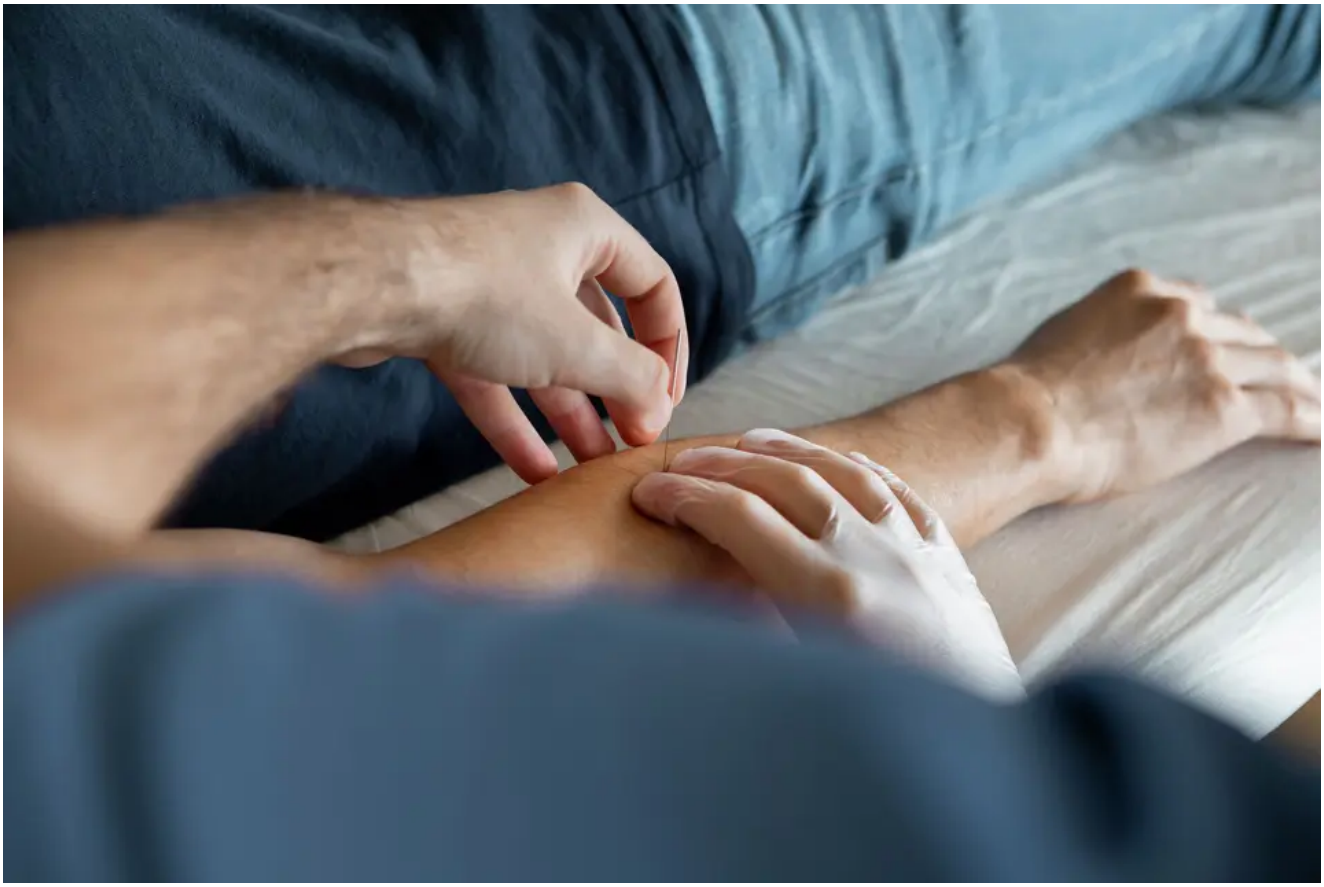
I’m an acupuncturist. Allowing physical therapists to perform dry needling raises questions



A bill in the California Legislature that would allow physical therapists to perform dry needling but doesn’t set minimum training requirements. Licensed acupuncturists need thousands of hours of practice and education to obtain certification for invasive procedures.

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When star NFL linebacker T.J. Watt suffered a partially collapsed lung following a needling procedure at a Pittsburgh Steelers facility in 2025, the incident drew national attention. It also underscored a fundamental reality: Even routine medical techniques can carry serious risks when they involve penetrating the human body.

That reality sits at the center of a growing policy debate in California — one that reflects a broader national trend.

In April, the Assembly Business and Professions Committee advanced Assembly Bill 2497 by a narrow 10-8-1 vote. The bill would expand the scope of practice for physical therapists to include needling procedures that penetrate the skin, commonly referred to as dry needling. The bill does not explicitly include a provision for a minimum level of training for physical therapists to do dry needling; that is instead left up to the Physical Therapy Board of California.

To a patient, dry needling and acupuncture likely look like identical procedures. But to a practitioner, dry needling is a subset of the broader acupuncture field and is a skill that requires careful technique and many hours of practice.

While AB2497 is framed as a way to improve access to care, it raises a more complex question: How far should states go in expanding medical scope of practice without redefining the standards that ensure patient safety? While professional athletes may have immediate access to emergency medical care, many Californians do not.

California is not alone. In recent years, multiple states have adopted widely varying approaches to regulating needling techniques performed by non-physician providers, creating a patchwork of standards across the country.

Concerns about consistency in training and patient safety have also been raised at the national level. Organizations such as the American Medical Association have emphasized that invasive procedures involving needle insertion should be supported by appropriate education, clinical training and demonstrated competency to minimize risk to patients.

California has already established clear statutory boundaries: Invasive needle procedures such as acupuncture may be performed by licensed acupuncturists, physicians, surgeons, dentists, podiatrists and professionals who meet comprehensive education and licensure standards. This definition establishes needling as a regulated medical act, one tied to formal education, clinical training and licensure.

AB2497 does not alter that definition directly. Instead, it creates a parallel pathway — allowing similar procedures to be performed under a different professional designation, with different training expectations.

Supporters argue that such changes are necessary to expand access, particularly as demand for musculoskeletal care continues to grow. In large and diverse regions like the Bay Area, where patients may face long wait times or uneven access depending on insurance coverage, the appeal of broader provider availability is clear.

But access and safety are not interchangeable.

Procedures that involve penetrating the skin carry inherent risks. Pneumothorax — a collapsed lung — is a rare but recognized complication when needling is performed near the chest. There are other potential complications too, including nerve injury, excessive bleeding and prolonged aggravation. Preventing such outcomes requires not only technical proficiency, but a depth of anatomical knowledge and clinical judgment developed through sustained training.

The pneumothorax experienced by Watt was not an isolated incident. American freeskier Torin Yater-Wallace sustained a collapsed lung from dry needling performed by a physical therapist prior to competition at the 2014 Winter Olympics. Similarly, world-class Canadian judo athlete Kim Ribble-Orr suffered a career-ending lung injury and infection in 2006 after dry needling performed by her massage therapist

There are approximately 13,000 licensed acupuncturists in California, who completed a four-year master's or doctoral-level education, including minimum 2,050 hours of didactic instruction and 950 hours of supervised clinical training before they are permitted to insert a needle into a patient. These rigorous requirements were established deliberately by the Legislature to protect the public from harm associated with invasive procedures. Patient safety must remain paramount. The Legislature should not lower training standards for invasive procedures or circumvent the protections it has carefully enacted.

The policy challenge is not simply whether more providers can perform these procedures, but whether training standards should evolve in parallel with expanded authority.

This issue also raises questions about regulatory consistency. If the same physical act — needle insertion — is governed by different standards depending on the provider, it may complicate oversight and blur the expectations that patients rely on when seeking care.

For patients, outcomes matter more than distinctions in terminology. Trust in the healthcare system depends on the assumption that invasive

procedures are performed by practitioners whose training reflects the level of risk involved.

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The narrow vote in Sacramento suggests that lawmakers recognize the complexity of the issue. As AB2497 moves forward, lawmakers should consider the broader national question of how to expand access to care without allowing standards to erode in the process.

In healthcare policy, incremental changes can have lasting consequences. Especially when those changes involve invasive procedures, caution is not resistance — it is a responsibility.

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