist Licensing Board believes that the dry needling of trigger points is likely within the physical therapist scope of practice (excluding PTAs). The board acknowledges that the dry needling of trigger points is an advanced intervention requiring post physical therapy graduate training and education. Further, the board recommends that the acupuncture committee, physical therapist and medical boards work in partnership with their professional associations to define a minimum competency by which a physical therapist can safely practice the intervention of dry needling of trigger points. In the interest of public safety, until training and education can be determined, the board strongly advises its licensees to not perform dry needling of trigger points.
PA	N	PA PT board was advised by legal counsel that dry needling is not within the scope of practice of a PT
RI	Y	Feb 14, 2012 PT board minutes: Board members revisited the matter of dry needling for intramuscular therapy. A board member questioned if it pertained to other professions, including Acupuncturist. The board administrator related guidance from Atty. Tom Corrigan stating the use of a needle by one profession does not preclude a different profession from having a different use for a needle. Board members comment dry needling is within their scope of practice provided the licensed professional is comfortable trained and has appropriate background knowledge. For licensed physical therapists that are not qualified there are educational seminars they may sign up for and gain the required background and training.
SC	Y	In an email written in October 2004 in response to a licensee's question regarding scope of practice and dry needling, the Chairperson affirmed that dry needling appears to fall within the SOP of a licensed PT in SC if they are fully trained in its use and comply with all legal and ethical requirements for professional practice in physical therapy.
SD	N	The South Dakota Board of Medical and Osteopathic Examiners considers procedures involving the breaking or altering of human tissue for diagnostic, palliative or therapeutic medical purposes to be the practice of medicine. The board determines that dry needling is significantly different from "electromyography (EMG)", which the board previously opined was an activity within the scope of practice for a physical therapist. **Decision:** The South Dakota Board of Medical and Osteopathic Examiners determined that the procedure known as "dry needling" does not fall within the physical therapist scope of practice as defined in SDCL ch. 36-10.

State	Y: Allows N: Does not allow	Other Information
		This opinion issued by the Board of Medical and Osteopathic Examiners is advisory in nature. It does not constitute an administrative rule or regulation and is intended solely to serve as a guideline for persons registered, licensed, or otherwise regulated by the Board of Medical and Osteopathic Examiners.
TN	Y	Yes, dry needling is within the SOP August 12, 2011- overturned previous policy that it was not within scope
TX	-	Texas does not have an official position and is legally not allowed to offer advisory opinions; however, the board has made no determination that dry needling is outside the scope of practice for PTs
UT	N	The Utah board determined that the addition of dry needling would require a change in the statute and further defining in the rule.
VA	Y	Updated Board Policy Guidance Document on Aug 26, 2010
VT	-	Reported by one resource that in February 2012, the Vermont Office of Professional Regulation issued a statement that dry needling is within the scope of physical therapy in that state. Unable to substantiate this claim.
WI	Y	BOARD MINUTES JULY 2009: **BOARD DISCUSSION OF DRY NEEDLING** Statute 448.50 (6) allows for "therapeutic intervention" within the scope of physical therapy. Larry Nosse discussed the use of dry needling as a therapeutic technique. This process uses sterile techniques, the surface skin is cleaned, it does not draw blood, and the physical therapists are trained in blood-body precautions. Mark Shropshire noted that the American Academy of Orthopedic and Manual Physical Therapists has made a position statement that dry needling is within the scope of practice of physical therapy. California, Nevada, Tennessee, and Florida do not allow this technique within the scope of practice within physical therapy because these states have language noting that PTs cannot puncture the skin. **MOTION:** Otto Cordero moved, seconded by Jane Stroede, that the board considers trigger point dry needling as within the scope of practice of physical therapy provided that the licensed physical therapist is properly educated and trained. Motion carried unanimously.
WV	Y	July 18, 2012: Opinion of the West Virginia Board of Physical Therapy Regarding Dry Needling Therapy: "In summary, the Board is of the opinion that dry needling is within the scope of the practice of "physical therapy" as defined by West Virginia Code §30-20-9."
WY	Y	In a letter dated Aug 18, 2009 the Wyoming Board of Physical Therapy affirmed that nothing in the current practice act would preclude PTs performing dry needling with proper credentials.

Appendix B: Training Guidelines

STATE	TRAINING REQUIREMENTS
CO	**COLORADO PHYSICAL THERAPY LICENSURE RULES AND REGULATIONS** **4 CCR 732-1 RULE 11 - REQUIREMENTS FOR PHYSICAL THERAPISTS TO PERFORM DRY NEEDLING** A. Dry needling is a physical intervention that uses a filiform needle to stimulate trigger points, diagnose and treat neuromuscular pain and functional movement deficits; is based upon Western medical concepts; requires an examination and diagnosis, and treats specific anatomic entities selected according to physical signs. Dry needling does not include the stimulation of auricular or distal points. B. Dry needling as defined pursuant to this rule is within the scope of practice of physical therapy. C. A physical therapist must have the knowledge, skill, ability, and documented competency to perform an act that is within the physical therapist's scope of practice. D. To be deemed competent to perform dry needling a physical therapist must meet the following requirements: 1. Documented successful completion of a dry needling course of study. The course must meet the following requirements: a. A minimum of 46 hours of face-to-face IMS/dry needling course study; online study is not considered appropriate training. b. Two years of practice as a licensed physical therapist prior to using the dry needling technique. E. A provider of a dry needling course of study must meet the educational and clinical prerequisites as defined in this rule, D(1) (a) &(b) and demonstrate a minimum of two years of dry needling practice techniques. The provider is not required to be a physical therapist. F. A physical therapist performing dry needling in his/her practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information: 1. Risks and benefits of dry needling 2. Physical therapist's level of education and training in dry needling 3. The physical therapist will not stimulate any distal or auricular points during dry needling. H. When dry needling is performed this must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique as well as the outcome after the procedure. I. Dry needling shall not be delegated and must be directly performed by a qualified, licensed physical therapist.

STATE	TRAINING REQUIREMENTS
	J. Dry needling must be performed in a manner consistent with generally accepted standards of practice, including clean needle techniques, and standards of the center for communicable diseases. K. The physical therapist must be able to supply written documentation, upon request by the Director, which substantiates appropriate training as required by this rule. Failure to provide written documentation is a violation of this rule, and is prima facie evidence that the physical therapist is not competent and not permitted to perform dry needling. L. This rule is intended to regulate and clarify the scope of practice for physical therapists.
DC	**District of Columbia Municipal Regulations Title 17, Chapter 67, Physical Therapy** **6715 SCOPE OF PRACTICE** A physical therapist may also perform intramuscular manual therapy, which is also known as dry needling, if performed in conformance with the requirements of section 6716. **6716 REQUIREMENTS FOR PHYSICAL THERAPISTS TO PERFORM INTRAMUSCULAR MANUAL THERAPY** 6716.1 Intramuscular manual therapy may be performed by a licensed physical therapist who meets the requirements of this section. 6716.2 Intramuscular manual therapy shall be performed directly by the licensed physical therapist and shall not be delegated. 6716.3 Intramuscular manual therapy shall be performed in a manner that is consistent with generally accepted standards of practice, including clean needle techniques, and other applicable standards of the Centers for Disease Control and Prevention. 07-01-11 16 Title 17 District of Columbia Municipal Regulations 6716.4 Intramuscular manual therapy is an advanced procedure that requires specialized training. A physical therapist shall not perform intramuscular manual therapy in the District of Columbia unless he or she has documented proof of completing: (a) A board-approved professional training program on intramuscular manual therapy. The training program shall require each trainee to demonstrate cognitive and psychomotor knowledge and skills. The training program shall be attended in person by the physical therapist, shall not be attended online or through any other means of distance learning, and shall not be a self-study program (b) A professional training program on intramuscular manual therapy accredited by the Commission on Accreditation in Physical Therapy Education (CAPTE). The training program shall require each trainee to demonstrate cognitive and psychomotor knowledge and skills. The training program shall be attended in person by the physical therapist, shall not be attended online or through any other means of distance learning, and shall not be a self-study program; or (c) Graduate or higher-level coursework in a CAPTE-approved educational program that included

STATE	TRAINING REQUIREMENTS
	intramuscular manual therapy in the curriculum. 6716.5 A physical therapist shall only perform intramuscular manual therapy following an examination and diagnosis, and for the purpose of treating specific anatomic entities selected according to physical signs. 6716.6 A physical therapist who performs intramuscular manual therapy shall obtain written informed consent from each patient who will receive intramuscular manual therapy before the physical therapist performs intramuscular manual therapy on the patient. 6716.7 The informed consent form shall include, at a minimum, the following: (a) The patient's signature; (b) The risks and benefits of intramuscular manual therapy; (c) The physical therapist's level of education and training in intramuscular manual therapy; and (d) A clearly and conspicuously written statement that the patient is not receiving acupuncture. 6716.8 A physical therapist who performs intramuscular manual therapy shall maintain a separate procedure note in the patient's chart for each intramuscular manual therapy. The note shall indicate how the patient tolerated the intervention as well as the outcome after the intramuscular manual therapy. 6716.9 A physical therapist who performs intramuscular manual therapy shall be required to produce documentation of meeting the requirements of this section immediately upon request by the board or an agent of the board. 6716.10 Failure by a physical therapist to provide written documentation of meeting the training requirements of this section shall be deemed prima facie evidence that the physical therapist is not competent and not permitted to perform intramuscular manual therapy.
GA	Currently drafting rules for the statute.
LA	**Subchapter B. General Provisions** **§123. Definitions** A. As used in this Title, the following terms and phrases, defined in the practice act, La. R.S.37:2401–2424, shall have the meanings specified here. Dry Needling—a physical intervention which utilizes filiform needles to stimulate trigger points in a patient's body for the treatment of neuromuscular pain and functional movement deficits. Dry Needling is based upon Western medical concepts and does not rely upon the meridians utilized in acupuncture and other Eastern practices. A physical therapy evaluation will indicate the location, intensity and

STATE	TRAINING REQUIREMENTS
	persistence of neuromuscular pain or functional deficiencies in a physical therapy patient and the propriety for utilization of dry needling as a treatment intervention. Dry needling does not include the stimulation of auricular points. **§311. Treatment with Dry Needling** A. The purpose of this rule is to establish standards of practice, as authorized by La. R.S. 37:2405 A.(8), for the utilization of dry needling techniques, as defined in §123, in treating patients. B. Dry needling is a physical therapy treatment which requires specialized physical therapy education and training for the utilization of such techniques. Before undertaking dry needling education and training, a PT shall have no less than two years experience working as a licensed PT. Prior to utilizing dry needling techniques in patient treatment, a PT shall provide documentation to the executive director that he has successfully completed a board–approved course of study consisting of no fewer than 50 hours of face–to–face instruction in intramuscular dry needling treatment and safety. Online and other distance learning courses will not satisfy this requirement. Practicing dry needling without compliance with this requirement constitutes unprofessional conduct and subjects a licensee to appropriate discipline by the board. C. In order to obtain board approval for courses of instruction in dry needling, sponsors must document that instructors utilized have had no less than two years experience utilizing such techniques. Instructors need not be physical therapists, but should be licensed or certified as a healthcare provider in the state of their residence. D. A written informed consent form shall be presented to a patient for whom dry needling is being considered, telling the patient of the potential risks and benefits of dry needling. A copy of a completed form shall be preserved in the patient treatment record and another copy given to the patient. E. Dry needling treatment shall be performed in a manner consistent with generally accepted standards of practice, including sterile needle procedures and the standards of the U.S. Centers for Disease Control and Prevention. Treatment notes shall document how the patient tolerated the technique and the outcome of treatments.
MD	Currently drafting
MS	D. To be deemed competent to perform intramuscular manual therapy a physical therapist must meet the following requirements: 1. Documented successful completion of a intramuscular manual therapy course of study; online study is not considered appropriate training. a. A minimum of 50 hours of face-to-face IMS/dry needling course study; online study is not considered appropriate training.

STATE	TRAINING REQUIREMENTS
	b. Three years of practice as a licensed physical therapist prior to using the intramuscular manual therapy technique. 2. The physical therapist must have board approved credentials for providing intramuscular manipulation which are on file with the board office prior to using the treatment technique. E. The provider of the required educational course does not need to be a physical therapist. A intramuscular manual therapy course of study must meet the educational and clinical prerequisites as defined in this rule, D(1)(a)&(b) and demonstrate a minimum of two years of intramuscular manual therapy practice techniques. F. A physical therapist performing intramuscular manual therapy in his/her practice must have written informed consent for each patient where this technique is used. The patient must sign and receive a copy of the informed consent form. The consent form must, at a minimum, clearly state the following information: 1. Risks and benefits of intramuscular manual therapy. 2. Physical therapist's level of education and training in intramuscular manual therapy. 3. The physical therapist will not stimulate any distal or auricular points during intramuscular manual therapy. G. When intramuscular manual therapy is performed, this must be clearly documented in the procedure notes and must indicate how the patient tolerated the technique as well as the outcome after the procedure. H. Intramuscular manual therapy shall not be delegated and must be directly performed by a qualified, licensed physical therapist. I. Intramuscular manual therapy must be performed in a manner consistent with generally accepted standards of practice, including but not limited to, aseptic techniques and standards of the center for communicable diseases.
MT	Currently drafting
NC	As of June 2012: **Position:** Based on currently available resource information, it is the position of the North Carolina Board of Physical Therapy Examiners that Intramuscular Manual Therapy (Dry Needling) is within the scope of practice of physical therapists. Intramuscular Manual Therapy is an advanced skill that requires additional training

STATE	TRAINING REQUIREMENTS
	beyond entry-level education and should only be performed by physical therapists who have demonstrated knowledge, skill, ability, and competence as follows: Completion of an Intramuscular Manual Therapy course of study at a program approved by the Board with a minimum of 54 hours of classroom education, which must also include instruction in the clinical application of IMT (Dry Needling). Since Intramuscular Manual Therapy requires ongoing re-evaluation and reassessment, it is not in the scope of work for physical therapist assistants or physical therapy aides.
NE	A physical therapist who wished to perform tissue penetration for the purpose of dry needling must meet the following requirements: 1. Complete pre-service or in-service training. The pre-service or in-service training must include: a. Pertinent anatomy and physiology; b. Choice and operation of supplies and equipment; c. Knowledge of technique including indications and contraindications; d. Proper technique of tissue penetration; e. Sterile methods, including understanding of hazards and complications; and f. Post intervention care; and g. Documentation of application of technique in an educational environment. 2. The training program shall require training to demonstrate cognitive and psychomotor skills. Also, the training program must be attended in person by the physical therapist. 3. Maintain documentation of successful completion of training.
OH	11/2011 Currently working to identify general guidelines for determining competence.
TN	Clinical proficiency and competency in this particular clinical field area of treatment and examination
VA	Guidance Document 112-9 **Board of Physical Therapy Guidance on Dry Needling in the Practice of Physical Therapy** Upon recommendation from the Task Force on Dry Needling, the board voted that dry needling is within the scope of practice of physical therapy but should only be practiced under the following conditions: • Dry needling is not an entry level skill but an advanced procedure that requires additional training. • A physical therapist using dry needling must complete at least 54 hours of post professional training including providing evidence of meeting expected competencies that include demonstration of cognitive and psychomotor knowledge and skills. • The licensed physical therapist bears the burden of proof of sufficient education and training to ensure competence with the treatment or intervention. • Dry needling is an invasive procedure and requires referral and direction, in accordance with § 54.1-3482 of the Code of Virginia. Referral should be in writing and specific for dry needling; if the initial referral is received orally, it must be followed up with a written referral.

STATE	TRAINING REQUIREMENTS
	• If dry needling is performed, a separate procedure note for each treatment is required, and notes must indicate how the patient tolerated the technique as well as the outcome after the procedure. • A patient consent form should be utilized and should clearly state that the patient is not receiving acupuncture. The consent form should include the risks and benefits of the technique, and the patient should receive a copy of the consent form. The consent form should contain the following explanation: Dry needling is a technique used in physical therapy practice to treat trigger points in muscles. You should understand that this dry needling technique should not be confused with a complete acupuncture treatment performed by a licensed acupuncturist. A complete acupuncture treatment might yield a holistic benefit not available through a limited dry needling treatment.

STATE OF TENNESSEE
OFFICE OF THE ATTORNEY GENERAL

June 19, 2014

Opinion No. 14-62

Trigger-Point Dry Needling and the Practice of Physical Therapy

QUESTION

Is Intramuscular Manual Therapy ("IMT"), also known as Trigger-Point Dry Needling, within the scope of the practice of physical therapy under the Occupational and Physical Therapy Practice Act, Tenn. Code Ann. §§ 63-13-101 to -318?

OPINION

No.

ANALYSIS

Under the Occupational and Physical Therapy Practice Act, "practice of physical therapy" means:

> (A) Examining, evaluating and testing individuals with mechanical, physiological and developmental impairments, functional limitations and disability or other health and movement-related conditions in order to determine a physical therapy treatment diagnosis, prognosis, a plan of therapeutic intervention and to assess the ongoing effect of intervention;
>
> (B) Alleviating impairments and functional limitations by designing, implementing, and modifying therapeutic interventions that include, but are not limited to, therapeutic exercise, functional training, manual therapy, therapeutic massage, assistive and adaptive orthotic, prosthetic, protective and supportive equipment, airway clearance techniques, debridement and wound care, physical agents or modalities, mechanical and electrotherapeutic modalities and patient-related instruction;
>
> (C) Reducing the risk of injury, impairments, functional limitation and disability, including the promotion and maintenance of fitness, health and quality of life in all age populations; and

(D) Engaging in administration, consultation, education and research[.]

Tenn. Code Ann. § 63-13-103(15). IMT, or "dry needling," involves the application of a fine, filiform needle to the neuromusculoskeletal system to restore movement, reduce pain, and address other musculoskeletal disorders.[1] Dry needling must therefore be regarded as a therapeutic intervention, but it is not listed among the therapeutic interventions identified in § 63-13-103(15)(B). Although that list is not exclusive, and includes "manual therapy," "physical agents and modalities," and "mechanical and electrotherapeutic modalities," nothing in subdivision -103(15)(B) clearly indicates a legislative intent to include within the practice of physical therapy the invasive use of needles for therapeutic purposes. *See Tidwell v. Collins*, 522 S.W.2d 674, 676 (Tenn. 1975) ("The premier rule of statutory construction is to ascertain and give effect to the legislative intent."). Furthermore, while there are no doubt distinctions to be drawn between the two, dry needling's obvious similarity to acupuncture cannot be ignored, and physical therapists may not perform acupuncture, which is a branch of medicine. *See* Tenn. Code Ann. § 63-6-1002(a), (b).

Under Tenn. Code Ann. § 63-6-1001(7), "'practice of acupuncture' means the insertion of acupuncture needles and the application of moxibustion to specific areas of the human body based on oriental medical diagnosis as a primary mode of therapy." In 2005, this Office opined, precisely because acupuncture is regarded as a branch of medicine, that chiropractors may not practice a treatment modality that uses the insertion of needles to bring about the same result. *See* Tenn. Att'y Gen. Op. 05-20 (Mar. 8, 2005). That "same result" is "the promotion, maintenance and restoration of health and the prevention of disease." Tenn. Code Ann. § 63-6-1001(2). In 2006, the legislature amended the acupuncture certification statutes to expressly except chiropractors who have satisfied certain requirements. *See* 2006 Tenn. Pub. Acts, ch. 775, § 2 (amending Tenn. Code Ann. § 63-6-1002(a)); *see also* Tenn. Code Ann. § 63-4-101(a) ("Nothing in this chapter shall be construed to authorize the chiropractic physician to practice any branch of medicine osteopathy, . . . or surgery, *acupuncture being the exception*.") (emphasis added).

Similar legislation would be necessary in order to bring dry needling within the scope of the practice of physical therapy. *See, e.g.*, 2014 Utah Laws ch. 354 (amending physical-therapy-practice statute to include trigger-point dry needling among therapeutic interventions).[2] Like acupuncture, dry needling uses the

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[1] "Dry needling (DN) is a skilled intervention used by physical therapists (where allowed by state law) that uses a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments." *Physical Therapists & the Performance of Dry Needling* 2 (Jan. 2012), *available at* http://www.apta.org/StateIssues/DryNeedling/

[2] This legislative change in Utah came in the wake of an opinion from the Utah Department of Commerce's Division of Occupational and Professional Licensing that trigger-point dry needling fell outside the scope of the practice of physical therapy because the "Division's research regarding the

insertion of needles for therapeutic purposes—to restore movement, reduce pain, and address other musculoskeletal disorders. Although current rules of the Tennessee Board of Physical Therapy allow physical therapists to perform kinesiologic electromyography (invasive needle study of the muscles to determine the degree and character of a muscle during certain movements) and diagnostic electromyography (invasive needle study of multiple muscles for diagnosis of muscle and nerve disease), the purposes of these procedures are solely academic or diagnostic, and they may be performed only in a university setting or upon referral from an allopathic or osteopathic physician, a dentist, or a podiatrist. *See* Tenn. Comp. R. & Regs. 1150-01-.02(1)(b)(2)(i), (iii); *id.* 1150-01-.04(4).

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practice of trigger point dry needling confirms that it is the practice of acupuncture." October 22, 2013 letter from Debra F. Hobbins, Bureau Manager, Division of Occupational and Professional Licensing, *available at* http://www.acupuncturesafety.org/Resources/Documents/Utah%20DOPL.pdf.

Roots of Physical Medicine, Physical Therapy, and Mechanotherapy in the Netherlands in the 19th Century: A Disputed Area within the Healthcare Domain

Thomas J.A. Terlouw, PT, MSc, PhD (Medical History)

Abstract: Physical medicine, which in the context of this article includes mechanotherapy, hydrotherapy, balneotherapy, electrotherapy, light therapy, air therapy, and thermotherapy, became a new field of labor in the healthcare domain in the Netherlands around 1900. This article gives an account of the introduction and development of mechanotherapy as a professional activity in the Netherlands in the 19th century. Mechanotherapy, which historically included exercises, manipulations, and massage, was introduced in this country around 1840 and became one of the core elements of physical medicine towards the end of that century. In contrast to what one might expect, mostly physical education teachers, referred to as "heilgymnasts," dedicated themselves to this kind of treatment, whereas only a few physicians were active in this field until the 1880s. When, in the last quarter of the 19th century, differentiation and specialization within the medical profession took place, physicians specializing in physical medicine and orthopaedics began to claim the field of mechanotherapy exclusively for themselves. This led to tensions between them and the group of heilgymnasts that had already been active in this field for decades. The focus of attention in this article is on interprofessional relationships, on the roles played by the different professional organizations in the fields of physical education and medicine, the local and national governments, and the judicial system, and on the social, political, and cultural circumstances under which developments in the field of mechanotherapy took place. The article concludes with the hypothesis that the intra- and inter-occupational rivalries discussed have had a negative impact on the academic development of physical medicine, orthopaedics, and heilgymnastics/physical therapy in the Netherlands in the first half of the 20th century.

Keywords: The Netherlands, Nineteenth Century, Physical Medicine, Orthopaedics, Physical Therapy, Physical Education, Mechanotherapy, Professionalization.

Physical medicine or physical therapy has very ancient origins. For thousands of years, people with illnesses and disabilities were treated with various methods, making use of movements (with or without the aid of mechanical devices) as well as air, water, heat and cold, electricity, and light[1,2]. Despite its long history, however, astonishingly little historical research has been done on this special branch of medicine. A quick glance through the pertinent literature in the field of the history of medicine of the last two decades reveals that the development of physical medicine as a professional activity in the field of healthcare in the past two centuries has seldom been an object of scholarly conducted research. Before this period the situation wasn't much better. In 1985, Glenn Gritzer and Arnold Arluke pointed out that this field of interest has been ignored by sociologists and historians alike[3]. Prompted by their comment, a historical research program was implemented in the Netherlands aiming to get a better insight into the development of physical medicine in that country in the past two centuries. Since the results thereof are predominantly published in Dutch[4-10], this article hopes to inform a broader circle of physical therapists, medical historians, and other interested readers.

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During the second half of the 19th century, a period of increasing specialization in the field of medicine, terms like "physical medicine," "physical therapy," "physiotherapy," and the like came into use to categorize the various healing methods of exercise, manipulation, and massage (also collectively known as mechanotherapy), hydrotherapy, balneotherapy, electrotherapy, light therapy, air therapy, and heat and cold therapy (thermotherapy) under one heading. In 1851, the military physician Lorenz Gleich (1798–1865) had already used the term "physiotherapie" (German for physical therapy) in one of his publications[11]. One of the first to use the generic term "physikalische Heilmethoden" (German for physical therapies) was the German physician and professor of medicine at Würzburg University, M.J. Rossbach (1842–1894)[12]. In the Netherlands, there was a growth in publications on physical medicine around 1900; specialized journals concerning aspects of physical medicine were launched and the first organizations of physicians dedicated to aspects of physical medicine were founded. Although the various healing methods of mechanotherapy (exercises, manipulations, and massage), hydrotherapy, balneotherapy, electrotherapy, light therapy, air therapy, and heat and cold therapy (thermotherapy) had been grouped together by 1900, it is important to note that each of these therapies had its own interesting development that is eligible for further historical research, as Günter B. Risse has already pointed out[13].

This article provides an account of the introduction and further development of mechanotherapy as a professional activity in the Netherlands in the 19th century. It is based mainly on primary sources (e.g., journals in medicine and physical education from the 19th century). In the few relevant archives, little could be found on the constituents of physical medicine. Secondary sources (well researched and annotated studies) that shed a light on this topic are almost entirely nonexistent. There are several reasons for focusing on the history of mechanotherapy in particular. The first one is practical. The history of all the constituents of physical medicine in the Netherlands in the 19th century is too expansive to cover easily since research in this field is still in its infancy. Secondly, doing research on the developments in mechanotherapy in the 19th century is not only important because mechanotherapy became one of the core elements of physical medicine in the Netherlands around 1900, but, even more importantly, these developments had a big impact on how physical medicine as a whole would evolve in the first half of the 20th century. Thirdly, studying the development of mechanotherapy is very interesting from a socio-historic point of view, since there were different groups of professionals active in this field, which allows us to look into interprofessional relationships in the healthcare domain and analyze the struggle between these professional groups over the preservation and expansion of their occupational boundaries and professional autonomy. This is why this article focuses on the roles played by individual and collective actors and on the social, political, and cultural circumstances under which developments in this field took place. The chosen perspective is based on a sociological model for professionalization and collective power developed by the Dutch sociologist T.P.W.M. van der Krogt. This eclectic model is based upon trait, function, and power/control approaches to professionalization[14].

This article is divided in three chronological sections. In the first section, attention is paid to certain developments in the Netherlands and in several neighboring countries in the first half of the 19th century that prepared the ground for the introduction of medical gymnastics. Within the context of the ongoing discourse among Dutch intellectuals at the time concerning the importance of physical education in the upbringing of new generations, teachers and physicians gradually became more receptive to other views on how to use gymnastic exercises. They saw medical gymnastics (including massage), as developed in Sweden and Germany, as a very promising form of conservative medical treatment and began to use it—sometimes in combination with other therapies—to treat illnesses and disabilities for which there was no satisfactory solution at the time. The first signs of the actual use of mechanotherapy (exercises, manipulations, and massage) in the Netherlands were spotted in publications around 1840. At that time, it was referred to as "medical gymnastics" (or Swedish gymnastics, Nordic gymnastics, kinesitherapy, or orthopaedic gymnastics). The second section shows that there was an increasing interest in the application of medical gymnastics, by then referred to as "heilgymnastics" (in Dutch: *heilgymnastiek)* from the 1860s onwards. In contrast to what one perhaps might expect, mostly physical education teachers, soon referred to as "heilgymnasts" (in Dutch: *heilgymnasten*), dedicated themselves to this kind of treatment whereas only a few physicians were active in this field. We take a closer look at these practitioners, how and where they practiced, and what kind of patients they treated. When, during the late 1870s and 1880s, differentiation and specialization in the field of medicine intensified and new legislation in the healthcare domain came into effect, conflicts arose between heilgymnasts and members of the medical profession, especially those who were specializing in orthopaedics and physical medicine. These conflicts will be analyzed together with the roles played by the different professional organizations in physical education and medicine, the local and national governments, and the judicial system. Finally, the third section focuses on the founding of the Society for Practising Heilgymnastics in the Netherlands (in Dutch: *Genootschap ter Beoefening van de Heilgymnastiek in Nederland*) by heilgymnasts as early as 1889. The aims of this society, the first of its kind in the world, were to look after the interests of heilgymnasts, enable them to elevate their professional level, and bring about a better understanding with physicians. Despite what heilgymnasts had hoped for, however, the founding of the society did not bring about a détente between physicians and heilgymnasts. On the con-

trary, it lifted the controversy from the level of heated discussions between individuals in periodicals to that of a dispute between professional organizations, since around 1900 physicians had founded their own organizations in physical medicine and orthopaedics. The tensions between these groups of professionals would last until the second World War and are assumed to be, at least partly, responsible for the slow academic development of physical medicine, orthopaedics, and heilgymnastics/physical therapy in the Netherlands in the first half of the 20th century.

Introduction of Medical Gymnastics in the Netherlands: 1840–1860

The first signs of the use of medical gymnastics in the Netherlands appear in publications around 1840. Preceding these signs, several significant developments had taken place in neighboring countries as well as in the Netherlands.

Developments in Neighboring Countries: Germany and Sweden

In Germany, the work of the so-called "Philanthropen" around 1800 was very influential[15]. Of these, the German pedagogue J.C.F. GutsMuths (1759–1839) was the most significant. In his book *Gymnastik für die Jugend* (1793), he criticized the prevailing notions on education, which were, to his taste, too much concentrated on the intellect[16]. Influenced by thoughts on education of J. Locke (1632–1704) and J.J. Rousseau (1712–1778) and inspired by the "Leibeskultur" (German for: physical culture) of the ancient Greeks and Germans/Teutons, GutsMuths wanted to combine the physical perfection of the so-called primitive with the cognitive abilities of the civilized human, creating a harmony between body and mind. An extensive physical education program should play an important role in the education of youngsters. Certainly at a time when the Napoleonic wars were directing attention as never before towards the need for physical fitness among the masses, his thoughts easily found their way through Europe[17]. Other pedagogues and gymnasts who had an impact on developments in physical education in the Netherlands during the late 18th and the first half of the 19th century were F.L. Jahn (1778–1852), E.W.B. Eiselen (1792–1846), and somewhat later A. Spiesz (1810–1858). They were all industrious in this field and published several influential books that were read by Dutch intellectuals[18-21].

The most important stimulant for the rise of medical gymnastics in the Netherlands, however, came from Sweden at the beginning of the 19th century. The work of the Swedish gymnast P.H. Ling (1776–1839) is considered crucial for the introduction and application of medical gymnastics in and outside Sweden in the first half of the 19th century (Figure 1). Influenced by GutsMuths, the Romantic natural philosopher F.W. Schelling (1775–1854) and Cong-Fou based on the teachings of the Tao-Sée[22-25], Ling developed a physical education system comprising military, aesthetical, pedagogical, and medical gymnastics. His work was continued by his disciples C.A. Georgii (1808–1880), L.G. Branting (1799–1881), and C.F de Ron (1809–1887). In Ling's Central Gymnastic Institute (CGI) in Stockholm, founded in 1813, patients were treated, and training and guidance were given to those who wanted to become medical gymnasts. Many German physicians, such as M.M. Eulenburg (1811–1887), D.G.M. Schreber (1808–1861), K.H. Schildbach (1824–1888), and A.C. Neumann (1803–1870), and physical education teachers, such as H. Rothstein (1815–1865), H.O. Kluge (1818–1882), J.A.L. Werner (1794–1866), and A.S. Ulrich (1826–1889), visited this institute. All of them started institutes for medical gymnastics in Germany. The activities and publications of Ling, his disciples, and the German physicians and physical education teachers changed the viewpoint on physical education and drew attention to the use of exercises for medical ends in many countries, including the Netherlands.

Education and Physical Education in the Netherlands

When Belgium was separated from the Netherlands and both became independent states in 1840, a constitutional revision was necessary. Some of the leading Liberals as well as pro-

Fig. 1. Per Henrik Ling (1776–1839), stimulator of medical gymnastics (Source: Van Schagen KH, ed. De Lichamelijke Opvoeding in de Laatste Drie Eeuwen. Haar Ontwikkeling, Doel en Stelselmatige Toepassing. Deel I. [Dutch for: Physical Education in the last Three Centuries: Development, Goal, and Systematic Implementation. Part I]. Rotterdam, the Netherlands: Nijgh & Van Ditmar, 1926.)

gressive Roman Catholics in the Netherlands tried to introduce a number of democratic reforms. But, because of strong opposition by King William II (1792–1849), who reigned from 1840–1849, they had to wait for almost a decade until an agreement was reached in favour of these reforms. It was the threat of revolution in 1848—revolutions haunted many European states that year—that made the King accept rigorous changes in the constitution. One of the things that would be altered was the educational system.

The spread of Enlightenment ideas on education, mainly coming from Germany, had already been influencing the thinking about the educational system in the Netherlands in the years before 1848. As knowledge was considered to be the source of all virtues in society, intellectuals were convinced that it should be widely spread in order to prevent the masses from sliding off into pauperism. Furthermore, education for all was thought to be beneficial for the desired change from a predominantly agricultural society to an industrial one.

At the same time, however, it was emphasised in various Dutch publications on education that intellectual education was heavily overrated in the schools[4,26]. The popular creed "mens sana in corpore sano" (Latin for: A healthy mind in a healthy body) was frequently used in these manuscripts to indicate that the authors were strong advocates of seeking some kind of balance between the mental and physical education of new generations. They believed that more attention should be paid to physical education. This was thought to be not only in the interest of the individual but that of the state as well. By offering physical education in schools, the nation would be supplied with stronger and tougher youngsters eligible for safeguarding the borders of the country and colonies. At the same time, it would lead to "healthy-minded," more social, hardworking, and disciplined citizens, which was also considered beneficial for the state. Another argument in favor of physical education in schools was that ancient folk games could be preserved for posterity this way.

While individuals promoted physical education in the Netherlands by means of writing books and articles, another powerful force was working in this direction in the first half of the 19th century: the Society for Public Welfare (in Dutch: *Maatschappij tot Nut van 't Algemeen*, hereafter referred to as MNA). This apolitical society, founded in 1784, is considered one of the most influential organizations to contribute to the intellectual disclosure of many rural communities and to the dissemination of elements of modern culture throughout the Netherlands. That public support for the MNA was substantial can be deduced from the fact that the number of so-called departments of the MNA grew from as few as 25 in 1795 to about 235 around 1850[27,28]. Throughout the country, the MNA departments took responsibility for solving various social problems. They were engaged in promoting education for all citizens, building schools, improving learning methods, training teachers, giving lectures intended to educate people on all sorts of topics, founding libraries, etc.

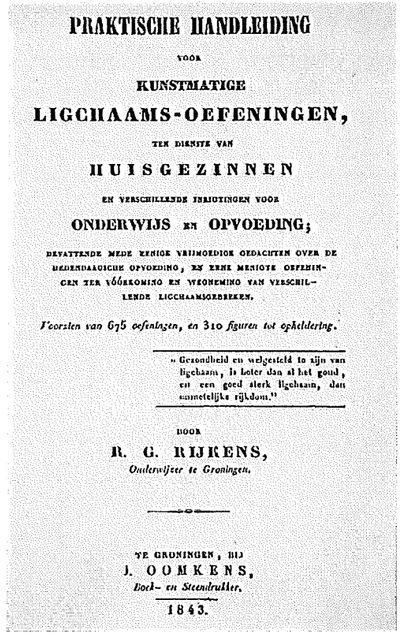
The MNA also tried to counter prejudices against physical education and to get it admitted into the schools with the help of local and national governments. It played an important role in giving physical education a place within the curricula of primary and secondary schools, which is reflected in the Dutch education acts of 1857 and 1863. The MNA also organized prize contests to draw the attention of the people to the importance of physical education. From the 1840s onwards, the MNA established gymnastic schools in major cities out of its own pocket. Here, schoolteachers could also be educated to become gymnastic teachers.

Despite these endeavors, however, other circumstances had a negative effect on the speed of developments in physical education in the Netherlands in the first half of the 19th century. First, the social turmoil in Germany caused by developments in physical education, the so-called 'Turnsperre'[29], made Dutch authorities reluctant to stimulate initiatives in this area. Then there were practical problems that curbed physical education in its development, e.g., a shortage of teachers and accommodations and a lack of learning methods. The few teachers who could provide physical education lessons at that time originated mostly from the military[30-31]. Although they used foreign textbooks to acquire skills and specific knowledge, their lessons maintained a strong military character.

Growing Interest for Medical Gymnastics

With the ongoing discourse on the importance of physical education within the educational system, teachers and physicians gradually became more receptive to other views on how to use gymnastic exercises. In their classrooms and practices, they often were the first to be confronted with children who suffered from disabilities and illnesses. Since conventional medical interventions had little or no effect, the enthusiastic reports from Sweden and Germany must have led these teachers and physicians to believe that what was called "medical gymnastics" could be a remedy to cure these kinds of ailments.

R.G. Rijkens (1795–1855), a schoolteacher in Groningen, is thought to be the first to have implemented physical education in a primary school in the Netherlands (around 1839)[31-34] (Figure 2). Not only did Rijkens strongly believe that it was of the utmost importance that children's minds and bodies should be developed in harmony, he was also one of the first teachers who pointed out the importance of gymnastic exercises as a treatment for certain diseases or disabilities. In 1843 he published an extensive book about physical education, the *Practical Guide for Artificial Exercises of the Body for Families and Institutions of Education*[35]. The first part of the book dealt with legitimizing physical education as an important element in the upbringing of children. The second part is a practical guide with a substantial section



PRAKTISCHE HANDLEIDING

VOOR

KUNSTMATIGE

LIGCHAAMS-OEFENINGEN,

TEN DIENSTE VAN

HUISGEZINNEN

EN VERSCHILLENDE INRIGTINGEN VOOR

ONDERWIJS EN OPVOEDING;

BEVATTENDE MEDE EENIGE VRIJMOEDIGE GEDACHTEN OVER DE HEDENDAAGSCHE OPVOEDING, EN EENE MENIGTE OEFENINGEN TER VÓÓRKOMING EN WEGNEMING VAN VERSCHILLENDE LIGCHAAMSGEBREKEN.

Voorzien van 675 oefeningen, en 310 figuren tot ophelderíng.

" Gezondheid en welgesteld te zijn van ligchaam, is beter dan al het goud, en een goed sterk ligchaam, dan sameteljke rijkdom."

DOOR

R. G. RIJKENS,

Onderwijzer te Groningen.

TE GRONINGEN, BIJ

J. OOMKENS,

Boek- en Steendrukker.

1843.

Fig. 2. Roelof Gerrit Rijkens (1795–1855) and his 'practical guide' (1843) (Sources: Stichting Iconographisch Bureau Den Haag and Rijkens RG. Praktische Handleiding voor Kunstmatige Ligchaams-Oefeningen, ten Dienste van Huisgezinnen en Verschillende Inrigtingen voor Onderwijs en Opvoeding. [Dutch for: Practical Manual for Artificial Physical Exercise for Families and Educational Institutions]. Groningen, the Netherlands: J. Oomkens, 1843.)

dedicated exclusively to medical gymnastics. Rijkens described a number of specific disorders and the exercises to treat them. Most of the exercises were derived from the work of the German physical education teacher J.A.L. Werner; others were chosen in consultation with a physician. Among the disorders likely to be cured by medical gymnastics the author listed "bended extremities, the clubfoot, weak ankles and feet, bended knees, limping, torticollis, squint, the narrow chest, and spine curvature deviations." Rijkens emphasized that it was advisable to consult a "knowledgable physician" before starting to treat children with these kinds of ailments. Such a physician, however, should be informed about the latest developments where diagnoses and (gymnastic) treatment were concerned. Noteworthy is the fact that Rijkens allocated a merely advisory task to physicians, whereas schoolteachers by profession were supposed to point out the children who were in need of treatment and subsequently, to take care of this treatment. It is very likely that Rijkens treated children with medical gymnastics himself.

At this time, around 1840, no reports on treatments with medical gymnastics had yet been published in the medical journals. This would change in less than 10 years. In the 1840s, a group of young progressive physicians appeared on the stage and called for reforms in medicine. Some of them were referred to as "hygienists' (in Dutch: *hygiënisten*)[36]. These Dutch sanitary reformers were an important element in bourgeois radicalism, which saw the European revolutions of 1848 as a critical context for general socio-political change. They played an important role in the founding of the Dutch Society for the Promotion of Medicine (in Dutch: *Nederlandsche Maatschappij tot bevordering der Geneeskunst*, hereafter referred to as NMG) in 1849, and they were very active in many local and national organizations concerned with healthcare. Furthermore, they held positions on the editorial boards of various renowned medical journals. Dissatisfied with their own social status and with the poor health of the population, the hygienists advocated better public health, which was sought through improving houses, schools and other buildings, sewer systems, waterworks, and so forth. According to them, physicians should supervise all these activities themselves. Because personal hygiene had a place on their agenda as well, they also showed an interest in the possibilities of physical exercise to raise the standard of the physical well-being of the population and to combat various diseases and forms of disablement. Between 1848 and 1865, an increasing number of articles on pedagogical and medical gymnastics were published by these hygienists in medical journals.

An example is the 1849 article "Announcements Concerning Kinesitherapy" by the hygienist J. Bosman Tresling (1803–1881)[37]. According to this physician from the city of Groningen, it was the first article of its kind published in the Netherlands. The 36-page article concerned itself only with medical gymnastics and is based mainly upon the publica-

tions of Ling's disciples Georgii and Rothstein[38,39]. Bosman Tresling elaborated on the gymnastic system of Ling and extensively reviewed publications by German physical education teachers and physicians. He emphazised that, where physical education teachers had been playing a major role in developing, implementing, and writing about medical gymnastics in the first half of the 19th century, Dutch physicians had not paid much attention to this relatively new form of medicine yet. Three years later Bosman Tresling published another long article on this matter, entitled "New Announcements Concerning Kinesitherapy"[40]. This time he based his article mainly on the publications of the German physicians A.C. Neumann, M.M. Eulenburg, and D.G.M. Schreber, to whom he referred as "kinesitherapists." Again he elaborated on different ways of treating various diseases and deformities with medical gymnastics (including massage).

Physicians like Bosman Tresling would not only write articles about medical gymnastics. From the 1850s onwards they gave lectures on the subject as well[41-42]. As in their articles, they stated that proper treatment by means of medical exercises could only be provided by persons who were skilled physical education teachers as well as skilled physicians. The problem was that those persons did not (yet) exist. The physical education teachers who were active in the field of medical gymnastics in the 1850s were not formally educated/trained in this direction. The same applied to physicians in this period. In university curricula, no attention whatsoever was paid to this kind of treatment. Physicians and physical education teachers, therefore, had to improve their skills while treating patients (learning on the job) and educate themselves by reading foreign, mostly German, articles and textbooks on the subject. This would remain the case throughout the second half of the 19th century. There was yet another strategy to improve one's skills and knowledge: to visit institutions abroad run by those who were considered to be the experts in medical gymnastics. Well documented are the travels to practices in several neighboring countries undertaken by the Amsterdam physician and city orthopaedist J.L. Dusseau (1824–1887) and the physical education teacher J.G. Milo Jr. (1840–1921) (Figure 3).

The Practice of Medical Gymnastics Before 1860

After 1850, an increasing number of medical journal articles mentioned persons active in the field of medical gymnastics. In the 1858 *Medical Journal* (in Dutch: *Geneeskundige Courant*), for example, the physical education teacher C.A.J. de Gruyter from Deventer reported on treatments with medical gymnastics he had given to patients since 1855[43]. The disorders he claimed to treat included St. Vitus dance, headaches, congestions, contractions menorrhoea and defecation problems, and nosebleeds. His treatments were mainly based on what he had learned from the publications of the German physician D.G.M. Schreber.

Also active in the field of medical gymnastics before 1860 were the already mentioned Amsterdam city orthopaedist Dusseau and some physical education teachers who were treating groups of children suffering from various deformities and illnesses in the special school for gymnastics that was founded by the Amsterdam Department of the MNA[4]. One of them was the physical education and fencing teacher

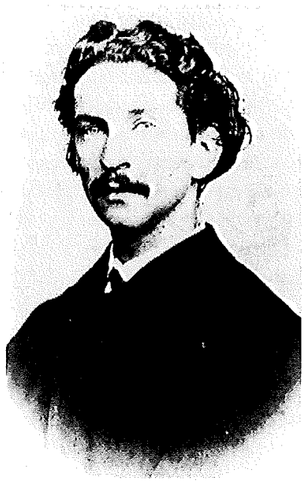


Fig. 3. City Orthopaedist Dr. Justus Lodewijk Dusseau (1824–1887) and Physical Education Teacher J.G. Milo Jr. (1840–1921). Pioneers in the field of heilgymnastics (Sources: Vereniging Nederlands Tijdschrift voor Geneeskunde and Bakker, LF. Nederlandse Orthopaedische Vereniging 1898–1998. De Geschiedenis van de Orthopaedie in Nederland. [Dutch for: The Dutch Orthopaedic Association 1898–1998. The History of Orthopaedics in the Netherlands]. Nijmegen, the Netherlands: NOV, 1998.)

Fig. 4. Physical education teacher and physician Johan Georg Mezger (1838–1909) who frequently treated royalty in the Amstel Hotel (Source: Kostelijk P.J. Dr. Johann Georg Mezger—1838–1909—en Zijn Tijd. [Dutch for: Dr. Johann Georg Mezger—1838–1909 and His Time]. Leiden, the Netherlands: Universitaire Pers, 1971).

J.G. Mezger (1838–1909) (Figure 4). In the 1850s, he worked closely with Dusseau, who must have introduced him to Swedish medical gymnastics[30]. Not long after taking the exam to become "a domestic physical education teacher" (1859), Mezger resigned as a teacher and went to Leiden to study medicine in 1860. In 1868 he finished medical school and in the same year he got promoted after defending his thesis *The Treatment of Distorsio Pedis with Frictions*[44]. Finally, in 1870, he passed the exam to become a physician. He treated many people in the 1870s and 1880s in his flourishing practice in the Amstel Hotel in Amsterdam. Massage seems to have had Mezger's interest. He received credit from many authors for bringing massage back to the attention of the medical profession in the 19th century[45].

Other physical education teachers at the MNA gymnastics school in Amsterdam who engaged in treating people with medical gymnastics were M.A. van der Est, who eventually started his own practice elsewhere in Amsterdam where he treated patients with electrotherapy in addition to medical gymnastics, J.S.G. Disse, J.A. van Monsjou, and J. Pieters[33,46,47].

By then, it was clear that the institutionalization of medical gymnastics was taking place within both the domains of physical education and medicine. In Sweden and Germany, and to a lesser extent in France and the United Kingdom, this situation led to tensions between both groups of professionals, as noted by Dusseau in 1858[48]. In the Netherlands, however, signs of such tensions were not found in the periodicals and books before 1860.

The Rise of Medical Gymnastics, 1860–1889

New Legislation Concerning Education and Healthcare

With an upcoming Liberalism, an emancipated citizenry, and changing economic structures in the Netherlands around 1850, a new era presented itself. Along with it came a strong need for a kind of education that would meet the changed demands of time; i.e., it should be more directed towards solving practical problems in modern economic life and eventually raise the standard of living of all. Furthermore, it should enable the new generations to stimulate trade, industry, and agriculture in order "to put the Netherlands on the map" again. After the revision of the constitution in 1848, several changes were made in the legislation concerning education. In 1857, the new *Primary School Act*, which was intended to improve the education at the lowest level, was passed[49]. In 1863, this act was supplemented with the *Secondary School Act* and in 1876 with the *Act for Higher Education* [50-51].

The *Primary School Act* allowed primary schools to give physical education lessons as an official part of their curriculum. Consequently, because primary school teachers had to be educated in this direction, more attention was paid to the theory and didactics related to physical education. This development got an extra impulse when the *Secondary School Act* went into effect in 1863, during the second cabinet period (1862–1866) of the Liberal Prime Minister J.R. Thorbecke (1798–1872). This act stated that pupils should be given a broad general knowledge base. Among the new school types established, where this kind of education should be implemented, was the Higher Citizen School (in Dutch: *Hogere Burgerschool* [HBS]). Pupils had to take 14 to 18 subjects, and each of these subjects was to be given by specialized teachers. Because physical education was one of the obligatory subjects, qualified teachers in this field were needed as well. To meet this demand, the *Secondary School Act* provided for special exams that were organized once a year by a special committee. This development led to the emergence of a new group of professionals. Mainly members of this group who would engage in medical gymnastics in the second half of the 19th century.

During the period 1842–1862, different state committees revised the legislation in the healthcare domain that had originated in 1818. This eventually led to the acceptance by Parliament of the four *Medical Acts of Thorbecke* in 1865[52-55]. Objectives of these acts were, among other things, to improve the control of the state with regard to preventing the

outbreak of disease and the implementation of hygienic measures, to reduce the variety of medical practitioners, to organize the education and licensing of the different professions within this domain, and to abolish quackery.

Although some of the ideas of the hygienists and other progressive physicians were not quite honored, these medical acts were quite favorable towards the members of the medical profession. The once great number of varied medical practitioners was eventually reduced to only one: the physician (in Dutch: *arts*). To become a physician, one had to take two state exams and meet several other specific conditions. Once a physician, one was ensured a high degree of autonomy in his practice. It was laid down legally that physicians themselves could define their profession (what is medicine?), they could decide how they would run their practice (which therapy and how it should be applied?), and they could determine what the results of their actions would be (what constitutes illness/health?)[56]. In effect, the new physician actually was granted a monopoly in the field of healthcare with these medical acts. Only he who was authorized by law was allowed to practice medicine and to make this publicly known. Although the underlying thought of the Dutch government was to combat quackery, these laws unintentionally led to a situation in which it would become very hard, if not impossible, for new occupations to establish themselves in the healthcare domain[57]. One could say that the medical acts of Thorbecke came too soon for the new professionals, who were active in the field of medical gymnastics: the cake of the healthcare domain had de facto been cut and parcelled out in 1865.

After the *Higher Education Act* of 1876 came into effect, several regulations followed in the late 1870s and early 1880s in medicine that placed the education and examination of physicians solely in the hands of the medical faculties at the universities. Twenty years after the medical acts of Thorbecke, physicians had succeeded in gaining control over the recruitment, education, and examination of future colleagues. Apart from obtaining a relatively high level of autonomy with regard to their practice, physicians now enjoyed a legally sanctioned autonomy with regard to their education as well.

Practice of Medical Gymnastics after 1860

In the second half of the 19th century, interest in the application of medical gymnastics, more and more referred to as "heilgymnastics" (in Dutch: *heilgymnastiek*), increased. It was considered a "relatively new and very promising field in medicine" by physicians. While new legislation with regard to physical education and medicine was prepared and came into effect, heilgymnastics was already being practised in several places in The Netherlands. Those who engaged in such activities who were not physicians were referred to as "heilgymnasts" (in Dutch: *heilgymnasten*).

From data derived from seven renowned medical journals and five physical education journals between 1860 and 1889, we learn that an increasing number of people were interested and active in the field of heilgymnastics[4] (Figure 5). The number of articles that explicitly deal with heilgymnastic treatments doubled every decade (1860–1869: 10, 1870–1879: 26, 1880–1889: 48). When we take everything into account that is written in both types of journals (not only articles and reviews, but advertisements, messages, etc., as well) and look at the status of those who are mentioned in relation to heilgymnastic activities in the same three decades, we can see that there was an increase in references regarding the activities of non-physicians (1/9/25). Also, physicians seem to have been much more active in the 1880s than before (2/1/10). The combined activities of physicians and non-physicians were reported as well (1/11/6). In these references, it seems that heilgymnasts were in charge of the actual treatment whereas the role of physicians was described as charged with the supervision or having referred their patients or having consented to a treatment or having a consulting role.

In addition to physicians and heilgymnasts, another group of people was active in the field of heilgymnastics in the period 1860–1889[46,58]. In the periodicals, these were referred to as "quacks" (in Dutch: *kwakzalvers*) or "bunglers" (in Dutch: *beunhazen*). They were described as incompetent (i.e., having no education whatsoever) and accused of seeking opportunities to earn money in the easiest possible way. It seems that the more popular heilgymnastics became over the years, the bigger this group grew. It is impossible to say, however, exactly how many bunglers there were and where they were active. Until further evidence is presented, it is

Fig. 5. Example of a heilgymnastic treatment (Source: Schreiber J. Praktische Anleitung zur Behandlung durch Massage und methodische Muskelübung. [German for: Practical Guide for Treatment with Massage and Systematic Exercises]. Wenen/Leipzig, Germany: Urban & Schwarzenberg, 1888).

presumable that they constituted a minority among those who were actively engaged in heilgymnastics.

The vast majority of the ailments that were treated with heilgymnastics consisted of deformities of the spine, chest, shoulder blades, and limbs. Paralysis, bad innervation, insufficient breathing, neuralgia, chorea minor, gout, rheumatism, headaches, chlorosis, scrophulosis, tuberculosis, adipositas, and general weakness are also mentioned as indications for treatment.

Heilgymnastic treatments were mainly given in the major cities, especially in the western provinces of North-Holland and South-Holland. Of these cities, Amsterdam seemed to have harbored most heilgymnastic activity. Of 64 references in total, 23 (36%) were related to the Dutch capital. Where the clientele of heilgymnasts is concerned, it appears that most patients came from the middle class, with a minority coming from the upper and lower classes. From extensive reports of two heilgymnasts, we learn that about 25% of their patients were children until 10 years of age, whereas people between 10 and 20 years of age made up 50% to 60% of the patients. The ratio of men/women was roughly 40/60[59,60].

What did all those involved in heilgymnastics think about the situation at hand? What was, for example, the reaction of physicians to the fact that so many heilgymnasts were active in a field that was supposed to be a part of medicine? What were the thoughts of heilgymnasts on the presence of physicians in the field of heilgymnastics? How did members of both groups legitimize their professional activities in this field in the second half of the 19th century? How was this whole situation perceived by other relevant members of society?

Physicians Claim Heilgymnastics Exclusively for Themselves

As we have seen, among physicians the so-called hygienists were the most driven where it came to promoting and stimulating pedagogical gymnastics and the application of medical gymnastics since the 1840s. It was mainly due to their efforts and those of other young progressive physicians that new legislation in the field of education (1857 and 1863) and that of healthcare (1865) came into effect. These acts would have an enormous impact on the further development of medical gymnastics in the Netherlands. Although most of the hygienists were not active in this field themselves, with their books, articles, editorials, lectures, and letters, they managed to make local and national authorities, physicians, and the public more receptive to this new and promising branch of medicine. It was generally considered supplementary to pharmaceutical and surgical therapies and seen as a successful way of treating certain disorders and ilnesses. Both pedagogical gymnastics, which was regarded as a part of hygiene, and medical gymnastics, which was considered to lie more in the field of surgery, were believed to have a place within the curricula of the medical faculties[61,62]. However, the role of the influential hygienists ended in the 1880s when most of them passed away. But other Dutch physicians began to take a strong interest in heilgymnastics, namely those who were specializing in the areas of orthopaedics and physical medicine.

In the 1880s and 1890s, a strong differentiation and specialization was going on within the field of medicine in the Netherlands. This led to fierce competition among groups of physicians for a position within the medical faculties and in the healthcare market. Surgeons who were specializing in orthopaedics began to claim this field exclusively as their own[63-65]. For these orthopaedists, it was essential to make clear to their peers and the outside world what orthopaedics stood for. Their definition of the field, which was for the most part inspired by German colleagues, included heilgymnastics; therefore, their claim on heilgymnastics grew stronger during the last two decades of the 19th century. The same was true for physicians who began to specialize in physical medicine, an up-and-coming field in the 1890s in the Netherlands.

An oversupply of physicians in the bigger cities in the western part of the Netherlands, as a result of the ongoing urbanization in the last quarter of the century, was responsible for this stronger medical claim of heilgymnastics as well. When the Netherlands was struck by an economic depression in the beginning of the 1880s, physicians felt threatened, not in the least by severe competition from their own colleagues[66,67]. Since heilgymnasts, like physicians, mainly worked in the bigger cities, one can imagine that this extra competition in the healthcare market was not welcomed at all. Physicians feared and suffered a loss of income because of these practioners. Therefore, they readily gave support to the orthopaedists' claim that heilgymnastics, which was defined as a form of conservative medical treatment, should be the exclusive terrain of physicians.

Of course, physicians did not mention these less noble motives when claiming the field of heilgymnastics. Like many before them, they legitimized their claim by pointing at the healthcare and university acts of the 1860s, 1870s, and 1880s. After all, the monopoly in healthcare that had been granted by the legislation in 1865 enabled them to define the extent of their domain as they pleased. Furthermore, they stated that practising heilgymnastics—an important and effective form of conservative medical treatment—should exclusively be entrusted to physicians since only they would know best—because of their medical education—how to best serve the interests of the suffering patient. It is noteworthy, however, that by the end of the 19th century, orthopaedists and other physicians regarded and discussed massage as a separate part of heilgymnastics and stressed that only massage was the exclusive terrain of physicians[63,67-69]. Were they claiming only

this part of heilgymnastics because they were aware of the fact that the legal basis for claiming the whole of heilgymnastics (including massage) was too weak[4]?

At first, the claims and the protests against the activities of heilgymnasts came mainly from individual physicians who published letters and articles in periodicals, but in 1888 the Dutch Society for the Promotion of Medicine (NMG) took a stand in this matter as well. The NMG asked the national government to take proper measures to prevent unauthorized persons from being active in the field of orthopaedics and massage by means of a better use of the punitive measures as mentioned in the medical laws[70-72]. However, no action was ever taken by the government.

Despite the claim of orthopaedists and other physicians and the request of the NMG, the practice of heilgymnastics in the Netherlands remained mostly in the hands of physical education teachers and others, with or without the supervision of a physician. Only a few physicians seemed to have been active in this field, e.g., S.B. Ranneft (1852–1909) and J.A. Korteweg (1851–1930) from Groningen, W. Renssen (1856–1917) from Arnhem, and C.B. Tilanus from Amsterdam[46,73]. One could say that a tension existed between the physicians' growing claim on heilgymnastics (on a theoretical level) and their not wanting to actively engage in this field (on the practical level). Why were so few physicians active in this field?

One reason may be that in this period, most physicians were more interested in specialized clinical curative medicine than in "rather simple and old-fashioned healing methods," such as heilgymnastics[45]. Attention within the curricula of the medical faculties was directed mainly towards those subjects that could strengthen the scientific basis of medical clinical practice (physiology, chemistry, histology, bacteriology, etc.). Consequently young physicians were not acquainted with heilgymnastics during their education and thus remained unfamiliar with it. Another reason may be that physicians perceived practising heilgymnastics as very labor-intensive: one had to give long and strenuous therapy sessions and treatment could go on for months. In addition, when compared to issuing pharmaceutical drugs for example, giving a heilgymnastic treatment would mean making less money and having to work much harder for it, not a very appealing perspective (Figure 6). The fact that physicians may have looked down on practising this "craft," because it did not comply with their self-image as "men of science" may have played a role in this respect as well.

Increasing Number of Physical Education Teachers Active in the Field of Heilgymnastics

As noted, the biggest group active in the field of heilgymnastics were physical education teachers. In the period 1857–1879, about 140 persons, of whom 15 were females, were licensed as secondary school physical education teachers (Act of 1863), while 1160 people, of whom 60 were females, became qualified to give physical education lessons in a primary school (Act of 1857). These numbers increased rapidly during the 1880s[74-77]. It is not known how many of these professionals actually engaged in heilgymnastic activities, but the impression is that they formed a minority within the population of physical education teachers.

The fact that physical education teachers became active in this field is understandable, considering the history of the introduction of heilgymnastics in the Netherlands described earlier. From the beginning, these professionals were taught

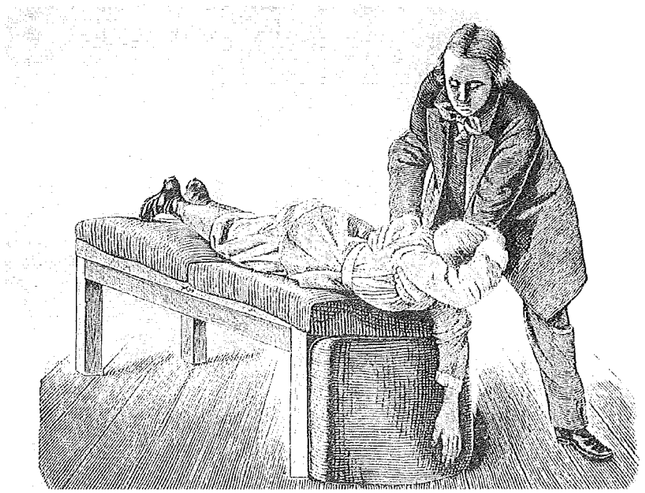


Fig. 6. Example of a heilgymnastic treatment (Source: Schreiber J. Praktische Anleitung zur Behandlung durch Massage und methodische Muskelübung. [German for: Practical Guide for Treatment with Massage and Systematic Exercises]. Leipzig, Germany: Urban & Schwarzenberg, 1888).

that heilgymnastics was a part of the greater physical education system. During their—mostly autodidactic—studies, physical education teachers were confronted with theories and case studies regarding the application of heilgymnastics and so became acquainted with it at an early stage of their careers. To practise in the field of heilgymnastics, they needed many of the skills that were also required for teaching gymnastics, their actual field of competence. They knew much about how to teach people certain movements, about different types of exercises, about the materials that could be used to perform these exercises, and so forth. Thus, from this technical point of view, it seems to have been a small step for physical education teachers to start working in this new field. Although physical education teachers as well as physicians stated they were able to apply heilgymnastics, most of them were at the same time aware that they were lacking essential knowledge and skills[78-81]. In the 1860s and 1870s, many pleas appear in the periodicals in which improving the education of the physical education teacher as well as that of the physician in this respect is advocated[81-83].

Another factor that stimulated the involvement of physical education teachers in the field of heilgymnastics was their position as schoolteachers. In this capacity they were confronted with children suffering from some kind of illness or disablement, and more than once they would have witnessed that these children did not receive any treatment or were treated with braces, corsets, and the like without much effect. This may have given them the idea that heilgymnastics might be more successful in these instances. The fact that physicians did not engage in heilgymnastic treatments could have been an extra stimulant for physical education teachers to start treating these children themselves[81,84]. Scientific curiosity as to the effect of exercises but also altruism and social concern may have played a role in this as well.

There were also other motives that drove physical education teachers to become active in heilgymnastics. Here we refer to some awkward circumstances characterizing the field of physical education in the Netherlands at this time. The inadequate organization of the gymnastic exams[85-87], a shortage of proper teaching methods and training schools[4,88], and a lack of research facilities and a forum for exchanging experiences[89-91] were all circumstances that caused a lot of frustration and forced physical education teachers to acquire their skills and knowledge mostly in an autodidactic manner[4,92]. These factors had an obvious negative effect on how physical education was regarded.

Other circumstances cast a shadow on the status of the physical education teacher as well. For one thing, these teachers had to put up with bad working hours, because for many school principals and other authorities, physical education was just not important enough[93,94]. Therefore, pupils had to take these classes—if at all—very early in the morning or in the late afternoon and early evening[33,95-97]. Furthermore, children of various ages were often put together to receive physical education lessons for reasons of convenience, which made these lessons difficult to give[33]. Also the fact that, despite many pleas of physical education teachers, physical education still was not part of the final exams in the secondary schools had a negative effect on how physical education was perceived[98]. And last but not least, compared to other teachers, physical education teachers at the time had the lowest salary, which often forced them to take on different odd jobs next to teaching to be able to maintain a certain standard of living[33,34,96,99,100]. Treating people with heilgymnastics was one such job. Apart from economic reasons, these professionals may well have thought that this would also boost their status. By practising heilgymnastics, they would be active in the field of medicine, a field of science that was looked upon with much more respect.

Organizations in the Field of Physical Education Abolished Heilgymnastics

Many tried to improve the situation in physical education. The hygienists, not only as individual physicians, but also as members of different medical advisory and control boards, had tried to elevate the level of physical education in the Netherlands in the period 1840–1890[4,101,102]. The two most important organizations in the field of physical education, the Association of Physical Education Teachers in The Netherlands (in Dutch: *Vereeniging van Onderwijzers in de Gymnastiek in Nederland*), founded in 1862, and the Dutch Physical Education Confederation (in Dutch: *Nederlandsch Gymnastiek-Verbond*), founded in 1868, also tried very hard to improve the circumstances in this field[31,103]. During the 1880s, however, when the domain of heilgymnastics became more and more disputed, these organizations had great difficulty taking a stand in the discussion: Should heilgymnastics be regarded as an extension of pedagogical gymnastics (and therefore belonging to their field of professional interest) or as a part of the medical discipline (and thus off limits for them as non-physicians)? In the middle of the 1880s, the organizatons took a strategic stand and decided to consider heilgymnastics as a separate discipline, thus separate from physical education (pedagogical gymnastics), and they agreed to serve only the interests of physical education in general and the interests of its schoolteachers in particular[104]. This decision of the executive committees of the physical education organizations had everything to do with the deplorable circumstances under which physical education teachers were being educated and performing their duties in schools and with the low position of physical education in the professional hierarchy of education. There was still a lot to strive for in the area of pedagogical gymnastics, and the executive committees were aware of the fact that in order to improve the situation, they were very much dependent upon the support of physicians, many of whom occupied seats on

municipal committees and boards of organizations that had a say about the future of different aspects of physical education. The organizations of physical education just didn't want to run the risk of getting into conflict with physicians. Their new policy meant a major setback for the relatively small group of heilgymnasts/physical education teachers who wanted to promote heilgymnastics. The effect was an immediate decrease in the number of publications on heilgymnastics in physical education journals. It also led, after fierce discussion among physical education teachers, to the abolition of subjects like orthopaedics and healthcare in meetings and in certification examinations for physical education teachers[105-107].

The physical education teacher G.J. Mullers probably expressed the feeling of many colleagues in 1885 when he wrote that he was convinced that a discussion about treating "orthopaedic" disorders in a meeting of physical education teachers was not in the interest of the profession and its organizations[90]. He argued that the certificate as an examined physical education teacher did not give any guarantee that one had acquired sufficient knowledge and skills in the field of heilgymnastics. The opinion and skills of a physician were, therefore, the only things to hold on to in this respect. That was to say, unless someone had made an intensive study of heilgymnastics and had acquired a great experience treating people with it, he had no right to speak and act in these matters. To solve the problematic "heilgymnastic issue," Mullers advocated installing a state-exam for heilgymnastics. Then the public could be assured that they were dealing with real professionals in this field. Furthermore, he wrote, if physical education teachers wanted to be active in this field, they should found an organization of their own that would look after their special interests. He even called this a matter of great urgency.

The Legislature, the Public Health Inspectorate, and the Judicial System

We have seen that the domain of heilgymnastics was a matter of controversy within the world of physical education and medicine throughout the second half of the 19th century. In the late 1870s and 1880s, the discussion of who was to treat patients with heilgymnastics became more grim in medicine and physical education periodicals. In the middle of the 1880s, physical education teachers became divided over the question of whether heilgymnastics belonged to the domain of physical education, while the organizations in the field of physical education decided to drop the heilgymnastic issue from their agendas altogether for political reasons. At the same time, physicians claimed this domain more rigorously than ever before and even the NMG took a clear stand on this matter. The question arises how the national government dealt with the situation at hand. Didn't the legislature issue various laws during the second half of the 19th century that were to regulate the activities in these fields? When noticing that things did not function the way they should, was it not up to the members of Parliament to address the government with the question to do something about it?

During the second half of the 19th century, both local and national governments kept a low profile in this respect[31,103,108,109]. In the archives of the national government, nothing is found with regard to heilgymnastics. It seems that either the problems with regard to the "new" heilgymnastic domain were not recognized by the members of Parliament or they were thought of as not important enough to spend time on.

What did the Public Health Inspectorate (in Dutch: *Geneeskundig Staatstoezicht*) undertake with regard to the heilgymnastic activity of non-physicians? The tasks of the Public Health Inspectorate, installed by one of the medical laws of Thorbecke in 1865, were to investigate where and how public health was threatened, to advise as to how these problems could be solved, and to guard the maintaining of healthcare laws and other regulations. In the period 1866–1902, reports were published each year in which the different divisions of the Inspectorate gave an account of their activities on behalf of the crown (in Dutch: *Verslag aan den Koning van de Bevindingen en Handelingen van het Geneeskundig Staatstoezigt*). From these reports, we learn that the heilgymnastic domain was an issue several times over the years[4]. The inspectors and advisory boards of the Public Health Inspectorate were aware of the problematic situation concerning heilgymnastics, but they knew that under the ruling laws they could not do very much against physical education teachers who engaged in heilgymnastic activities. Nevertheless, they kept warning these heilgymnasts, threatening with prosecution for breaking the (medical) law.

The heilgymnasts, on their part, just continued their work and could not be bothered with these kinds of threats. During the period 1865–1889, only a few of them were actually brought before the judicial system. As far as the records show, only one physical education teacher was ever sentenced with a fine because he had given a massage[110]. Although the inspectors and advisory boards of the Public Health Inspectorate acknowledged that something had to be done about the situation, they did not know how to proceed. For a while, they believed an improvement could come from changes in the educational system of physicians or physical education teachers, but they soon found that there was no political basis (among physicians) for such a solution.

The Founding of Organizations in the Field of Physical Medicine

During the last decades of the 19th century, the process of industrialization intensified in the Netherlands[111]. With it came

an increase of migration, urbanization, competition, commercialization of social relations, and a loss of importance of traditional institutions (i.e., secularization). From the 1880s onwards, there was a tremendous growth of political movements and societies for various activities and strivings. The more people felt isolated and threatened in their rapidly changing world, the more they sought refuge in these societies. At the same time, the end of the 19th century was a time of opportunity, of emancipation. There was an increase in vertical social mobility, not only because of economic changes but also due to more and better education for all layers of the population. Among the groups who wanted to emancipate were the heilgymnasts. Ten years before physicians specializing in orthopaedics and physical medicine founded organizations dedicated to these fields, heilgymnasts organized themselves.

The Society for Practising Heilgymnastics in the Netherlands

In July 1889, two physical education teachers and heilgymnasts, E. Minkman (1848–1912) and J.H. Reijs Jr. (1854–1913), sent a circular to nine of their colleagues with an invitation to attend a meeting[112]. They wrote that heilgymnasts should unite in solving the problems that the field of heilgymnastics was facing. The many different ways to treat patients with certain disorders called for a thorough analysis to separate the good treatments from the bad. No practitioner was believed to be capable of doing this all by himself. Another problem was the increasing number of bunglers who worked in this field. Reijs and Minkman wanted to make clear that heilgymnastics was not just a form of physical education and that further scientific education and a lot of practice were needed to become a good heilgymnast. They wanted to discuss all these matters and intended to found an organization to promote the theory and practice of heilgymnastics.

About a month later, on the first of September, seven heilgymnasts, all physical education teachers, assembled in a little cafe in Utrecht[113,114]. Two other heilgymnasts could not attend the meeting but sent a letter in which they expressed their sympathy for this initiative. Both wanted to be registered as a member of the new organization. Two others did not want to join because of various reasons[115]. Those present at the meeting shared the concerns of the initiators with regard to the future of heilgymnastics and that of the heilgymnasts. All felt they were losing the overview with respect to the huge number of methods and systems of treatment. They too saw that it had become increasingly difficult for the individual heilgymnast to choose the right treatment for each particular patient. The absence of a specialized education facility and of a forum to exchange knowledge and experiences was seen as a major obstacle to the further development of their profession. There was a commonly felt need for legislation with regard to heilgymnastics: it should provide for exams, diplomas, and education programs (the initiators wanted an education for heilgymnasts on an academic level), while at the same time it should make it more difficult for bunglers to work in this field. The activities of these bunglers were seen as a menace to the reputation of the relatively new profession. They often were used as an example by those wanting to criticize the whole group of non-medical practitioners (heilgymnasts).

Improvement in these areas was to be expected neither from the professional organizations of physical education teachers nor from those of physicians. The heilgymnasts felt very uncomfortable with the fact that nothing had been done and, so it seemed, would be done about these problems by these organizations on their behalf. Especially from the physicians little help was expected. During the 1880s, the heilgymnasts had witnessed an increasing number of conflicts between members of the medical profession and those physical education teachers who engaged in heilgymnastic activities.

The heilgymnasts who covened in Utrecht strongly believed that a solid organization of serious, well educated, and well trained heilgymnasts could bring about a positive change. Such an organization could look after their interests much better (e.g., getting proper financial compensation for labor) and would enable them to elevate the professional level of the heilgymnasts. As intended, the meeting of the heilgymnasts resulted in the founding of the Society for Practising Heilgymnastics in the Netherlands (in Dutch: *Genootschap ter beoefening van de Heilgymnastiek in Nederland*, hereafter referred to as *Genootschap*). The *Genootschap* counted nine members. The two men who had taken the initiative, E. Minkman and J.H. Reijs Jr., were chosen to be the first chairman and secretary. H. van Kreel (1860–1921) was elected as treasurer (Figure 7). These three heilgymnasts constituted the first executive committee, which took on the task of writing the bylaws of the *Genootschap*. It made sure that the issues discussed during the first meeting were put down in these bylaws[116]. The aims of the *Genootschap* were described as follows: practising heilgymnastics and studying and developing the theory in this field; bringing about more uniformity in the ways of treating patients; and stimulating a good understanding between physicians and heilgymnasts.

The *Genootschap* provoked moderate reactions from organizations and practitioners in the fields of physical education and medicine during the first year of its existence[4]. Only the reaction that came from the editors of the *Dutch Journal for Medicine* (in Dutch: *Nederlands Tijdschrift voor Geneeskunde*) will be mentioned here. In three short reports they reported on the first two meetings of the *Genootschap*[117-119]. The emphasis in the second report lay with an issue that apparently was very important to physicians: the fact that the members of the *Genootschap* were held to the demand only to treat a patient after a physician had given his approval.

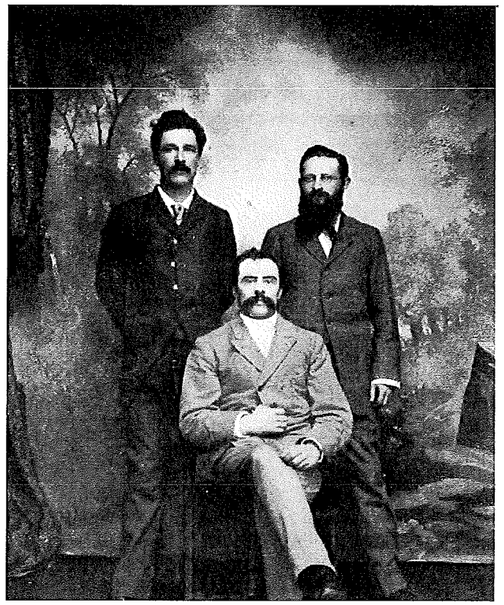


Fig. 7. The First Executive Committee of the Society for Practising Heilgymnastics in the Netherlands in 1889: J.H. Reijs Jr. (1854–1913), H. van Kreel (1860–1921) and E. Minkman (1848–1912) (Source: Maandschrift gewijd aan de Heilgymnastiek 1914;24:179).

The heilgymnasts of the *Genootschap* had put this requirement on themselves in order to create a good understanding between physicians and heilgymnasts (the third aim of the *Genootschap*). That there were good relationships between heilgymnasts and physicians and that some of the latter sympathized with the *Genootschap* can be deduced from the fact that several well-known Dutch physicians joined the *Genootschap* as special members and two German physicians, E. Fischer and J. Schreiber (1835–1908) and C.M. Nycander (1831–1909), who was educated at P.H. Ling's Central Gymnastic Institute in Stockholm and now active in Belgium, were listed as correspondent members.

The Quest for Legislative Recognition

Very soon, however, other physicians proclaimed again that the activities of the *Genootschap* were a threat to the process of differentiation and specialization that was going on in the field of medicine, especially with regard to orthopaedics and physical medicine. During the last decade of the 19th century and the first decade of the 20th, competition in these areas became fiercer in the Netherlands. Physicians began to take an interest in heilgymnastics and other forms of physical therapy on a bigger scale. As the number of physicians increased around the year 1900 and working conditions for them, especially for those who had just started their practice in the bigger cities, became worse, the resistance against the position and activities of heilgymnasts and their organization increased. In an attempt to gain control over this particular field of medicine, five similar organizations were founded in this period by physicians who were active in physical medicine and orthopaedics (in both of these fields heilgymnastics was included): The Dutch Orthopaedic Association: The Association of Physicians for Practising Orthopaedics, Mechanotherapy, Medical Gymnastics and Massage (in Dutch: *Nederlandsche Orthopaedische Vereeniging. Vereeniging van Artsen ter Beoefening van Orthopaedie, Mechanotherapie, Geneeskundige Gymnastiek en Massage*) in 1898; the Dutch Association for Electrotherapy and Radiology (in Dutch: *Nederlandsche Vereeniging voor Electrotherapie en Radiologie*) in 1901; the Medical Association for Physical Therapy and Hygiene (in Dutch: *Geneeskundige Vereeniging voor Physische Therapie en Hygiëne*) in 1902; the Association for Physical Therapy (in Dutch: *Vereeniging voor Physische Therapie*) in 1903; and the Dutch Association for Thalassotherapy (in Dutch: *Nederlandsche Vereeniging voor Thalassotherapie*) in 1905.

The founding of the *Genootschap* in 1889 and these organizations around 1900 lifted the controversy over this portion of the health care domain between physicians and heilgymnasts from the level of a dispute between individuals in journals to that of a strategic friction between professional organizations. Both groups not only suffered competition from the other, but they had to put up with other competitors on the healthcare market as well. First of all, the number of bunglers kept rising. These people, often with no experience or knowledge of heilgymnastics, saw possibilities for themselves and tried to benefit from the increased popularity of heilgymnastics and the credulity of the public. Secondly, there was competition from often very young and inexperienced physical education teachers, who started to offer heilgymnastic services to the public immediately after they had obtained their qualification as a physical education teacher and sometimes after having attended only a very short course in heilgymnastics abroad. These youngsters were heavily criticized by the established heilgymnasts as well by physicians. Last but not least, the upcoming women's movement around 1900 and the consequences this had on the labor market (women of good standing were increasingly used by physicians to assist them in their heilgymnastic practices) gave rise to anxiety, especially among the members of the *Genootschap*.

According to the *Genootschap* community, all of these circumstances underlined the need for legislation in the field of heilgymnastics (with a state exam, a state diploma, and proper education). With legally sanctioned profession-

als, the public would know where to go and the physicians would know where to send their patients. From 1889 onwards, the members of the *Genootschap* tried to acquire the legal status for their profession in many different ways. It would take some 50 years, however, before heilgymnastics received the legal status they had ceaselessly strived for. During the German occupation in 1942, an act was sanctioned that stated that heilgymnastics was to be regarded as a "paramedical" rather than as a "medical" activity[120]. The act provided for criteria with respect to the training and examination of heilgymnasts.

Summary

Towards the end of the 19th century, physical medicine, a field that included mechanotherapy, hydrotherapy, balneotherapy, electrotherapy, light therapy, air therapy, and thermotherapy, became a contested area in the healthcare domain in the Netherlands. This was especially true for mechanotherapy, which consisted of exercise, manipulations, and massage, a form of therapy that had been documented as far back as the 1840s and used to treat disabled and chronically ill people with the aim to improve their functional ability. In contrast to what one might expect, mostly physical education teachers, soon referred to as heilgymnasts, dedicated themselves to this kind of treatment, whereas only a few physicians were active in this field. When groups of physicians began to specialize in the newly defined content areas of physical medicine and orthopaedics in the last quarter of the 19th century, they suffered heavy competition from these heilgymnasts and others. This became worse after the heilgymnasts organized themselves and founded the Society for Practising Heilgymnastics in the Nederlands in 1889. In the same period, differentiation and specialization processes within the medical profession led to fierce competition among groups of physicians for a position within the medical faculties and in the healthcare market. Although research on the developments in the field of physical medicine in the Netherlands in the late 19th and first half of the 20th century is still in progress, it seems plausible to suggest that the competition suffered on both fronts by these physicians had a negative impact on the academic development of physical medicine, orthopaedics, and heilgymnastics/physical therapy in the Netherlands during that time. Physical medicine couldn't truly manifest itself as a speciality within the medical profession in the Netherlands. From the 1920s onwards, physicians who specialized in physical medicine realized their speciality was "tainted" because of the activities of so many non-physicians in the field. These physicians gradually shifted their professional attention towards the up-and-coming specialities of orthopaedics, rheumatology, and, somewhat later, rehabilitation medicine. Compared to countries like Germany, the United Kingdom, and the United States, physical medicine in the Netherlands fell rapidly behind where scientific research was concerned. The practice of physical medicine was gradually taken over by heilgymnasts. Physicians increasingly granted them more freedom in using their own judgement when treating patients with physical therapies. In 1942, an act was passed in which the emerged division of labor in this field was confirmed, while control over diagnosis and treatment would remain an unsettled issue until new legislation came about in the 1990s.

As mentioned in the introduction to this article, choices were made to portray certain aspects of the development of physical medicine in the Netherlands. Research in this field is still in its infancy and studies published on this topic and related ones are scarce. Therefore, this article should be considered as a rough sketch of one piece of a puzzle of which the exact size has yet to be established. I would like to convey my sincere hope that more medical historians and other scholars will engage in historical and sociological research on physical medicine/physical therapy in their own country in order to get a better insight into this heavily neglected field of study. Only then we will be able to get a clear picture of the simularities and the differences in various countries and perhaps be able to make an effort to explain them. In due course I hope to be able to present further results of my research on developments in the field of physical medicine in the Netherlands from 1890 to 1942. As I was finishing this article, I received a dissertation written by Anders Ottosson in Sweden[121]. Although I was not able to understand the full text, as it was written in Swedish, from browsing through it and reading the English summary I've gotten the strong impression that this is a very interesting study that shows much resemblance to my own research. Contact has already been made to see if there is a possibility to work together on this topic. It is my hope that others will join us.

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The National Chiropractic Council™

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June 16, 2011

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The National Chiropractic Council ("NCC") is a federal risk purchasing group which purchases physical therapy malpractice insurance on a group basis for its members. It has come to NCC'S attention that after the March 15, 2011 meeting, the Illinois Physical Therapy Licensing and Disciplinary Committee determined that the technique of "dry needling" falls within the physical therapy scope of practice. Attached as Exhibit "A" herein is a copy of the March 15, 2011 meeting agenda. In fact, the continuing education committee of the Illinois Physical Therapy Association approved Kinetacore's request for continuing education approval for "intramuscular manual therapy" also known as dry needling. Attached as Exhibit "B" herein is a copy of the approval letter from the Illinois Physical Therapy Association. This determination concerns NCC not only on a malpractice perspective, but also concerns NCC from the perspective of public health and safety.

According to the World Health Organization, the term "acupuncture" literally means to puncture with a needle. "Dry needling" is a term that was developed to define the technique of placing an acupuncture needle into a muscle trigger point rather than injecting the trigger point with lidocaine or cortisone. Dry needling focuses on releasing muscle tension by treating specific trigger points, alleviating nerve tissue irritation by reducing the nerve impulse, or stimulating local blood supply where it may be naturally poor, for instance at the junction between tendons or ligaments and bone. It became known a "dry" needle since nothing was injected. Dry needling is a derivative of acupuncture and defined by the World Health Organization as "acupuncture."

In fact, one of the pioneers of the dry needling technique, Chan C. Gunn, stressed that many trigger points were close to or identical to acupuncture points. Chan C. Gunn's belief was that Western practitioners would better accept the technique if the point locations were described in anatomical rather than traditional Chinese medical terms.[1]

Proponents of the addition of dry needling to the scope of physical therapy maintain that trigger point dry needling does not have any similarities to acupuncture other than using the same tool. These same proponents of the technique re-define traditional Chinese medicine as being based

[1] Gunn, CC et al. *Spine*, 1980

on a traditional system of energetic pathways and the goal of acupuncture to balance energy in the body. They emphasize the channel relationship of acupuncture points, de-emphasize or completely exclude the use of ASHI points, and emphasize that acupuncture is based on the energetic concepts of Oriental medicine diagnosis. They therefore define dry needling as different and distinct from acupuncture because it is based on Western anatomy.[2]

However, these proponents fail to recognize that acupuncture schools teach both "western" neurophysiological concepts along with "traditional" meridian concepts. As such, acupuncturists are highly trained within both fields of medicine. In fact, the profession of Chinese medicine utilizes neurophysiological principles. As such, there is no such distinction between "eastern" and "western" acupuncture.

Needless to say, dry needling is a contentious issue. However, the issue needs to be ultimately viewed from the perspective of public health and safety. Currently, the leading dry needling courses being offered in the United States include the Travell Series through Myopain Seminar in Maryland and dry needling courses offered by the Global Education of Manual Therapists located in Colorado.

The Travell Series is comprised of an 80 hour course on myofascial trigger points and a 36 hour course on dry needling. The course is designed for licensed healthcare practitioners including acupuncturists.[3] The dry needling course offered by the Global Education of Manual Therapists is a 27.5 introductory course with an option for another 27.5 level two seminar.[4]

Licensed acupuncturists typically receive at least 3000 hours of education.[5] The dry needling courses currently being offered, including the Travell Series and the courses offered by the Global Education of Manual Therapists not only allow physical therapists to use needles on patients without sufficient training, but constitutes a public health hazard.

California, Hawaii, New York, North Carolina, and Tennessee, all prohibit physical therapists from performing dry needling. In addition, the state of Florida disallows physical therapists from using any technique which ruptures the skin.

In California, physical therapists recognize that invasive procedures clearly move beyond the scope and training of physical therapy and in some instances hire licensed acupuncturists to treat patients. Many physical therapists respect the fact that use of needles is both an invasive procedure beyond the professional scope of physical therapy and directly related to the practice of acupuncture.

According to Ben Massey Jr., PT, MA, the Executive Director of the North Carolina Board of Physical Therapy Examiners, "Dry needling is a form of acupuncture. In North Carolina, a

[2] Hobbs, Valerie, DiplOM, LAc, *Dry Needling and Acupuncture Emerging Professional Issues*
[3] http://www.myopainseminars.com/seminars/travell/index.html
[4] http://www.gemtinfo.com/physical-therapy/Trigger-Point-Dry-Needling-Level-II-Training/page18.html
[5] http://aaaonmonline.org/pressroom.asp?pagenumber=48266

practitioner who performs acupuncture must have a license from the North Carolina Board of Acupuncture."[6]

Illinois defines "acupuncture" as "the evaluation or treatment of persons affected through a method of ***stimulation of a certain point or points on or immediately below the surface of the body by the insertion of pre-sterilized, single-use, disposable needles***... "[7] (Emphasis added). As discussed above, dry needling focuses on releasing muscle tension by treating specific trigger points, alleviating nerve tissue irritation by reducing the nerve impulse, or stimulating local blood supply where it may be naturally poor. As such, dry needling falls squarely within the Illinois definition of "acupuncture" as it involves the insertion of needles on the surface of the body to stimulate specific points.

Physical therapy state boards of Maryland, New Mexico, New Hampshire and Virginia have determined that dry needling falls within the scope of physical therapy in those states. However, the Illinois statute defining "acupuncture" is distinguishable from these states' statute.

For example, the New Mexico Acupuncture and Oriental Medicine Practice Act defines acupuncture as "the use of needles inserted into and removed from the human body for the prevention, cure or correction of any disease, illness, injury, pain, or other condition by controlling and regulating the flow and balance of energy and functioning..."[8]

Proponents of the addition of dry needling to the scope of physical therapy point out that dry needling is not to control and regulate the flow and balance of energy and is not based on Eastern esoteric and metaphysical concepts. As such, based on the definition of "acupuncture" as set forth in the New Mexico Acupuncture and Oriental Medicine Practice Act, the physical therapy state board determined that dry needling falls within the scope of physical therapy practice.

However, unlike the New Mexico statute, 225 ILCS 2/10 is not narrowly tailored to limit the practice of "acupuncture" to the control and regulation of the flow and balance of energy and functioning.

Moreover, the Illinois Physical Therapy Act does not provide for any statutory authority to physical therapists to perform dry needling.[9] In fact, 225 ILCS 90/1 provides that "Physical Therapy" means the following:

> (A) Examining, evaluating, and testing individuals who may have mechanical, physiological, or developmental impairments, functional limitations, disabilities, or other health and movement-related conditions, classifying these disorders, determining a rehabilitation prognosis and plan of therapeutic intervention, and assessing the on-going effects of the interventions.

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[6] http://aaaonmonline.org/pressroom.asp?pagenumber=48266
[7] 225 ILCS 2/10
[8] New Mexico Statutes Annotated 1978, Chapter 61, Professional and Occupational Licenses, Article 14A, Acupuncture and Oriental Medicine Practice 3, Definitions
[9] 225 ILCS 90/ et seq.

(B) Alleviating impairments, functional limitations, or disabilities by designing, implementing, and modifying therapeutic interventions that may include, but are not limited to, the evaluation or treatment of a person through the use of the effective properties of physical measures and heat, cold, light, water, radiant energy, electricity, sound, and air and use of therapeutic massage, therapeutic exercise, mobilization, and rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental impairment, functional limitation, or disability.

(C) Reducing the risk of injury, impairment, functional limitation, or disability, including the promotion and maintenance of fitness, health, and wellness.

(D) Engaging in administration, consultation, education, and research.

Physical therapy includes, but is not limited to: (a) performance of specialized tests and measurements, (b) administration of specialized treatment procedures, (c) interpretation of referrals from physicians, dentists, advanced practice nurses, physician assistants, and podiatrists, (d) establishment, and modification of physical therapy treatment programs, (e) administration of topical medication used in generally accepted physical therapy procedures when such medication is prescribed by the patient's physician, licensed to practice medicine in all its branches, the patient's physician licensed to practice podiatric medicine, the patient's advanced practice nurse, the patient's physician assistant, or the patient's dentist, and (f) supervision or teaching of physical therapy. Physical therapy does not include radiology, electrosurgery, chiropractic technique or determination of a differential diagnosis; provided, however, the limitation on determining a differential diagnosis shall not in any manner limit a physical therapist licensed under this Act from performing an evaluation pursuant to such license. Nothing in this Section shall limit a physical therapist from employing appropriate physical therapy techniques that he or she is educated and licensed to perform. A physical therapist shall refer to a licensed physician, advanced practice nurse, physician assistant, dentist, or podiatrist any patient whose medical condition should, at the time of evaluation or treatment, be determined to be beyond the scope of practice of the physical therapist.

For the Illinois Physical Therapy Licensing and Disciplinary Committee to determine that dry needling falls within the scope of practice for its physical therapists means that the Illinois Physical Therapy Licensing and Disciplinary Committee is ignoring 225 ILCS 2/10 defining "acupuncture" and making a policy to include dry needling by a rule, rather than the physical therapy profession having to sponsor and pass a bill that explicitly changes state physical therapy law.

Additionally, the Illinois Physical Therapy Licensing Board's reliance on 225 ILCS 90/1, Paragraph D that provides "[n]othing in this Section shall limit a physical therapist from employing appropriate physical therapy techniques that he or she is educated and licensed to perform"[10] to justify that dry needling is within in scope of physical therapy is not only overreaching but almost irresponsible and dangerous. The Illinois Physical Therapy Act does not provide further standards or guidelines regarding dry needling education and/or certification. As such, it is impossible to determine what is considered "qualified education and experience" in dry needling. As stated above, to allow physical therapists to use needles on patients without sufficient training, but constitutes a public health hazard.

Based on the foregoing, NCC will not provide malpractice insurance for any physical therapist who inserts needles and/or utilizes the technique of dry needling.

Thank you for your professional courtesies in this regard. Should you have any further questions or concerns, please do not hesitate to contact me.

Sincerely yours,

Michael J. Schroeder
Vice-President and General Counsel

[10] 225 ILCS 90/1, Paragraph D

EXHIBIT A

M E M O R A N D U M

TO: PHYSICAL THERAPY LICENSING AND DISCIPLINARY COMMITTEE
Barbara J. Sullivan, P.T., Chairperson
Ricardo A. Fernandez P.T. Member
Diane M. Davis, P.T. Member
Mary T. Keehn, P.T. Member
Patricia Y. Naylor, P.T. Member
Greg Monson, P.T. Member
Kiran Desai, Public Member

FROM: Cheryl Fox, Board Liaison
Health Services Section

DATE: March 3, 2011

SUBJECT: Business Meeting - March 15, 2011

The Physical Therapy Licensing and Disciplinary Committee will convene for a meeting commencing at **10:30 a.m.** on **Tuesday, March 15, 2011,** in the Springfield office of this Department, 320 W. Washington St., **3rd floor**, for the purpose of conducting a business meeting.

Please contact me at 217/557-5633 if you are unable to attend to ensure a quorum is present. The agenda is herewith attached.

This meeting will be accessible to disabled individuals in compliance with Executive Order #5 and pertinent state laws upon notification of anticipated attendance. Disabled persons planning to attend and needing special accommodations should contact me at 217/557-5633 five days prior to the meeting to inform me of their anticipated attendance.

CF

ILLINOIS PHYSICAL THERAPY

LICENSING AND DISCIPLINARY COMMITTEE

AGENDA

MARCH 15, 2011

I. CHAIRPERSON TIME
   A. Fox Valley Program Graduates
   B. Issue regarding Naprapaths becoming licensed Physical Therapists

II. BOARD DISCUSSION TIME

III. UPDATE ON THE FSBPT ANNUAL MEETING

IV. UPDATE ON THE "DRY NEEDLING" ISSUE

V. RULES REVIEW

VI. APPLICATION REVIEW

EXHIBIT B

ILLINOIS PHYSICAL THERAPY ASSOCIATION IPTA

Autonomous Practice | Direct Access | Doctor of Physical Therapy | Evidence-Based Practice | Practitioner of Choice | Professionalism

A Chapter of the American Physical Therapy Association
300 E 5th Avenue • Suite 430 • Naperville, Illinois 60563
630/904-0101 • Fax: 630/904-0102

May 6, 2011

Lesley Poladsky
Kinetacore
2418 E. Bridge Street
Brighton, CO 80601

Dear Ms. Poladsky,

The Continuing Education Committee of the Illinois Physical Therapy Association (IPTA) has reviewed your request for Continuing Education Approval and contact hours. Based on the data you submitted, your request has been approved.

Course Name	Course Date	Approved CE Hours	Approval Period*
555-3830 Intramuscular manual therapy: Management of the Neuromuscular System Application for Pain Management & Sports Injuries	Multiple Dates	27	5/1/2011 – 5/1/2012

* Please note that this approval is effective for one year from the initial course offering date stated on your application, as noted above, which allows you to offer the course for CE credit at any time during the approval period. **In order to ensure that subsequent offerings are recognized for credit, it is your responsibility to notify IPTA if you decide to offer the course on dates that are not included on the original application.**

The following statement must be shown on course certificate issued to participants:
"The Illinois Chapter Continuing Education Committee has certified that this course meets the criteria for approval of Continuing Education offerings established by The Illinois Physical Therapy Association."

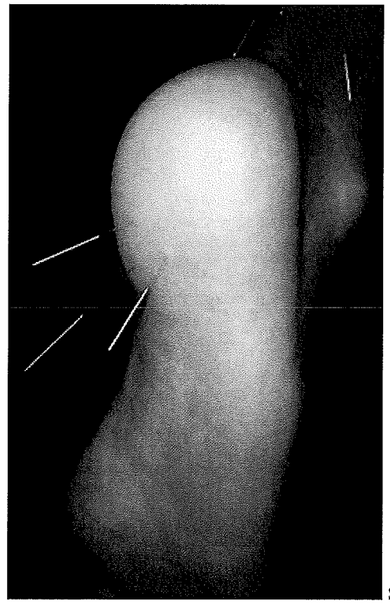
Thank you for contacting the IPTA. If we can be of further assistance, please do not hesitate to contact us.

Sincerely,

Linda L Miller

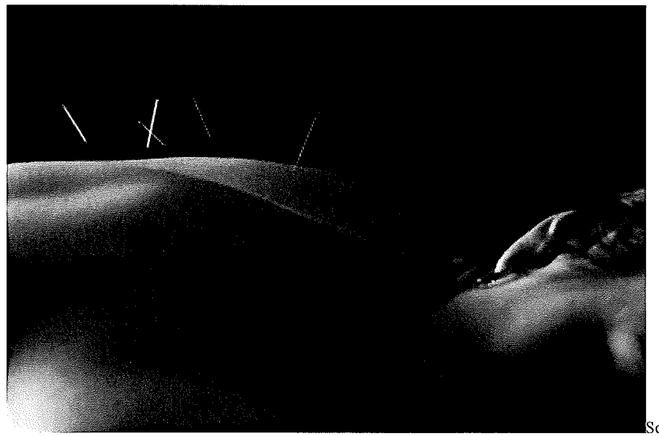
Linda Miller
Education & Event Coordinator

The term "Dry Needling" is a rebranding of Acupuncture. By looking at the following images it is easy to see this simple truth, and also why the two terms are so confusing to members of the general public who don't know there is a difference in training between someone who provides this:



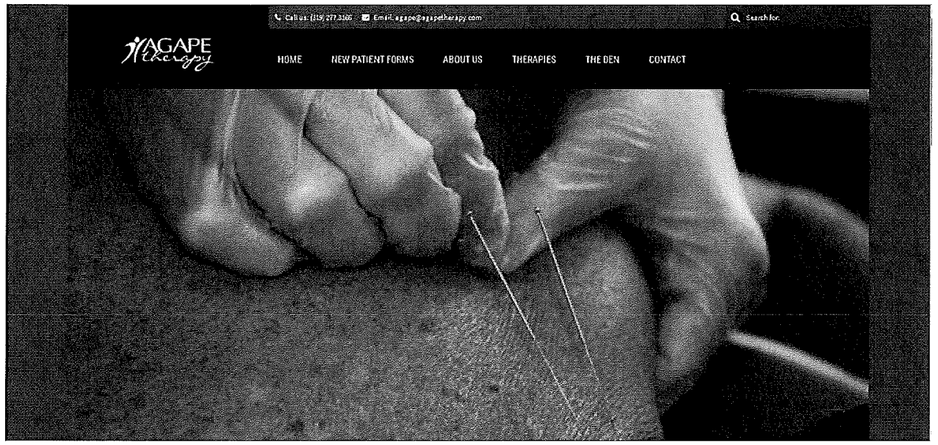
Source: http://www.grovespinesports.com/Services/dryNeedling.html

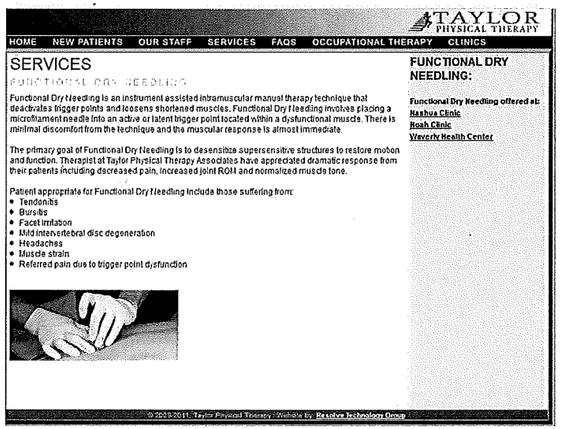
And this:



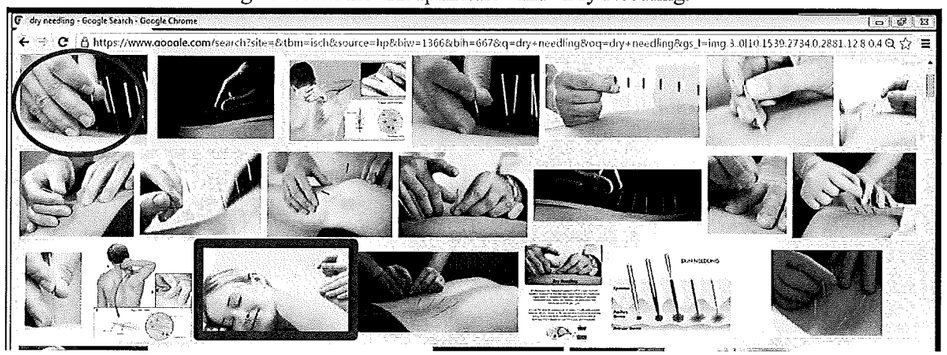
Source: www.midwestacupunctureclinic.com

Here are some more photos of "dry needling" on Physical Therapist websites:

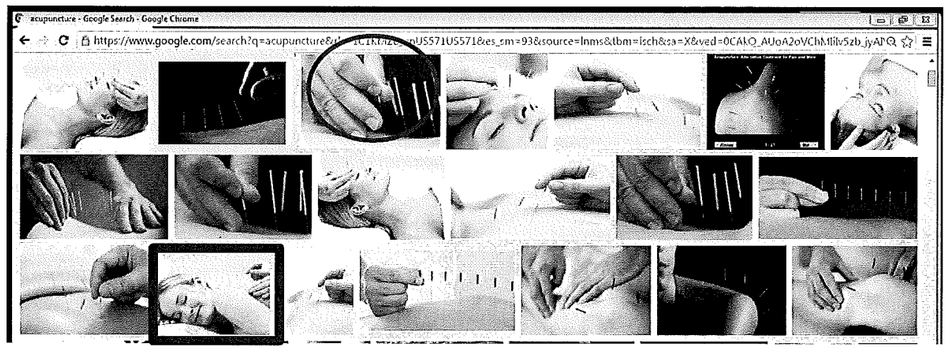




And here are the search engine results for "Acupuncture" and "Dry Needling."



Can you tell which results come from which search? Some photos are the **exact same.**



"Dry Needling" is an illegal and misleading rebranding of Acupuncture.

THE SAFE USE OF DIFFICULT & DANGEROUS ACUPUNCTURE POINTS

by Alicia Grant & Prof. Bo-Ying Ma

Safety is an important area of both public and medical concern. Following the vigorous growth of acupuncture in the west, more attention has been paid to recent reviews of adverse events. This does not need to surprise us; as far back as the Tang dynasty in China a famous author Wang Tao wrote a book called *Wai Tai Mi Yao* (A Medical Selection from the Secret Collection of the Royal Library). One sentence reads "Needles can kill people but cannot save dead peoples' lives". Later many scholars criticised this sentence because Wang Tao was a director of the Royal Library and not an acupuncturist. In fact it was not his 'invention' - it is a quote from the *Ling Shu* (chapter 60). This sentence was intended to warn practitioners to be careful to use needles safely and to learn TCM theory and technique in its entirety - it does not mean acupuncture is dangerous or useless.

However, there are some acupuncture points which are difficult and potentially dangerous to needle if one does not have a good technique. In the past, textbooks had no special chapter listing such points. Only two relatively modern books, each called "The Prevention and Treatment of Acupuncture Accidents", published in Chinese in 1988 and 1996, contain one chapter on the acupoints in ancient Chinese acupuncture books that some doctors regarded as requiring special caution. Our paper aims to explain clearly how to use these points safely. A knowledge of anatomy and pathology is essential. Good technique includes the exact angle and accurate depth of insertion. This can avoid many accidents.

From the anatomical viewpoint

In general a dangerous acupoint means that it is near important organs, nerves or arteries.

The head and face area

• Jingming BL-1 is near the ophthalmic and angular arteries and veins. With the eye closed the patient is asked to look laterally away from the side being needled, the eyeball is gently rolled aside and held with one hand and the needle inserted 0.3-0.5 cun perpendicularly along the orbital wall. No manipulation is performed.

• Chengqi ST-1 has branches of the infra-orbital and ophthalmic arteries and veins. Insertion is perpendicular, 0.3-0.5 cun along the infra-orbital ridge, and before insertion the patient is asked to look upwards and the eyeball is gently pressed upwards with a finger of the practitioner's other hand. The extra point Qiuhou (M-HN-8) is often used in preference. No manipulation is performed.

• Tinghui GB-2, Ermen SJ-21 and Tinggong SI-19 are near the auricular branches of the superficial temporal artery and vein. Palpate to feel the pulse so that it may be avoided, and needle to a depth of 0.3-0.5 cun.

• Some acupoints are near the medulla oblongata, e.g. Fengchi GB-20, Fengfu DU-16 and Yamen DU-15. At Fengchi GB-20 insertion should be perpendicularly 0.5-1.0 cun towards the tip of the nose. For the other two potentially dangerous points, insertion is perpendicular to the same depth. Deeper insertion could cause loss of consciousness and the needle, if angled towards one side, may injure the vertebral artery, causing headache and dizziness.

The neck

• Renying ST-9 lies very close to the carotid body and the carotid sinus. Interference with the former will affect respiration and with the latter cause a lowering of blood pressure which may lead to loss of consciousness. Insertion should be perpendicular to a depth of 0.2-0.4 cun.

• Tianrong SI-17 is close to the common carotid artery, which should be palpated and pressed aside. Insertion is perpendicular 0.3-0.5 cun.

• Tiantu REN-22 lies in front of the trachea and the needle is first inserted perpendicularly in the middle of the suprasternal fossa 0.2-0.4 cun. If the trachea were perforated it would produce a strong cough but not a pneumothorax. The needle may then be directed downwards along the posterior aspect of the sternum to a depth of 0.5-1.0 cun. If it should be angled sideways however, it could touch either the lung, resulting in a pneumothorax, or the aorta, producing haemoptysis with possible fatal consequences.

The chest

The lung in a thin person lies 10-20mm under the skin and there is danger of pneumothorax if the needle punctures the lung or pleural cavity. There are 90 incidents of this in the literature. The following points need special care because if the angle and depth are not correct the lung may be punctured.

• Jianjing GB-21. On the anterior aspect of the chest (at the mid-clavicular line) the pleural cavity extends down to the 8th intercostal space, and the upper lobe of the lung rises into the supra-clavicular fossa on inspiration. Although Jianjing GB-21 is usually needled perpendicularly to a depth of 0.3-0.5 cun, the authors prefer to pick up the trapezius muscle and insert the needle obliquely, then release the muscle, especially with emaciated patients.

• Quepen ST-12 and the adjacent extra point Jingbi (M-HN-41)[1] lie near the lung and are needled obliquely and posteriorly to a depth of 0.2-0.4 cun.

• Zhongfu LU-1 and Yunmen LU-2 lie just outside the lung but oblique insertion towards the lateral aspect of the chest is recommended to a depth of 0.5-0.8 cun.

• Tianchi P-1 is inserted obliquely only 0.2-0.4 cun.

• Riyue GB-24 is inserted obliquely 0.3-0.5 cun.

• Points Bulang KID-22 to Shufu KID-27, Shidou SP-17 to Zhourong SP-20 and Qihu ST-13 to Rugen ST-18 should be needled obliquely laterally to a depth of 0.3-0.5 cun.

• On the axillary line, laterally, the pleural cavity extends down to the 10th intercostal space. All points over this area should be needled obliquely to a depth of 0.3-0.5 cun, for example Dabao SP-21, Yuanye GB-22 and Zhejin GB-23.

The back

• On the posterior chest (back), under the thoracic spine, the pleural cavity extends to the twelfth rib at the lateral border of the erector spinae muscles, and this includes acupoints on both Bladder channel lines, namely Dazhu BL-11 to Weishu BL-21 and Fufen BL-41 to Weicang BL-50, which should be needled obliquely 0.3-0.5 cun. Similar care needs to be taken with acupoints Sanjiaoshu BL-22 to Shenshu BL-23 and Huangmen BL-51 to Zhishi BL-52 as these lie over the kidney area of the back.

• On the Small and Large Intestine channels, Jianwaishu SI-14, Jianzhongshu SI-15 and Jugu L.I.-16 lie over the lung and should therefore be needled obliquely to a depth of 0.3-0.6 cun.

The abdomen

In general, points on the abdomen are safe when not needled more than 0.5-0.8 cun deep. When the urinary bladder is full, deep needling at points Qugu REN-2 and Zhongji REN-3, and even Guanyuan REN-4, Shuidao ST-28, Guilai ST-29, Henggu KID-11, Dahe KID-12 and Qixue KID-13 may penetrate the bladder causing risk of infection. Wherever possible the patient should be asked to empty the bladder before needling. In cases of urinary retention scrupulous clean needle technique should be observed.

Infants

The top of the head should not be needled before the anterior fontanelle has closed (at up to 2 years old).

Blood vessels

It is advisable to palpate before needling to avoid certain blood vessels e.g. the radial artery at the wrist at Taiyuan LU-9, the dorsal pedal artery at the foot at Chongyang ST-42 (Chongyang), the superficial temporal artery at the ear at Tinghui GB-2, Ermen SJ-21 and Tinggong SI-19, the carotid artery at the neck at Renying ST-9 and the angular artery near the eye at Jingming BL-1. Also, when needling Jiquan HE-1 the axillary artery should first be palpated to avoid puncturing it. Insertion is perpendicular, 0.5-1.0 cun.

Anatomical aberrations

• Sternum: 5-8% of people in the western world have a sternal foramen, which may lie beneath the point Shanzhong (Tanzhong) REN-17. This does not show on X-ray but only on a CT scan, nor is it palpable as it is covered by a thin layer of membrane. Penetration through the sternal foramen may lead to a cardiac tamponade; seven instances have been recorded, including one fatal case in Norway. The needling depth for Shanzhong REN-17 should be no greater than 2 cm using horizontal (transverse) needling technique.

• Blood vessels: when palpating for the radial artery before needling Taiyuan LU-9, it may be found to be absent in a small minority of subjects. This is usually due to an anatomical aberration whereby the radial artery has bifurcated and the larger branch is then palpable between Lieque LU-7 and Yangxi L.I.-5. In TCM this is called "fan guan mai".

From a physiological viewpoint

• Pregnancy: Do not needle Sanyinjiao SP-6, Hegu L.I.-4 and Kunlun BL-60 at any stage of pregnancy unless the patient is overdue and the purpose is to induce labour. Zhiyin BL-67 should also not be needled during pregnancy unless you want to turn a foetal breech position at 32+ weeks.

In the *Lei Jing Tu Yi* (by the Ming Dynasty author Zhang Jing Yue) it was mentioned that Jianjing GB-21 should not be used during pregnancy, but is indicated for difficult labour. In 1981 an article in the journal *Jiang Xi Zhong Yi Yac*[2] reported that Jianjing GB-21 was very successful for preventing vomiting, including morning sickness - using only that single point. In our experience Jianjing GB-21 is effective for morning sickness but we would only recommend that it be used by an experienced acupuncturist when other methods have failed.

During the first 3 months of pregnancy do not needle points on the lower back such as Baliao (Shangliao BL-31 to Xialiao BL-34), and avoid using the auricular point Uterus (Zigong). After the third month do not needle points on the lower back or abdomen, such as Qugu REN-2, Zhongji REN-3 and Tianshu ST-25, and in addition after the fifth month avoid points Xiawan REN-10 to Zhongwan REN-12, although the latter may be needled, with shallow insertion and no manipulation, for stomach pain.

In Chinese textbooks since the 1980s it has been emphasised that Sanyinjiao SP-6, Hegu L.I.-4, Kunlun BL-60, Jianjing GB-21, Qugu REN-2, Zhongji REN-3 and auricular point Uterus, which are all contraindicated in pregnancy, should also be avoided during menstruation unless one is actually treating an abnormal menstrual condition.

• Weak, debilitated, hungry, thirsty or stressed patients have an increased tendency to faint. Allow them to rest, eat or drink first. Avoid using strong points such as Fengchi

GB-20, Quchi L.I.-11, Hegu L.I.-4 and Zusanli ST-36 and avoid manipulation of the needle.

Any patient may faint in response to needling. When inserting needles the practitioner should observe the patient's face for tell-tale signs of pallor or sweating and all patients should be asked to report if they feel nauseous or dizzy. All patients are preferably treated on a treatment couch, lying or supported in a sitting position, both because they will be less likely to faint when supine and because the first action in case of fainting must be to remove the needles, and this can be difficult if they have slumped to the floor from a chair. They may also injure themselves falling. If faintness is reported or observed, the top of the treatment couch can be quickly lowered, increasing circulation to the head.

From a pathological viewpoint

• Bleeding tendency: this may occur with patients on warfarin or else on long-term cortisone treatment which thins the skin. Haemophilia is a total contraindication to acupuncture. As far as cortisone is concerned, in our experience, injections of a cortico-steroids into a joint will render acupuncture of that joint ineffectual for several weeks

• Scrupulous clean needle technique should be observed when needling points in the potentially dangerous triangle formed by Yintang (M-HN-3) and bilateral Dicang ST-4, as well as at Jingming BL-1, especially when treating facial skin infections such as acne. If the posterior wall of the frontal sinus is infected, infections of the central nervous system can result. This invasion may occur through direct invasion of venous channels and can spread to the skull by septic thrombophlebitis via the valveless veins of Brechet and can be life-threatening. In the area of Jingming BL-1 veins link to the cerebral veins. In western medicine the triangular area bordered by the middle of the eyebrows and the corners of the mouth - approximating to Yintang (M-HN-3) and Dicang ST-4 - is regarded as especially susceptible to the introduction of infection via the veins.

• Enlarged organs: the liver, spleen, gall bladder, kidney and heart may all be enlarged due to disease, and all practitioners should have sufficient training in palpation to determine if this is so. When the liver or spleen are enlarged, take care with Jiuwei REN-15, Juque REN-14, Jingmen GB-25, Qimen LIV-14, Burong ST-19, Chengman ST-20 and Liangmen ST-21, which in this case should be punctured obliquely 0.3-0.5 cun. The kidney, if not greatly enlarged, will not be endangered by needling nearby points at a correct depth. If greatly enlarged, the patient's pathology will reflect this, and extreme caution should be exercised with local and adjacent needling.

• Epidemic disease: here it is the acupuncturist who needs to take care not to contract the patient's disease, e.g HIV or hepatitis B and C, by accidentally pricking themselves when removing the needles.

• Patients with pacemakers may not be given electro-acupuncture to the chest area.

• The following points may cause faintness in some people: Zhongzhu SJ-3, Waiguan SJ-5, Hegu L.I.-4, Quchi L.I.-11, Shousanli L.I.-10, Jianyu L.I.-15, Renying ST-9, Tianzong SI-11, Tianjing SI-13, Jianwaishu SI-14, Fengchi GB-20, Jianjing GB-21, Yanglingquan GB-34 and the auricular point adrenal. This is usually because they have a strong sensation or are particularly sensitive.

Causes of risk

From consideration of the above guidelines and from analysing reports of accidents with acupuncture, we can define the following main risk factors:

- inadequate training in acupuncture
- limited knowledge of anatomy or of certain physiological or pathological conditions
- failure to check for abnormal anatomy
- poor needling technique (depth and angle or stimulating too strongly)
- inadequate knowledge of records in ancient books or recent articles
- not paying attention to the patients' condition when they arrive

Safety can be guaranteed

The principle is to understand and remember why a point can be dangerous; every risk can be avoided if due care is taken. There is no need to be apprehensive: the British Acupuncture Council recently surveyed 34,407 treatments for adverse effects[3]. There was an underlying serious adverse effect rate of between 0 and 1.1 per 10,000 treatments. A total of 43 minor adverse effects were reported, a rate of 1.3 per 1,000. A survey by Exeter University of 31,822 treatments by members of BMAS (British Medical Acupuncture Society) and the AACP (Acupuncture Association of Chartered Physiotherapists) also resulted in 43 minor adverse effects[4]. Among the 43 adverse effects reported by each, most complaints were of a few common short-term symptoms that usually automatically disappeared, some of which are really regarded by acupuncturists as positive, such as a feeling of relaxation (11% of the 43) and feeling energised (6.6%). However even if acupuncture is so demonstrably safe we still need to be cautious for the patients' benefit and should remember that unexpected accidents have occurred. By avoidance of the risk factors, safety can be guaranteed.

Regarding needling technique, we would like to emphasise the following:

• Check that the needles are not in close proximity to organs or arteries.

• Consider the patient's build with regard to depth of needling. It is noted in the *Huang Di Nei Jing* (Yellow Emeror's Classic of Internal Medicine) that the recommended depth of insertion is for a patient of average build. All cun measurements refer of course to the patient's cun, not the acupuncturist's, who should check their hands against the patient's.

• If it is possible for the needle to touch a bone at a special

point, e.g. Shanzhong REN-17 but it has not done so at the normal recommended anatomical depth, do not insert deeper: this is how the cardiac tamponade accident occurred in Norway. This also applies to Tianzong SI-11 as the scapula can also have a foramen.

• If the skin is lifted on insertion of the needle, penetration of the organ can be avoided.

• On the chest and back over the lung the angle of insertion is oblique or horizontal. The tip of the needle is usually directed obliquely towards the midline on the urinary bladder channel and obliquely and laterally on all other channel points passing over the trunk.

• When needling points around the eye, the patient is asked to look in the opposite direction to the point being needled and the practitioner gently holds the eyeball in that position while carefully inserting the needle. The needle is not retained for very long.

• Points near arteries should be palpated to ascertain the exact position of the artery and one finger should press against the artery while the other hand inserts the needle. Following the above techniques will ensure that your practice will be safe and effective.

Notes

1 Jingbi M-HN-41 is located 1 cun superior to the junction of the medial third and lateral two thirds of the clavicle, at the posterior borer of the sternocleidomastoideus.

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Public Protection Through Quality Credentials

June 13, 2011

Mary J. Rogel, Ph.D., Dipl. Ac. (NCCAOM), L.Ac.
Chairperson
Illinois Board of Acupuncture
James R. Thompson Center
100 W. Randolph St., Suite 9-300
Chicago, IL 60601

Dear Dr. Rogel:

It has come to our attention that your office is reviewing whether an acupuncture technique known as "dry needling" falls within the definition of the practice of physical therapy in the state of Illinois. As the only national organization that has its certification programs accredited by the National Commission for Competency Assessment (NCCA), the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM®) assures entry-level competency of individuals entering the profession of acupuncture and Oriental (AOM) medicine. The NCCAOM; therefore, has serious concerns regarding any regulation that allows physical therapists (PTs) without proper training and assessment to practice any form of acupuncture, including dry needling.

Dry needling has been defined as a form of acupuncture by NCCAOM certified and licensed practitioners who use it as part of their medicine. Illinois requires acupuncturists who practice dry needling and other forms of acupuncture to meet recognized standards of competence and safety through a rigorous competency verification process to include completing education from a school accredited by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) and the passing of three separate NCCAOM examinations for the Certification of Acupuncture.

The mission of the NCCAOM 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. In order to fulfill this mission, NCCAOM has developed a certification process that provides a unified set of nationally verified, entry-level standards for safe and competent

practice. It is with this high level of standards that certified acupuncturists are qualified to practice dry needling. Unlike certified acupuncturists who received thousands of hours of training in many methods of acupuncture, PTs do not have a required curriculum for teaching dry needling to PTs. In addition, PTs do not have to successfully complete any assessments for the safe and competent practice of dry needling. This insufficient education and lack of an assessment of competence is not representative of the training that is necessary for the entry-level competence for any form of acupuncture, including dry needling. In fact, any new rule based on this lack of standards would directly contradict the licensing requirements that already exist in Illinois related to regulating the practice of acupuncture. Existing requirements for licensed acupuncturists include completion of an *accredited* education program and achieving NCCAOM Certification in Acupuncture, which includes passing examinations in Acupuncture with Point Location, Foundations of Oriental Medicine, and Biomedicine as well as documentation of an assessment-based clean needle technique certificate.

We consider the NCCAOM standards of eligibility, as well as successful performance on the examinations, to be the minimum requirements for the safe practice of all forms of acupuncture including dry needling. The level of competence accomplished by those completing the didactic, clinical, and practice hours attained by certified and licensed practitioners cannot be matched by those who would be practicing this form of acupuncture with hardly any training or assessment in this field. The practice of dry needling is more than merely placing needles at various points for different conditions. For this reason, the years of education and training that have been specified must be completed before a full comprehension of acupuncture diagnoses and treatments can be attained, and it is only from such a knowledge base that acupuncture's full efficacy and value can be realized by the public.

The NCCAOM is pleased to see that the great state of Illinois recognizes the need for adequate licensing procedures for all health care practitioners. Clearly, acupuncture, dry needling and other complementary and alternative therapies will be part of the health care landscape in years to come, as evidenced by recent studies and recommendations by the National Institutes of Health. It is the sincere hope of the NCCAOM that, in the interest of public welfare, the Illinois

Division of Professional Regulation will recognize established standards of professional competence in the practice of acupuncture and Oriental medicine in Illinois for the safety of its consumers. We highly recommend that physical therapists meet the *same* standard for education and examination that licensed acupuncturists must meet in order to practice safely and effectively in the state of Illinois.

I hope you will find this information valuable. Please consider the NCCAOM as a resource for current information about the standards of competence and practice within the field of acupuncture and Oriental medicine. Please feel free to contact me by phone 904-674-2501 or by email, kwardcook@thenccaom.org, if I can offer further information on this topic.

Sincerely,

Kory Ward-Cook

Kory Ward-Cook, Ph.D., MT(ASCP), CAE
Chief Executive Officer

cc: NCCAOM Board of Commissioners
Illinois Association of Acupuncture and Oriental Medicine