NORTH CAROLINA MEDICAL SOCIETY
HOUSE OF DELEGATES

RESOLUTION 1
(2014)

Subject: The Electronic Discontinuation of Medications

Introduced by: Sampson County Medical Society

Referred to: Reference Committee No. 1
Timothy M. Beittel, MD, Chair

WHEREAS, medication reconciliation is a common source of errors in patient care that leads to adverse outcomes; and

WHEREAS, there is no standard electronic way to communicate new medication allergies to a pharmacy or from a pharmacy to provider; and

WHEREAS, many times a patient will duplicate medications, continue medicines they are allergic to, or take medications that have been discontinued due to detriments to their care only because a pharmacy refills the medication automatically; and

WHEREAS, electronic prescribing has helped ease refill burdens and improved communication with pharmacies for most providers; and

WHEREAS, there does not exist a simple means of discontinuing medications at a pharmacy aside from direct phone call; therefore be it

RESOLVED, That the North Carolina Medical Society supports the development of a standardized, electronic method for the communication of the allergies to medications and/or the discontinuation of medications between the provider and the patient's pharmacy to improve medication reconciliation and patient safety ***(policy)***, and be it further

RESOLVED, That the North Carolina Medical Society request that the AMA, the American Pharmacists Association, and other appropriate, interested parties work together to develop a method to allow healthcare providers the ability to discontinue medications electronically, as well as report allergies to medications electronically or through e-prescribing, for the improved safety of patients ***(action)***.

Fiscal Note: $2,500 expected commitment to issue advocacy. Current resources will be allocated based on the priorities of the Society and the NCMS budget.

NORTH CAROLINA MEDICAL SOCIETY
HOUSE OF DELEGATES

RESOLUTION 2
(2014)

Subject: Adult Tdap Vaccination Coverage

Introduced by: Sampson County Medical Society

Referred to: Reference Committee No. 1
Timothy M. Beittel, MD, Chair

WHEREAS, due to the current increase in cases, Tdap (Tetanus, Diptheria, acellular Pertussis) vaccination is now recommended for all adults who have not had the vaccination; and

WHEREAS, the Centers for Disease Control and Prevention and the Advisory Committee Immunization Practices recommend all adults receive the Tdap vaccination, including as a pertussis booster, to protect themselves and their young family members from whooping cough; and

WHEREAS, the North Carolina Medical Society has existing policy supporting requirements for health plans to provide full coverage and reimbursement for all vaccines recommended by the CDC's Advisory Committee on Immunization Practices, including reimbursement for both the vaccine produce and appropriate administration fees; and

WHEREAS, physicians have become frustrated with access limitations to the vaccine because it is considered to be a tetanus vaccine and often requires a cut or scrape for payer coverage, including by Medicare; and

WHEREAS, a discrepancy exists between the recommendations of the CDC and ACIP and the insurance coverage of the Tdap vaccination, causing missed opportunities for patients to protect themselves and children from pertussis; and

WHEREAS, there has been a recent increase in the number of pertussis cases in North Carolina due to a lack of vaccination of adult patients as well as increased exposure to the infection; and

WHEREAS, unvaccinated grandparents and older adults still interact with babies; therefore be it

RESOLVED, that the North Carolina Medical Society work with the AMA, Medicare, and private insurers to obtain Tdap vaccination coverage for adults that need the pertussis booster, regardless of having a skin break, laceration, or abrasion ***(action).***

Fiscal Note: $2,500 expected commitment to issue advocacy. Current resources will be allocated based on the priorities of the Society and the NCMS budget.

NORTH CAROLINA MEDICAL SOCIETY
HOUSE OF DELEGATES

RESOLUTION 3
(2014)

Subject: Prior-Authorization Process

Introduced by: Robert Yapundich, MD
Delegate, Region 4 Representative

Referred to: Reference Committee No. 1
Timothy M. Beittel, MD, Chair

WHEREAS, the current prior-authorization process is very burdensome for the healthcare provider; and

WHEREAS, the general administrative cost of dealing with health plans is a major and growing factor in the cost of medical care, with prior studies documenting the cost of staff interacting with health plans at greater than $100,000 per physician per year; and

WHEREAS, the handling of prior-authorizations alone requires one full-time staff person to support every three physicians, in addition to the time spent by physicians and other staff; and

WHEREAS, each and every insurer, managed care plan, or other program has different and sometimes multiple prior-authorizations forms for their enrollee's health care services and/or drug authorizations; therefore be it

RESOLVED, That the North Carolina Medical Society opposes the use of the prior-authorization process as a method of allocating health care resources; ***(policy)*** and be it further

RESOLVED, That until the prior-authorization process can be eliminated, the North Carolina Medical Society supports a single, standardized prior-authorization form for all pertinent health plans in North Carolina; ***(policy)*** and be it further

RESOLVED, that the North Carolina Medical Society supports integral physician involvement in the development of value-based systems of care that obviate payer involvement in decisions related to medical care delivery. ***(policy)***

Fiscal Note: No additional funding above current resources estimated. Current resources will be allocated based on the priorities of the Society and the NCMS budget.

1) Dante Morra, Sean Nicholson, Wendy Levinson, David N. Gans, Terry Hammons and Lawrence P. Casalino. US Physician Practices Versus Canadians: Spending Nearly Four Times As Much Money Interacting With Payers. Health Affairs, 30, no.8 (2011):1443-1450. (published online August 3, 2011; 10.1377/hlthaff.2010.0893)

NORTH CAROLINA MEDICAL SOCIETY
HOUSE OF DELEGATES

RESOLUTION 4
(2014)

Subject: Reimbursement for Inpatient Smoking Cessation Specialists

Introduced by: The Greater Greensboro Society of Medicine

Referred to: Reference Committee No. 1
Timothy M. Beittel, MD, Chair

WHEREAS, cigarette smoking is the largest cause of preventable death in the US, impacting greatly on the four leading causes of death; and

WHEREAS, hospitalized patients, often facing a new diagnosis or exacerbation of a known diagnosis, are more open to make a quit attempt, and the smoke free environment gives them a running start; and

WHEREAS, evidence shows an intervention including a bedside consultation with a smoking cessation specialist, videos, brochures and at least a one month follow-up, is effective with an odds ratio of 1.5 compared to no intervention; and

WHEREAS, inpatient smoking cessation specialists perform this service have a four year degree in a health related field, and take a course and pass an examination and become certified; and

WHEREAS, hospitals, in austerity moves, are laying off smoking cessation specialists; and

WHEREAS, quitters have higher health care costs than continued smokers in the quarter before the quit date, in the quarter after the quit date, and in the first year after quitting (often due to a new diagnosis). Thereafter quitters costs are lower for the next six years; and

WHEREAS, former smokers enjoy health benefits, particularly in reduction of risk for heart disease, rapidly after quitting, compared to patients who continue smoking; and

WHEREAS, to improve population health, and to achieve goals in this era of “pay for performance,” it is urgent that smoking cessation specialists see all inpatient smokers; and

WHEREAS, there is an inadequate avenue for reimbursement, especially in Medicare patients in which hospitals are paid by “Diagnostic Related Groups” for inpatient smoking cessation specialists; therefore be it

RESOLVED, that the North Carolina Medical Society work toward gaining appropriate reimbursement for inpatient smoking cessation specialists. This may involve NCMS delegates to the AMA proposing this at the AMA meeting. It may involve collaboration with the NC Hospital Association ***(action).***

Fiscal Note: No additional funding above current resources estimated. Current resources will be allocated based on the priorities of the Society and the NCMS budget.

NORTH CAROLINA MEDICAL SOCIETY
HOUSE OF DELEGATES

RESOLUTION 5
(2014)

Subject: Transparency in Patient Communication and Apology in the Professional Context

Introduced by: The Greater Greensboro Society of Medicine

Referred to: Reference Committee No. 1
Timothy M. Beittel, MD, Chair

WHEREAS, our Society is committed to quality care, including efforts to reduce medical errors; and

WHEREAS, the AMA Principles of Medical Ethics state that "a physician shall be honest in all professional interactions"; and

WHEREAS, the US Institute of Medicine in its report, *To Err is Human*, encourages physician disclosure of medical errors; and

WHEREAS, maintaining a relationship of trust between patients and their physicians requires full disclosure of positive and adverse events, including medical errors; and

WHEREAS, the act of apology is an essential part of the process of error disclosure; and

WHEREAS, NCGS 8C-1, article 4, rule 413 provides that apology for an adverse outcome shall not be admissible in a malpractice action, but does not provide similar protection for apology that includes disclosure that a medical error has been committed; and

WHEREAS, other states including South Carolina and Georgia do provide statutory evidentiary protection for apology that includes disclosure that an error has been committed; and

WHEREAS, statutes that include protection for apologies in which a health care provider admits that a medical error has occurred will encourage disclosure of errors and will increase transparency and trust in therapeutic relationships; therefore be it

RESOLVED, That the North Carolina Medical Society work to amend the language of NCGS 8C-1 article 4, rule 413 to provide that all statements, affirmations, gestures, activities, or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error or a general sense of benevolence that are made by a physician to the patient, to a relative of the patient or to a representative of the patient, shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest ***(action).***

Fiscal Note: $20,000 expected commitment to legislative action. Current resources will be allocated based on the priorities of the Society and the NCMS budget.

NORTH CAROLINA MEDICAL SOCIETY
HOUSE OF DELEGATES

RESOLUTION 6
(2014)

Subject: Boarding of Individuals with Psychiatric Disorders

Introduced by: North Carolina Psychiatric Association
North Carolina College of Emergency Physicians

Referred to: Reference Committee No. 1
Timothy M. Beittel, MD, Chair

WHEREAS, the "boarding" of individuals with psychiatric disorders has become a growing phenomenon in North Carolina hospital Emergency Departments (EDs) and is described as the extended retention in EDs of psychiatric patients on involuntary civil commitments due to a lack of available hospital beds; and

WHEREAS, such boarding is contrary to established medical principles of respect and dignity of the individual patient, and inevitably results in compromised care; and

WHEREAS, the boarding of psychiatric patients negatively impacts individuals and families from across all socioeconomic levels and insured status; and

WHEREAS, there are a number of unstaffed and unused existing psychiatric beds in the state and the shortage of adequate acute psychiatric bed capacity is the most significant factor leading to boarding; and

WHEREAS, boarding is not imposed on non-psychiatric patients in EDs, and therefore is a discriminatory practice; and

WHEREAS, psychiatric boarding is not only a concern for Psychiatric and Emergency Medicine specialist physicians, but also the larger Medical Society in that scarce crisis resources of hospital EDs are diverted from the triage, assessment and treatment of patients in other medical emergencies; and

WHEREAS, this issue is a concern in other states, as evidenced by the recent Washington State Supreme Court decision that declared the boarding of psychiatric patients overnight after identification of need for hospital level of care as unconstitutional; therefore be it

RESOLVED, that the North Carolina Medical Society opposes the boarding of individuals with psychiatric disorders ***(policy);*** and be it further

RESOLVED, that the North Carolina Medical Society call on the North Carolina Governor and General Assembly to immediately increase availability of staffed State Psychiatric Hospital beds and fund additional psychiatric beds and units in community hospitals, with special attention to establishing high-risk psychiatric units capable of accepting complicated and aggressive patients, so as to end the current practice of psychiatric boarding ***(action)***

Fiscal Note: $20,000 expected commitment to legislative action. Current resources will be allocated based on the priorities of the Society and the NCMS budget.

NORTH CAROLINA MEDICAL SOCIETY
HOUSE OF DELEGATES

RESOLUTION 7
(2014)

Subject: North Carolina Medical Society Resolution on Expansion of Scope of Practice without Legislative Action and Statement on Dry Needling

Introduced by: New Hanover-Pender County Medical Society

Referred to: Reference Committee No. 1
Timothy M. Beittel, MD, Chair

WHEREAS, licensure laws that govern medical professions in North Carolina are under the purview of the North Carolina General Assembly; and

WHEREAS, expansion of scope of practice may only be accomplished by the approval of the North Carolina General Assembly; and

WHEREAS, expansion of scope of practice of medical professions in North Carolina without action by the North Carolina General Assembly is inappropriate and potentially dangerous to the citizens of North Carolina; and

WHEREAS, in September 2010, the North Carolina Board of Physical Therapy Examiners issued a Position Statement broadening the physical therapy scope of practice to the insertion of needles into the dermis or muscular fascia tissue with the intention of promotion, maintenance, restoration of health and prevention of disease with only 54 hours of training; although the physical therapy profession does not include any training with needles in their educational curriculum; and

WHEREAS, in order to protect the public, the North Carolina General Assembly determines which professional groups are properly trained and skilled; and

WHEREAS, pursuant to the North Carolina Practice of Acupuncture Licensure Law only three professions are given the statutory authority in North Carolina to perform therapeutic procedures using acupuncture needles: physicians, licensed acupuncturist, and chiropractors. Physicians are required to complete 200-300 hours of post-graduate training, despite their medical training, which already incorporates the use of needles. A licensed acupuncturist must have a minimum of

1905 hours of post-graduate level training, 660 of which must be in clinical hours. A Chiropractor must have 300 hours of post-graduate training. A Physical Therapist, however, according to the position statement, requires only 54 hours of training to use needles in patients; and

WHEREAS, the Board of Physical Therapy Examiners has not conducted rule-making under the Administrative Practice Act to adopt rules that relate dry needling to the statutory definition of the practice of physical therapy. Any such process should consider standards of education and training that presumably would be at least as strict as those set by the General Assembly for physicians who use acupuncture needles for similar therapeutic purposes; and

WHEREAS, the North Carolina General Assembly should adopt legislation clarifying that scope of practice shall only be modified by its consent; therefore be it

RESOLVED**, T**hat the North Carolina Medical Society supports (1) legislation to clarify that scope of practice shall only be modified by the North Carolina General Assembly and (2) legislation to clarify that dry needling is not within the scope of practice of physical therapists unless standards of education and training are set by the General Assembly at a level at least as strict as those set by the General Assembly for physicians who use acupuncture needles for similar therapeutic purposes. ***(policy)***

Fiscal Note: $20,000 expected commitment to legislative action. Current resources will be allocated based on the priorities of the Society and the NCMS budget.

AAPM&R Position on Dry Needling

Dry needling is the use of solid needles (contrasted with the use of hollow hypodermic needles that are used for injections) to treat muscle pain by stimulating and breaking muscular knots and bands. Unlike trigger point injections used for the same purpose, no anesthetics are used. There is controversy regarding the definition of dry needling. Licensed medical physicians and licensed acupuncturists consider dry needling as *Western Style Acupuncture or Trigger Point Acupuncture* whereby the insertion sites are determined by tender painful areas and tight muscles. These sites may be treated alone or in combination with known acupuncture points. Other practitioners take the position that dry needling is different from acupuncture in that it is not a holistic procedure and does not use meridians or other Eastern medicine paradigms to determine the insertion sites. However, dry needling is taught in American acupuncture schools as a form of treatment for individuals using acupuncture needles.

Dry needling is an invasive procedure. Needle length can range up to 4 inches in order to reach the affected muscles. The patient can develop painful bruises after the procedure and adverse sequelae may include hematoma, pneumothorax, nerve injury, vascular injury and infection. Post procedure analgesic medications may be necessary (usually over the counter medications are sufficient).

There has been controversy in the United States as to who is qualified to practice dry needling. Since it is an invasive procedure using needles, many take the position that it should only be performed by licensed acupuncturists or licensed medical physicians (M.D. or D.O.). There are other practitioners performing this procedure who have taken a course or courses in this technique but do not routinely use needles otherwise in their practices.

The American Academy of Physical Medicine and Rehabilitation recognizes dry needling as an invasive procedure using acupuncture needles that has associated medical risks. Therefore, the AAPMR maintains that this procedure should only be performed by practitioners with standard training and familiarity with routine use of needles in their practice, such as licensed acupuncturists or licensed medical physicians.

June 2012

Documentation of Recent Adverse Events Related to Dry Needling / a
Ashi Acupuncture and Insufficient Training Standards

Article A: **Cotchett, Matthew P., Karl B. Landorf, and Shannon E. Munteanu. "Effectiveness of Trigger Point Dry Needling for Plantar Heel Pain: A Randomized Controlled Trial."** ***Journal of Foot and Ankle Research*** **6.Suppl 1 (2013): O8. Abstract. (n.d.): n. pag. Print.**

> "The frequency of minor transitory **adverse events** was **significantly greater in the real dry needling group** (70 real dry needling appointments [32%] compared with only 1 sham dry needling appointment [<1%]). … Conclusion: We found that dry needling provided statistically significant improvements in plantar heel pain, but **the magnitude of this effect should be considered against the frequency of minor transitory adverse events**."

Article B: **Janz S and Adams J. Acupuncture by Another Name: Dry Needling in Australia. AUST J Acupunct Chin Med 2011;6(2):3-11.**

http://www.ajacm.com.au/Journal_AJACM/Articles_and_Abstracts/AJACM_2011_Volume_6_Issue_2/2011_Volume_6_Issue_2_Abstracts.aspx#JanzAdams

> "This paper challenges the notion that dry needling is not a part of acupuncture practice and also **examines the risks associated with the practice of dry needling from a public health perspective**. … A review into the incidence of risks of dry needling reveals very limited literature with only one case report and no review articles identified. Based on the similarities between acupuncture and dry needling, the extensive literature on the serious risks of acupuncture is extrapolated to evaluate the risks of dry needling. Dry needling is not a new or separate practice to acupuncture; rather it is a subsystem of musculoskeletal acupuncture which has been practised continuously for at least 1 400 years. Dry needling is a pseudonym for a brief course of study in myofascial acupuncture also known as *ashi* acupuncture and trigger point acupuncture. **Dry needling is likely to result in an increased incidence of serious risks, particularly pneumothorax, due to the short training courses and deep needling techniques which typify the practice**. In the interest of public health and safety, the practice of dry needling should be restricted to suitably qualified practitioners."
>
> "Given the foregoing discussion and that the practice of dry needling is identical to the practice of trigger point acupuncture and ashi acupuncture the serious risks associated with acupuncture can be extrapolated to understand the risks of dry needling. … A search of English language articles in Scopus using keywords 'acupuncture' and 'risks' and limited from the year 2000 to 2011 resulted in 604 results. A further restriction to 'serious risks' limited results to 92; twenty-three of which pertained to acupuncture risks. … A systematic review of deaths after acupuncture found that 86 fatalities were reported among 32 articles. The most common cause of death was pneumothorax followed by puncture of the

review of deaths after acupuncture found that 86 fatalities were reported among 32 articles. The most common cause of death was pneumothorax followed by puncture of the heart, large blood vessels, central nervous system structures, the liver or infection. … The authors note that pneumothorax is not only the most common cause of death but also the most frequent serious non-fatal complication arising from acupuncture. **The authors observe that all deaths would likely be avoided with adequate acupuncture training**. In another review the authors speculate on the reasons for different rates of reporting from different Asian and Western countries but conclude **that adverse events would be avoided if all acupuncturists were trained to a high level of competency**."

"In an Australian study of adverse events in Chinese medicine (primarily acupuncture) it was found that **'adverse event rates for practitioners with 0–12 months of CAM (complementary and alternative medicine) education were significantly higher than for those with 37–60 months education'**. In the same study it was found that the risk of pneumothorax among medical practitioners practicing acupuncture was twice the rate of non-medically trained acupuncturists. The study found that only 25 of 458 medical practitioners surveyed had completed more than 12 months of traditional Chinese medicine (TCM) education with the remaining 72% either not answering the question on training or had completed less than two weeks of training."

"While studies into deaths and serious risks associated with acupuncture support thorough training in acupuncture, there is an assumption that much of this study should be focused on anatomy. The **Australian study demonstrates that it is not enough to have thorough training in anatomy and biomedicine alone**. Comprehensive training in acupuncture seems to be associated with a lower risk profile than being a medical practitioner. TrP-DN and IMS favour deep needling methods which carry an inherently greater risk of organ puncture than superficial methods.

"The paper has demonstrated that dry needling is not a new or separate practice from acupuncture which has its roots in Chinese medicine and which continues to evolve and develop within the domains of scientific research, medical acupuncture and Chinese medicine. Dry needling is a pseudonym for very brief training in myofascial acupuncture also known as trigger point acupuncture and ashi acupuncture. **The deep needling techniques which are preferred and characteristic of the dry needling** approach have **an inherently higher risk of pneumothorax and other serious risks** than other needling methods. Acupuncture is safe in well-trained hands; however **the risk of serious adverse events**, though rare, has been found to be **much higher among practitioners who have minimal training** in acupuncture **even if they have detailed knowledge of anatomy and biomedicine**."

Article C: **Lee, Jun-Hwan, Hyangsook Lee, and Dae-Jean Jo. "An Acute Cervical Epidural Hematoma as a Complication of Dry Needling." *Spine* 36.13 (2011): E891-893. Abstract. (n.d.): n. pag. Print.**

"We are presenting the first report of acute cervical epidural hematoma after dry needling."

Article D: **Blackwell, Tom. "Canadian Olympian's 'nightmare' after acupuncture needle collapses her lung."** ***National Post*** **(2013).**

> Massage therapist with limited (**105 classroom hours**, 174 self-directed clinical hours) training causes pneumothorax on Olympic athlete while performing ashi acupuncture (ie. Dry needling)
>
> "Research has also indicated that **pneumothorax** - a lung collapsed by air in the chest cavity - **is a rare complication**. A 2012 British Medical Journal study found reports of five acupuncture-linked pneumothorax cases over two years. While the Ontario government recently set up a new college to regulate acupuncture and other types of traditional Chinese medicine, **other health professions already allow their members to practice the art with some additional training**, Mr. Shekter noted. **The massage therapists' college**, for instance, requires that its professionals complete certain accredited courses. Mr. Spurrell did the acupuncture program at McMaster University, provided over **five three-day weekends, plus 174 hours of "self-directed home study**," according to its web site."

Article E: **Illinois Department of Financial and Professional Regulations Complaint / Claim Intake Form. Dec. 2011.**

> "On November 11, 2011 my physical therapist suggested trigger point dry needling. I trusted my physical therapist because she stated it was just like acupuncture. While she was entering the needle in my cervical spine she explained that the needle had to reach the bone in order to be effective. The experience was painful and uncomfortable because I was in pain and could not move for 10 minutes. … After the procedure I learned that the needles were not new nor were they sealed in individual packages. In addition I learned that she had very little clinical training. The consent form is extremely misleading and the physical therapist did not check to see if I completed and answered the questions. … This procedure could put me at risk and constitutes a public health hazard. This practice is misleading and creates a significant endangerment to public welfare."

Article F: **Maryland Dry Needling Incident Letter – October 2012**

The following incident occurred in October 2012 just after the Department of Health and Mental Hygiene closed their comment period for the first draft of dry needling regulations submitted by the Board of Physical Therapy Examiners. The young woman injured submitted the attached report to DHMH, the Acupuncture and PT Boards, and the Attorney General. She later submitted testimony to the Arizona legislature as they considered allowing dry needling with limited education standards. By that time, she had been diagnosed as having received pundendal nerve damage due to the dry needling.

"I am a 24-year-old woman who other than vulvodynia was perfectly healthy and now I am in a worst state after a first & last "dry needling" experience meant to just help with inner thigh muscle tightness … **My primary doctor believes that the location of the 2 inch "dry needling" bruise shows where the "dry needling" physical therapist hit a particular nerve**--between the knee and bend of the leg, inner left thigh where the seam of a pants leg would be--which hit would explain the pain down my legs and up my spine … **please note my bruise on my left leg, the "dry needle" caused immense "electrical" pain around my left knee cap—a pain I have never experienced in my whole life** and I wish to never experience again."

"Since August, I have seen a wonderful acupuncturist and doctor, Dr. Tiru Liang. I understand how "needling" should be done, because of my exceptional experience with an acupuncturist and medical doctor. That has acted as a baseline for comparison—the traumatizing "dry needling" experience with physical therapist."

Article G: **Canadian Physiotherapy Association 2012**
Publication states "over the past 12 months has identified a number of claims related to physiotherapists using dry needles in practice. These claims allege that physiotherapy patients have sustained injuries ranging from infection to pneumothorax as a result of their treatment."

Article H: **Jatinder K. Juss "Acupuncture induced pneumothorax—a case report". Acupuncture in Medicine. FindArticles.com. 16 Jan, 2012.**

"As acupuncture is increasingly being used in pain management, physicians need to be aware of its potential adverse effects. … The patient had received five, once weekly **Western acupuncture treatments from a physiotherapist** who was … fully trained in Western acupuncture. … **the therapist was using a trigger point needling technique**. **Training programmes** are accredited by the Acupuncture Association of Chartered Physiotherapists (a special interest group of The Chartered Society of Physiotherapists) and **involve 80 hours of basic training** with formal assessment including case reports, followed by additional CPD. In the hands of trained practitioners, the risk of serious adverse events with acupuncture is very low, estimated at 1:200 000, which is below that of many common medical treatments.

Article I: Baker, Paul. "Pneumothorax following acupuncture" *inmotion* (2006). P22.
Physical therapy liability claims for pneumothorax related to dry needling / ashi acupuncture increase in a one year period of time.

"A review of liability claims at Guild Insurance Limited, **over the past 12 months**, has shown that **a number of physiotherapy patients have allegedly sustained a pneumothorax following acupuncture**. … While there is little doubt acupuncture has significant benefits, **the importance of adequate training, knowledge, and experience are critical** to the successful defence action."

The following three physical therapist induced pneumothorax events occurred in Colorado over the last year since Colorado approved PTs to perform dry needling with 48 hours of training which can be completed over the course of two years. In comparison to these three events caused by physical therapists that have occurred since the approval of dry needling with limited training, the medical board reports that only three licensed acupuncturist induced pneumothoraxes have been reported since acupuncture became a regulated health occupation in 2002.

Article J: **FDA MAUDE Adverse Event Report. 2013**

> "A pt of a physical therapist, (b)(6), pt, received a pneumothorax after a dry needling treatment and was hospitalized at (b)(6) hospital on (b)(6). Treatment for the pneumothorax was provided by (b)(6), md. Pt providers use acupuncture needles to perform an acupuncture technique called dry needling."

Article K: **Axon, Rachel. "Torin Yater-Wallace bounces back from collapsed lung with top run." *USA Today* (2013, Dec. 14).**

> Colorado: "Torin Yater-Wallace got himself into the finals despite missing a week of practice. He guesses he collapsed the lung receiving dry needling therapy. He said he did not have any crashes that he could pinpoint in causing it."

No attachment: Colorado Department of Health

> Verifies that a dry needling induced pneumothorax resulted in a hospitalization at Aspen Valley Hospital in June 2013. However, no further information is available at this time due to HIPPA regulations and confidentiality during investigation rules, ""Based on Colorado statues, including C.R.S. section 25-3.5-704 and corresponding rules, your request for data pertaining to two cases of pneumothorax at two specific hospitals cannot be provided because of confidentiality agreements. Please contact me directly if you have any questions or concerns regarding this matter. Respectfully, Scott Beckley"