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Patient-centred care is currently dominating many discussions in the health care community and promises to continue to be a hot topic of conversation moving forward. It was certainly the theme for many health care conferences I’ve attended this past year.

This clinical method of putting patients at the centre of health care delivery is not new. In fact since the early 2000s, many health-related publications have covered this topic. In its 2001 publication titled, Crossing the Quality Chasm: A New Health System for the 21st Century, the U.S. Institute of Medicine defined patient-centred care as, “providing care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.”

Patient-centred care may not be a novel concept, but it surely has not been fully exploited after all these years. The increasing demand for a better, more efficient health-care system is pushing the envelope in patient care and, as a consequence, driving health-care professionals toward collaboration.

Adopting a patient-centred approach does not only require health-care practitioners to respect and respond to the patients’ preferences, needs and values.” It should also compel practitioners to go beyond the four walls of the clinic – acknowledging their own abilities and limitations – and work with other health experts to deliver the best possible clinical care for the patient.

Patient-centred care and interprofessional collaboration – the latter is almost a necessary consequence of the former. A practice cannot claim to be patient-centred without genuine intent and willingness to work not just within the same profession but with other health professionals as well.

Our upcoming Business Forum, to be held on June 5th in Mississauga, Ont. (see ad on page16-17), aims to create a venue for practitioners to further pursue this conversation. This year’s forum theme, “Patient-centred care through interprofessional collaboration,” as well as our line-up of education sessions and speakers, promise to provide RMTs the knowledge and tools to help elevate their practices to a level that is responsive to current health care trends.

I hope to see you all at the 2016 Massage Therapy Canada Business Forum!
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Gevin G. Cortes, RMT, Little Current, ON

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Tonia Nisbet, RMT, Sarnia, ON

The McMaster Contemporary Medical Acupuncture program provides a modern medical interpretation of an age old treatment modality, helping to explain some of the mysticism associated with traditional acupuncture. The integration of acupuncture with modern neurophysiological concepts, neuroanatomy, functional assessment and evidence-based protocols provided me with a wealth of practical knowledge that could be immediately integrated into my practice with astonishing results. The clarity, content and presentation of the curriculum, as well as the faculty, are second to none. Classroom lectures, practical workshops with countless supervised needle insertions and invaluable hands-on anatomy lab instruction created a well-rounded educational experience that left me feeling completely confident in my abilities. I can't say enough about your program! I will definitely be back for your advanced courses.

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TOUCH POINTS

RESEARCH

Olive, sunflower oil weakens babies’ skin defences: study

Using olive or sunflower oil on newborn babies’ skin damages the barrier which prevents water loss and blocks allergens and infections, new research led by The University of Manchester has found.

Despite most midwives recommending olive or sunflower oil for dry skin, as highlighted in a previous University study, there has been little research into the effects of these oils, outside of small studies in the lab.

This is despite changes to baby skin care being linked to a dramatic increase in eczema over the last few decades: from five per cent of children aged two to 15 in the 1940s to around 30 per cent today.

To test the effects of the two oils on babies’ skin, 115 newborn infants were recruited at Saint Mary’s Hospital to the pilot study, which was supported by the NIHR.

The babies were divided into three groups – olive oil, sunflower oil and no oil.

At the end of a 28-day trial period where babies in the oil groups were treated with a few drops on their skin twice a day, the lipid lamellae structure in the skin of each baby was investigated and in both oil groups the development of the skin barrier function was delayed compared to the no oil group.

Alison Cooke, the lecturer in midwifery who led the research said: “If the skin barrier function is a wall with bricks made of cells, then the lipid lamellae is the mortar that holds it together. If it isn’t developed enough then cracks appear which let water out and foreign bodies through.

“Oil prevents this mortar from developing as quickly and this could be linked to the development of conditions such as eczema.”

The skin of the babies who were given the oils tended to be better hydrated, however the researchers feel that since the implications of the effect on the lipid layer weren’t fully understood, this was not enough of a benefit to outweigh possible harm.

There is no UK national guidance on neonatal skin care, although there is evidence from studies carried out in South Asia that sunflower oil has an anti-microbial effect, which could benefit premature babies in developing countries.

However in healthy babies in the UK, the Manchester researchers say that they cannot recommend the use of either sunflower or olive oil on babies’ skin.

Alison added: “We need to do more research on this issue with different oils and also study possible links to eczema, but what is clear is that the current advice given to parents is not based on any evidence and until this is forthcoming the use of these two oils on new born baby skin should be avoided.”

The paper, “Olive Oil, Sunflower Oil or no Oil for Baby Dry Skin or Massage: A Pilot Assessor-blinded, Randomized Controlled Trial (the Oil in Baby SkinCare [ObSeRvE] Study),” was published in the journal Acta Dermato-Venereologica.

HUMAN FACTOR

BOOK REPORT

The Business of Massage Therapy – Building a Successful Career

ABOUT THE BOOK
A premiere guide to managing a successful massage career and running a holistic business, this book tackles both practical business management concerns and the intangible elements of success (reflection, balance and self-care). It also features information about marketing and new technologies – a knowledge often absent in the high-touch, low-tech world of massage therapy.

ABOUT THE AUTHOR
Jessica Abegg is a veteran massage therapist, yoga practitioner and holistic business coach. She is the founder of Practice Attraction, helping “heart-centric” business owners and holistic practitioners succeed in their practice.
PUBLIC HEALTH

Ontario to create clinic for patients with EDS

Ontario will set up a new clinic to help diagnose and treat people with Ehlers-Danlos Syndrome, or EDS, and it could expand to help patients with other rare diseases, Health Minister Eric Hoskins said.

About 6,700 people in Ontario live with EDS, a genetically-inherited disease that includes a group of connective tissue disorders, and causes acute and chronic pain, joint dislocation and lost vision.

An expert panel set up by the province found EDS is difficult to diagnose because it affects multiple systems, such as the nervous and/or orthopedic system, skin, joints, blood vessels, and internal organs, and symptoms can vary widely in each patient.

“A new centre of excellence at the University Health Network will be focused specifically on that disease, making sure we have the expertise and resources to support those individuals in Ontario living with EDS,” said Hoskins.

The new clinic will help people with rare diseases by giving doctors a single point of contact for information on related signs and symptoms, and to get advice from clinical experts on diagnosis and treatment options.

Ontario is working with British Columbia and Alberta on a national strategy to improve access to pharmaceuticals for rare diseases and address their high costs, and will create a working group to improve services for patients, added Hoskins.

Durhane Wong-Rieger, president of the Canadian Organization for Rare Disorders, said up to half of patients can’t get a proper diagnosis.

“Health spending in Ontario represents almost half the provincial budget and as our population ages, it is projected that health-care costs to government, individuals and employers will grow well beyond sustainable levels.”

The report marks the beginning of the OCC’s year-long Health Transformation Initiative, which will convene expert stakeholders and industry leaders to develop a blueprint for the future of sustainable health care in Ontario – including an opportunity for a partnership with the private sector within the single-payer model.

While three quarters of Ontarians believe that the provincial health-care system delivers better outcomes than those of comparable jurisdictions, international health research firm The Commonwealth Fund recently ranked Canada’s health system 10th out of 11 industrialized nations.

“Ontario is ready for health transformation,” said O’Dette. “Canadians have a genuine fear of what they perceive as ‘American-style’ health care, but this ignores both the considerable share of health coverage already delivered by the private sector as well as the integral role of industry in other countries with a single-payer model, like the UK and Australia.

This report comes at a time when system change is being considered, as the federal and provincial governments are on the cusp of renegotiating the health accords.

The Ontario government has also indicated its new priorities for an innovative, patient-first system, including the creation of the Office of the Chief Health Innovation Strategist and naming the province’s first Patient Advocate.

The OCC is planning to release a series of reports in 2016 which will outline recommendations on how Ontario can improve health outcomes, address fiscal challenges, and leverage untapped economic opportunity in the health sector.

For additional information and to read the full OCC report, visit transformhealth.ca.
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Ontario clinic regulation was proposed late 2015 by 13 regulatory health colleges, including the College of Massage Therapists of Ontario, to address perceived widespread infractions by businesses employing regulated health professionals. The “Working Group” cited concerns of practitioner exploitation, insurance fraud, using unregulated assistants, businesses maximizing billings, generating misleading advertising, providing insufficient infection control, poor record keeping maintenance and violating Health Information Custodian rules under privacy legislation.

The Working Group expressed the need to extend authority of regulators beyond their members to the employers/businesses that employ or contract practitioners to ensure the mandate of public protection. It produced a webinar, and surveyed practitioners and public through the Ontario Clinic Regulation website. While no health professional in good conscience and ethical application would condone the infractions cited by the Working Group, many practitioners expressed concerns in the survey about additional bureaucracy and operating costs borne by practitioners and passed on to patients.

Based on stakeholder submissions, many professional associations acknowledged problems exist but suggested an additional regulatory body was a duplication of existing authority. Practitioners and health professional associations responding to the survey cited a number of problems with the proposal. The biggest objections involve concerns of duplication of regulation, and that inspections could not possibly remain cost-neutral and therefore borne by the businesses and their practitioners.

RMTAO board chair Krystin Bokalo, in a January 19, 2016, letter to the Ontario Clinic Regulation Working Group stated, “We have been assured that clinic regulation will be performed on a cost-recovery basis. However, as in any marketplace the costs of the clinic inspection process will be passed down to the individual practitioners in the clinic, and therefore financially impact the individual members of the profession.” The RMTAO position paper provided a number of constructive recommendations to the Working Group on how proposed regulations could be structured to allow fair time for self-correction by practitioners.

Associations uniformly asked the Working Group to provide evidence regarding the depth and breadth of the problem, so the benefits of imposing such regulations could be measured.

Cultural shift
Many critics suggest the proposed Ontario Clinic Regulation would be duplicative, expensive, restrictive and ultimately ineffective to capture those gaming the system. Professional isolation, negated communication and a paucity of collaboration across the regulated health professions have created fertile ground for corruption, abuse and inefficiencies.

Broad-reaching change to any professional culture can only happen when we put knowledge, skills and tools into practitioners’ hands.

1. Create a comprehensive contract
Massage therapists are among a number of regulated health professionals that work as contracting “freelancers” – tenants under a larger business, or employees. Cross-contamination of the different working arrangements is common in our profession, and creates confusion, tension and corruption of business models, as well as risk of misclassification by Canada Revenue Agency.

The solution? Ask regulatory colleges and professional associations to hire legal counsel to draft employment, tenant and contractor/freelancer contracts, complete with all provisions regulated health professions must adhere to. Financial compensation, hours of employment and other non-regulatory variables specific to the common employment contract would be added as an addendum to further define the relationship.

Employers are already complicit in privacy legislation and mandatory reporting – if their employed regulated health professionals demonstrate incompetence, incapacity or abuse. A common contract containing all regulatory requirements legally bind both practitioners and the employers they work for, extending regulator influence beyond the practitioners they regulate.

2. Increase training and self-agency in contract negotiations
Increase the rigor and scope of business training for massage therapists,
including contract law, negotiation skills and accounting. Incorporate a mentorship and support infrastructure to assist practitioners at entry-level practice. Provide training for both practitioners and their employers to ensure understanding and adoption of the common contract. By charging fees for both mandated training and contract copies, regulators and associations would recoup the initial cost of drafting the common contract and in fact could see a profitable gain in their operating reserves while at the same time dramatically affecting the confusion and corruption in their particular professions.

3. Enable extra levels of accountability
All regulated practitioners and the businesses they work for would use these contracts exclusively for their members entering into any work contract. Audits would be conducted by existing Quality Assurance programs to ensure contracts were in place and practitioners and employers had both completed training (think health and safety provisions required in the restaurant industry). Non-compliance would be illegal for both regulated health professions and their workplace owner/operators, and subject to fines and penalties. Regulated health professional hotlines – in conjunction with existing fraud hotlines and reporting mechanisms for incompetence, incapacity or abuse – would be set up to report violations. No additional examiners, legislative act or oversight body would be required and practitioners and their employers would experience mutual obligation, reducing the likelihood of either violating these provisions.

Insurers would finally be handed their fair share of responsibility in dealing with insurance fraud. All receipts would require double signatures (practitioner and patient), and insurers would cross-check all provider receipts against regulatory registries. Insurers would provide claimants with annual statements of services received for the claimant to cross-check against fraudulent billing, and would share data with the regulated health professions re: utilization of services, costs and cases of fraud examined. This would include employee benefit plans, auto insurance and WSIB so insurers and providers could work together nationally against insurance fraud and corruption. Insurers must be prodded to do their part in supporting health professionals in preventing fraud.

Gatekeeper health care professionals can make themselves more accessible to cross-profession collaboration on treatment plans, and provide clear referrals citing desired clinical outcomes. Currently gatekeepers may placate workers requesting prescriptions to access their employee benefits without additionally communicating with the off-site provider who provides the services. More cross-professional communication would ameliorate many problems.

4. Strengthen advocacy for health-care professionals
Interested professional associations could install a regulated health professional’s legal representative as an extension of membership services, extending member support through advocating workplace and professional standards and providing legal services for a reasonable fee.

A clear set of contractual expectations, sufficient training, reporting and auditing mechanisms could be put in place with a simple expansion of existing regulations, standards and quality assurance procedures for an effective roll-out plan.

Rather than layering on more regulation, there’s an opportunity to increase cross-professional dialogue and engage the strength of existing regulators and legal processes already in place. Coupled with improved practitioner training and support, employer engagement and a comprehensive tool – the health professional contract – we can address this insidious professional problem as a fully embodied self-regulating profession while strengthening our relationships with other regulated health professionals.
A  abundance of fascia science and clinical understandings were  featured at the Fourth International Fascia Research Congress, held last November in Boston. Following are some of the highlights from the fascia conference that I find worth sharing with fellow massage therapy professionals. I have included the speakers for some of the topics discussed for references. Hopefully, you will find something here of translational value or causes you to reconsider a concept that continues to float without merit, like the mechanistic view of a body assembled of individual parts.

**ANATOMY CONSENSUS (CARLA STECCO)**

The folks responsible for the terminologia anatomica – considered the international human anatomy standard – have invited a collective of fascia experts to submit a definition of fascia based on current understandings. Currently, two predominant perspectives prevail: one more clearly anatomical, favouring discernable/dissectible, fibrous presentations; the other more broad and functional, favouring fascia’s force transmission, sensory and wound healing functions. During questions, Gil Hedley put forth an impassioned plea for consideration of the 3-D, loose connective tissue (CT) found throughout the body. This evoked a wave of affirmative head-nodding from the clinicians in the crowd.

When it comes to defining fascia not all great minds agree. However, the general consensus is that fascia’s fundamental characteristics are its contiguity and connectivity – three-dimensionally attaching, enclosing and separating all structures of the body from head to toe. Given its connective and continuous nature, one could surmise that if fascia is not happy, nobody’s happy.

**PAIN (SIEGFRED MENSE, ANDREAS SCHILDER)**

Fasciagenic pain is often described as beating, throbbing, stinging and hot, whereas muscle pain descriptors include beating, throbbing and dull.

Algesic agents injected deep into muscle belly and into fascia provoke notable differences. Fascial agitation elicits higher levels of pain and fascia also appears to process pain signals for a longer time and over a wider distribution than muscle.

**BACK PAIN**

With acute and chronic low back pain (ChLBP), a lower pain threshold is more evident in fascia than in muscle. The outer (superficial) layer of the thoracolumbar fascia (TLF) houses a significant number of substance P fibres, which likely means that back pain may be mostly originating from superficial tissue – indicating lighter/gentler techniques for pain management. Additionally, endocannabinoid receptors in superficial fascia appear to be responsive to softer manipulations/touch.

Fascial micro-injury is implicated in ChLBP and may also play a role in the diminished TLF sliding seen (via ultrasonography) in ChLBP patients. In addition to biomechanical implications, reduced sliding appears to limit
“One could surmise that if fascia is not happy, nobody is happy.”

the functionality of the endocannabinoid system. Which is of concern as endocannabinoids are believed to better manage inflammation and pain information originating in the fascial system (Bordoni and Zanier 2014).

PROPRIOCEPTION AND INTEROCEPTION (ANTONIO STECCO, ROBERT SCHLEIP)

Stecco suggests that restrictions in fascia (scars, adhesions, fibrosis and densification) can impede normal proprioception. Proprioceptive disinformation can lead to abnormal biomechanics, aberrant movement patterns, muscle compensations, joint distress and increased risk of acute or overuse injury.

Further, non-physiological mechanical stimuli can result in proprioceptors morphing into nociceptors (Bordoni and Zanier 2014).

To clarify, the hallmark of fibrosis is aberrant collagen (a structural change), whereas densification is described as altered viscosity in sliding spaces (a non-structural change). As noted, both have functional implications.

Interception (perception of our internal environment) is intimately linked to self-awareness. Due to its rich proprioceptive innervation, Schleip suggests that fascia be considered our most important peripheral organ of self-awareness. Interoception plays a role in physiological and psychological health and therefore, challenges with interoceptive discrimination and difficulty interpreting internal signals pose several concerns.

Some health issues linked to malintcroception include: eating disorders, anxiety, depression and inflammatory bowel disease (IBD). Although nervous system responses to interoceptive or exteroceptive stressors in patients with IBD are not fully understood, autonomic dysregulation is implicated. Alteration in vagal colonic regulation appears to play an important role in the predominant bowel habit pattern in irritable bowel syndrome (IBS). Evidence shows that decreased cardiovagal tone is present in certain subsets of patients with IBS. Approaches that engage interoceptors include manual and movement therapies that foster integration, sense of self and body literacy.

FUNCTIONAL ANATOMY (CAN YUCESOY)

Although it is difficult to fully appreciate the functional capacity of layers so intertwined and enmeshed, the various layers of fascia appear to display functional predominance: superficial is more exteroceptive, deep is more proprioceptive and epimysium is more involved in motor control. Yucesoy suggests that intramuscular fascia’s connection to and influence on the contraction elements of muscle can influence local force balance and determination of sarcomere length. This demonstrates that fascia not only supports muscle’s contractile apparatus but can also influence its functional output. Fascia and muscle are to be considered co-partners in force generation and transmission, endurance and efficiency.

FUNCTIONAL COUPLING

Sounds like the title of an interpersonal-relationship bestseller. This is about relationships, but of another sort. Andry Vleeming, professor in the department of rehabilitation and kinesiotherapy at Ghent Medical University in Belgium, provided an in-depth explanation of the role/relationship of the three functional rings (ribcage, pelvis and lumbar region) involved in the harmonious interplay of stability and mobility of the low back. As the lumbar area is naturally less stable (no bony ring) it is reliant on functional coupling of its muscular and fascial elements (deep abdominals, paraspinals, lateral raphe and TLF). The complex interactions between neighbouring tissues, a combination of muscle contraction, and multidirectional fascial stiffening/bracing forces, form an efficient and stable mechanism for movement and load lifting. To better understand low back pain, it is essential to appreciate how these elements cooperate to influence lumbopelvic stability.

ECM AND WOUND HEALING (BORIS HINZ)

Following injury, myofibroblasts (MFBs) contract in an effort to rapidly restore extracellular matrix (ECM) continuity and establish stability. Rapid/hyper repair (excessive remodeling) has its downside – fibrosis and tissue contracture.

In organs, fibrosis can lead to obstruction which poses a myriad of detrimental implications, as can fibrosis in other tissues. Since MFB activity is, in part, driven by tissue tension, can manually mediated reduction in tissue tension influence MFB activity in ways that reduce or prevent fibrosis and contracture? It appears that controlled, mechanical force applications can stimulate fibroblasts (precursor of MFBs and a major player in wound healing) in ways that degenerate or regenerate/reconstruct myofascial tissues, including loose CT. Better understanding of scar mechanobiology is key to developing productive scar prevention and treatment strategies.

SPORTS MEDICINE (MICHAEL KJAER)

Like defining fascia anatomy, tendinopathy consensus is contentious. What is agreed on? Overuse and repeat stress with insufficient rest/restoration time between agitations result in problematic collagen changes. Clear cellular differences are seen in healthy versus unhealthy tissue – but what tissue? This brings us to one bone of contention: changes appear to be more evident in interfascicular spaces (e.g. space between the tendon and paratenon). This leaves us to question what is tendinopathy and what ought to be our clinical focus? Is the primary issue a “rupture-healing” problem (Kjaer says no) or an interface/sliding problem? From a pain and functional perspective, best to pay attention to how sliding spaces can be preserved or restored following injury.
Perhaps the most dynamic part of our industry, is the story of the hands behind it. Individuals are attracted to the profession for radically different reasons and they run the gamut from sudden unemployment to health concerns to unexpected epiphanies. Often, it’s not a direct path after high school. For many, it’s a second or possibly third career choice.

The days of a predictable life defined by a single career with one company and a tidy retirement wintering in Florida has evaporated in a job climate that is ever changing. Second marriages, second mortgages, caring for elderly parents, financing children through university (while they live at home) —every dimension is shifting.

Once upon a time, you could complete a multiple-choice questionnaire about your personality and interests and it would spit out three viable career choices for you. Nowadays, a typical career path might divert in five or six different directions.

For three women in their 50s, returning to the classroom was daunting, but necessary. Here’s how massage therapy chose an organic farmer, a car parts factory worker and a feminist arts theatre company manager.

Taking a detour

“I had my heart set on becoming a massage therapist back in the ’70s, right after high school. I had read a magazine article about it and was intrigued, but my dad didn’t approve. I kept revisiting the idea but the door just didn’t open.”

For Connie Phillips, her path was a winding one. Life as an organic farmer in Oxford County, Ont., was taking its physical toll. She tended to 80 acres of soybeans, 4,000-layer hens and converted a pig barn to raise over 500 turkeys (making hers the second largest turkey farm in Canada). When she injured her back and spent two weeks in idle recovery, she was inspired by a visit with an uncle over Christmas. He was conducting a “life review” and considering a career shift. He had a BA in psychology and a masters in divinity. Phillips was intrigued, unaware that she could pursue a masters in divinity. Nine days later she was sitting in a classroom, enrolled in pastoral counselling and psychotherapy at Wilfrid Laurier University (WLU).

She spent five years working as a psychotherapist and recognized early on that people were holding pain in their bodies.

“[I knew that coping mechanisms and survival instincts were hardwired in the body in the heart and gut’s neuro receptors. I wanted to tap into that],” Phillips says.

Her “body curiosity” announced itself in an unexpected way, years later. Keen to take her psychotherapy background and complement it with the healing touch of massage therapy, she found herself immersed in the program at the Canadian College of Massage and Hydrotherapy (CCMH). It was a transformative season of emotional healing for her.

One month into the curriculum, students paired off to

Jules Torti, RMT, has been in practice since 1999 and a freelance writer since age six. In between massage engagements, she travels to Africa to be with chimpanzees and writes about her zany travels for Matador Network.
begin treatment of the posterior leg. Phillips was unaware that the trauma of being held at gunpoint by her husband years earlier had “locked” inside her legs. Immediately, and for three days after her treatment in class, her legs twitched and trembled.

Shaken and concerned, she approached an instructor who recommended a parasympathetic massage. She had awakened stored adrenalin. Assembling her past, Phillips learned that her cells had stored the trauma and accumulated. She was displaying classic symptoms of PTSD.

“In addition to the demands of school, I was coping with triggers that were coming at all angles—particularly seasons, certain personalities, smells, even tall people would set me off,” Phillips recalls. She began communicating with her body, accepting that PTSD was a healthy neurological response in coping and protecting herself.

She wanted to be able to treat clients as holistically as possible, not in a traditional reductionist approach. In her current practice, she is keyed in on muscle memory, working with compassion and translating that to a client so they can honour themselves and begin healing.

When talk therapy isn’t wanted or effective, Phillips now has other tools to employ. Ideally, she’d like to have a home-based practice where she can wear different hats. In 2014, she added a masters in spiritual emotional care in psychotherapy from WLU to her arsenal. Having recently purchased a former rural doctor’s house, with an office conveniently in the front, the walls of the 1840s home will hear a few more stories yet.

Her path was entirely uphill as Phillips started the CCMH program at 49. “My body was worn out from years of farming, I had pre-existing back issues, subluxations and poor posture.” Her choice was met with raised eyebrows by many. Ironically, she was able to recover and re-educate those muscles and her body has never felt so attuned.

Massage therapy was a career she wanted to enter in the '70s, but her father disapproved. She has no regrets, her journey through psychotherapy has added to her breadth and compassion. “Now was the right time,” she says.

Manufacturing a new career
Shelly Martin-Ganson worked at an interior car parts plant as an assembler, team leader and liaison for 22 years. In 2009, the plant announced bankruptcy and employees had a year to hatch a new game plan.

Martin-Ganson was 49. Who would hire her? She had been divorced for over 20 years and was taking care of her 87-year-old mother who had lived with her for 23 years. Finances were paramount – she needed to support her mother and be able to provide care for her at home.

While working in the factory a co-worker would periodically come up behind Martin-Ganson and massage her shoulders. She started returning the favour and he commented on how good she was at navigating the tight spots. She began approaching friends the same way, and the response seemed to be universal. She had the touch.

In 1996, no schools in the area offered evening classes for massage therapy. Instead, Martin-Ganson enrolled in an aromatherapy program at Gina’s School of Esthetics in Waterloo, Ont. When she received her certificate, she offered massages in her home to her co-workers. The factory allowed her to do on-site massages a few days a week as well.

Martin-Ganson was accepted into a second career program after opting for a company buy-out plan. “I jumped hoops to learn resume writing, CPR and a few other requirements the government had and was accepted into CCMH. And I plan on working until I’m 67 if my body holds up.”

Graduating in 2010, the shift from factory to spa life makes sense for Martin-Ganson. Her mother died a year ago, but the career jump allowed her to continue home-based care for her mother, and eventually establish a home-based business for herself.

Nowadays, a typical career path might divert in five or six different directions.
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It was time for an oil change and now she’s revving with eucalyptus essential oils and building better bodies instead of cars. She is now working less and being paid more than her years in the factory, which ironically, was bought out by Chrysler and remained open.

**A different vision**

For Linda Brown, massage therapy is actually her third career. In her early 20s, she was an early childhood education teacher working with autistic students. She shifted to non-profit theatre and cannonballed into arts administration.

“I ran a feminist theatre company, worked for 10 years in an arts funding agency and then worked in film production and social marketing,” Brown says. “My role – supporting and promoting the work of artists and arts organizations – involved a lot of computer work.”

Excessive computer work led to chronic neck and shoulder pain, and what she initially thought was simple eye strain. Brown soon learned it was a slowly progressing disease that would require cornea transplant surgery.

She felt stuck, especially knowing that she could no longer clearly see the computer screen she relied upon heavily for her job. Brown began considering career options that didn’t rely on clear vision, unsure of how the disease would progress.

During a random massage treatment, her therapist told her that she’d make a good RMT, and the seed was gently planted. The notion had never occurred to her. Brown was attracted to the independence, setting her own goals, direction and working as much or as little as she wanted. It would involve doing something meaningful.

She quit her job and enrolled at Sutherland Chan Massage Therapy School with the financial boost of student loans and family support. As her vision deteriorated, she would ask fellow students to read blackboard notes aloud to her. She used a magnifying glass to study and write exams. At 58, she was the oldest person in her class, although, she was in the company of a few “mature” students in their 30s and 40s. Brown received her registration in the mail on her 60th birthday in 2010.

In the last five years she has had two cornea implants and can now see perfectly.

She is wise to respond to any pain in her body by adjusting the way she is working. Her income has been substantially reduced since she entered the field but she has no regrets. Finding satisfaction in a solo practice two to three days a week, and at a spa, she plans to work another five years or longer.

“And my Canada Pension can now supplement my RMT income,” she declares.

Phillips, Martin-Ganson and Brown are solid proof of this profession’s diversity and strength. The stories behind our hands have endless beginnings.
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**Kerry D’Ambrogio**
- DOM, AP, PT, DO-MTP
- Developer of CranioSacral Therapy
Evidence suggests that myofascial release is an effective technique for a number of injuries. However, when it comes to anything fascia-related the professional community is divided with fundamentalist views on both sides. Some therapists approach myofascial release as a panacea, while others regard fascia as ‘dead tissue’ with no clinical significance.

**Fascial Revival**
Andreas Vesalius is considered to be the first anatomist and is best remembered for publishing the famous anatomy text, *De humani corporis fabrica* in 1543. If you look at these early illustrations, they present the fascia and muscles as one continuous soft tissue structure. Fast forward to the 20th century, most of the textbooks that students study in massage therapy school omit fascial structures in order to depict muscles in a cleaner fashion.

Recently, there has been a resurgence of this “forgotten tissue” and anatomy textbooks have made an effort to include fascial structures in their descriptions and illustrations. An example of this is *The Functional Atlas of the Human Fascial System* by Dr. Carla Stecco, an orthopaedic surgeon and a professor of human anatomy at the University of Padua in Italy – the same University that once employed Andreas Vesalius in the early 1500s.

Another example is *Anatomy Trains* by Thomas Myers. In this book, Myers presents conceptual “myofascial meridians.” A recent systematic review confirmed the superficial back line, the front functional line and back functional line as continuous soft tissue structures. Another recent article supports the notion of a functional continuity between soft tissue structures of the lower lateral line.

**What is Fascia?**
To better understand the possible actions of myofascial release, there is a need to clarify the definition of fascia and how it interacts with various other structures: muscles, nerves, vessels. “Fascia is fibrous connective tissue which are part of a body wide tensile force transmission system.” It is divided into superficial fascia, found immediately beneath the skin, and deep fascia, which envelops organs and tissues.

**What Effects Does Myofascial Release Have on the Body?**
The thing is, myofascial release is not well defined, and it is an umbrella term covering a wide variety of techniques. This includes osteopathic techniques, rolfing, structural integration, massage therapy, cupping and IASTM. Most of these treatments are a manual technique that tensions soft tissue structures and is accompanied by active or passive movement, to promote relative tissue motion that has the following effects on the body:

- **Contextual response** – This is likely to play a role in any therapeutic intervention – the way we present ourselves and present our techniques has influence on the treatment. The magnitude of a response may be influenced by mood, expectation and conditioning.

- **Neurological response** – Fascia is highly innervated by mechanoreceptors. This was documented by Robert Schleip in 2003. His article, “Fascial plasticity – a new neurobiological explanation,” is an easy-to-read
two-part article laying out a possible neurological explanation for the beneficial effects of myofascial release. In short, manual therapy stimulates fascial mechanoreceptors, which may, in turn, trigger tonus changes in connected skeletal muscle fibres. These muscle tonus changes might then be felt by the therapist.

**Mechanical response** – There is a large amount of literature to support the idea that along with the neurological and contextual responses, massage therapy has a mechanical effect on the fascial system. A summary of the proposed mechanisms includes, but is not limited to, nitric oxide release, altered hyaluronic acid production, changes in the extracellular matrix, fibroblast response to shear force.

“Fascia and the autonomic nervous system appear to be intimately connected. A change in attitude in myofascial practitioners from a mechanical perspective toward an inclusion of the self-regulatory dynamics of the nervous system is suggested,” Schleip wrote in his article, “Fascial plasticity – a new neurobiological explanation.”

**IMPROVING ‘SLIDE AND GLIDE’**
The adage, “motion is lotion,” applies to the fascial system – a conceptual model to describe the interconnections of fascial tissues with joint capsules, nerves and intramuscular connective tissues. Traditionally, when soft tissue structures have a reduced ability to “slide and glide,” adhesions are blamed.

An alternative possible mechanism that may explain this palpable induration is a fascial densification. This densification of loose connective tissue appears to correspond to the reduction of sliding between deep fascial layers. This may be due to age, trauma or inflammation. It is postulated that this reduced ability to slide and glide may affect the microvascularization of neural tissue, resulting in the local release of neurogenic inflammation. Neurogenic inflammation may lead to a reduction in the firing threshold of local nociceptors.

Myofascial release is an effective treatment technique – the catch is that it may not work in the way some were taught. Myofascial release may have more to do with improving function of the global fascial net by improving the “slide and glide” between soft tissue interfaces. This view diverges from the once-held belief that myofascial release can be used to induce long term mechanical deformation of fascial tissue.

This knowledge may not necessarily change the way that you apply the technique, but it may change the way you communicate with therapists and patients. The name myofascial release is better used as an analogous term to describe a palpable change in tissue texture, that is likely due to many overlapping responses that include contextual, neurological and mechanical responses.

For more articles on fascia and myofascial release, visit www.massagetherapycanada.com
In the winter issue of Massage Therapy Canada, I wrote about the supporting literature and research pertaining to Ligamentous Articular Strain Technique (LAST). I also discussed why manual therapy techniques that target areas of especially high concentrations of mechanoreceptors (tenoperiosteal and ligamentoperiosteal enthuses) are important to incorporate into your practice.

This article is a case study that incorporates LAST into treatment, resulting in dramatic transformation in rehabilitation for one of my patients.

ROCHELLE’S STORY
Rochelle is one of, if not the top among stuntwomen in Canada. She has been in many top blockbuster movies (including X-Men) and TV shows (currently The Flash and Arrow). She is an elite athlete, having competed in mixed martial arts and boxing, trained with the British Olympic Gymnastics team, and is an expert in more martial arts than I can name.

THE INJURY
When I first met Rochelle, she was eight weeks post severe second degree right ankle sprain/strain. She was non-weight bearing, on crutches and her right ankle was heavily wrapped in a tensor bandage.

Eight weeks prior to our initial introduction, Rochelle was on set in Vancouver. The scene was set for her to be running in four-inch heels, linked arm in arm with two other stunt performers, jumping off a dock, free falling 14 feet and landing on a squishy mat. Her feet were locked into full plantar flexion. The right ankle immediately rolled and popped upon contact with the mat, she collapsed and that was the last time she had put weight on it.

She received conservative treatment from another medical professional for the next eight weeks. At this point she was still in an extreme amount of pain and discomfort, unable to walk and bear weight, with minimal range of motion in her ankle. She was now questioning if she would ever return to her career and lifestyle. Rochelle sleeps and breathes stunts and acting. The concept of having to alter her life direction was weighing heavily on her and she was becoming depressed.

OBSERVATION AND ASSESSMENT
While lying supine, bandage off, her right foot was plantar flexed and supinated. Swelling was present at both right medial and lateral malleolus. Temperature was markedly colder around all aspects of the ankle. Dorsal pedis and posterior tibial pulses were normal compared bilaterally. Tissue tension/tone of both anterior and posterior compartment was increased on the right side. Her tibia was externally rotated on the femur, while the popliteus, gastroc and soleus muscles were hypertoned. The medial meniscus was tracking more anteriorly than lateral meniscus; this is the
reverse of what normal forced coupling is for the knee. There was pain on palpation around all aspects of both medial and lateral malleoli, including anterior and posterior talofibular ligamentous regions. There were no neurological signs or symptoms and deep tendon reflexes were normal.

Active range of motion was non-existent. She was very apprehensive and fearful that moving the foot would cause more damage. Passive range of motion was 50 per cent with pain at end range.

**RESEARCH REVIEW**

In a 2012 paper, “The role of ankle ligaments and articular geometry in stabilizing the ankle,” Watanabe et al. noted, “for unloaded condition, the lateral ligament accounted for 70% to 80% of anterior stability and the deltoid ligaments for 50% to 80% of posterior stability. Both ligaments contributed 50% to 80% to rotational stability. For the loaded ankle condition, articular geometry contributed 100% to translational and 60% to rotational stability. The ankle was less stable in plantar flexion and more stable in dorsiflexion.”

Remember that when Rochelle landed on her feet, they were locked in plantar flexion due to the high-heeled boots she was wearing.

Solomonow et al. state that the acute inflammation in ligaments that sets in within several hours may last several weeks and up to 12 months. Only up to 70 per cent recovery has been documented. Chronic inflammation can build up over several weeks, months or years, depending on dose-duration levels. Rest and recovery of as long as two years only allow partial recovery, full recovery has never been reported.

Bouffard et al. published a study documenting the effects of brief static tissue stretch on TGF-b1. TGF-b1 plays a key role in connective tissue, regulating the response of fibroblasts to injury, remodeling, scarring and pathological production of fibrosis.

Langvin et al. stated that in cases of minor sprains and repetitive motion injuries, scarring is mostly detrimental since it can contribute to maintaining the chronicity of tissue stiffness, abnormal movement patterns, and pain. Reducing scar and adhesion formation using stretch and mobilization is especially important for internal tissue injuries and inflammation involving fascia and organs. They proposed that therapies (massage), which briefly stretch tissues beyond the habitual range of motion, locally inhibit new collagen formation for several days after, and thus, prevent and/or ameliorate soft tissue adhesions.

The results of the Bouffard and Langvin studies show that brief, moderate amplitude (20 to 30 per cent strain) stretching of connective tissue decreases both TGF-b1 and collagen synthesis.

Based on the current research, manual/massage therapists have the potential to profoundly affect the course of tissue healing. By changing the physiological environment and decreasing the sympathetic nervous system response to injury. A response of decreased TGF-b1 could lead to decrease in fibrosis and decrease in fascial stiffening of the surrounding and injured tissues.

Rochelle and I determined that the main goal at that moment in time was to dramatically transform the direction of her rehabilitation. We decided that we were going to have
her standing, weight bearing and walking before she left the office. Yes, you read correctly.

**THE TREATMENT**

An evidence-informed practice always consists of incorporating research, principles of practice, communication about fear and anxiety pertaining to the injured tissues, informed consent, working within the patient’s tolerance levels, and common sense clinical experience. Research informs us that multimodal treatments provide longer lasting results. Although during this 90-minute treatment LAST was utilized heavily, I also incorporated fascial tissue treatment techniques, muscle energy techniques and principles of active isolated stretch.

After an orthopedic and palpative assessment of the affected appendicular and axial articular structures, the practitioner palpates for areas of dysfunction or an increased densification within the injured tissues. Slowly disengaging the tissues, via a combination of both direct and indirect techniques, the therapist exaggerates the permitted motions of the tissues to their end barrier. The therapist waits, at this point of tissue exaggeration, until he or she feels the tissues become more pliable and supple. A re-assessment of the permitted motion in the tissues is done to confirm more suppleness and mobility along with an improvement in kinesthetic and proprioceptive awareness by the patient.

First, we were able to return her right talus and metatarsals to neutral positions, improving their functionality immediately and decreasing pain and discomfort. Next, we focused on decreasing the hypertonicity of both the anterior and posterior compartments to maintain the neutral position and improve function of the talus. A combination of LAST, fascial mobilisation, muscle energy technique (MET), trigger point release and active isolated stretching were used to accomplish this.

We then focused our attention to the knee on her affected side. We addressed the increased tibial external rotation on the femur and the forced coupling dysfunction of her medial meniscus. Next, we treated the popliteus, gastrocnemius, hamstrings and quadriceps musculature, hoping to reduce their dysfunctional influence on the knee.

We recognized that her antalgic gait had contributed to lumbopelvic pain, tension and dysfunction, we addressed those concerns again incorporating LAST with MET. Next came the most crucial part of the treatment: re-education of gait and training her tissues to function more normally, providing proprioception and kinesthetic awareness messages. Gait was trained in reverse, and balance was trained via eyes open and closed standing on the affected leg.

At the end of our 90-minute appointment, we had accomplished our goals. She was able to stand on the affected leg with minimal pain, she was able to walk with near normal gait, unassisted by her crutches, and she was able to leave our office walking down our stairs using the hand rail for support.

Rochelle required additional therapies that were outside my scope of practice; therefore referrals were made to the appropriate medical practitioners for consultation.

Over the next year, she continued to receive manual therapy combined with active rehab and strength training. Although much progress was made, pain was still the defining factor preventing her from fully returning to and acquiring the level of athleticism she previously had known. Ultimately, she required surgery for excessive scar tissue build-up at the site of injury. Post surgery, we returned to our treatment and rehabilitation program.

Although it was a long journey, Rochelle accomplished her goal of returning to working full time as one of Canada’s top stuntwomen. She now regularly contributes to the TV series Arrow, The Flash, Wayward Pines, and the upcoming blockbuster movies X-Men, Planet of the Apes and Dead rising: Endgame.

No two patients or treatments are ever the same, and that results vary from patient-to-patient and treatment-to-treatment. What is important here is the recognition that we, as manual therapists, have the ability to profoundly affect the course of tissue healing, and we can dramatically transform the direction of rehabilitation for our patients. This is made possible by continually improving our education via live and online courses, mentoring with someone within or outside your profession, reading research articles, bringing research into our treatments, practicing with an evidence-informed treatment plan, focusing on the needs of the tissues and the patient, and referring to a team of trusted professionals to compliment our treatments.

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RMT TECH TALK
Make your websites work for your practice

By Jessica Foster

We are often asked to provide guidance on how website content should be written for optimal results. What we advise is you need to be aware that your content must be written to appeal to two very different audiences: the search engine robots and the human site visitors.

Moving up the rank
It is very important that you determine common search terms that your clients and potential clients would use when looking for the services you offer. When you have identified the common search terms, you will need to tailor your site’s content to appeal to those terms.

Talk to your clients and friends. Ask them how they would search online for the services that you offer. Compile a list and identify the top five or six search phrases they use. It doesn’t matter if they are technically correct phrases or not. Remember, this is likely how your potential clients will be searching online for your services.

For example, you may find they do not search for “myofascial release in Toronto” but rather “licensed massage therapist Toronto lower back pain” or even “relaxation massage Toronto.” This doesn’t mean that your website should not have a modality write up on myofascial release. It just means you need to tailor certain areas of your website with terminology that specifically mentions the common search terms you are targeting.

Try using the search phrases on your list, with the popular search engines (Google, Bing, Yahoo, etc.) to see where you are listed in the search results.

Next, edit your site’s content to include these words or phrases reasonably often to improve your ranking. Be patient, as it will take some time for the search engines to re-assess your site and update your listing. More than likely, you will start to see your listing move up in the rankings, which means you are on the right track. Keep going, continue to fine tune your content using the terms and you will climb the search engine rankings to appear on the first page, and even potentially become number one. This will ultimately generate much more traffic to your website.

Turning traffic into clients
As mentioned, your website content needs to engage the human visitors, your potential clients, and provide them with the information they need and are looking for. Put yourself in the mindset of a prospective client who is searching for a massage therapist in your city or town. What kind of information are they seeking? Make sure you have that relevant content on your site. Keep your site interesting with informative and newsworthy articles.

Remember, in today’s online world, your website is often the meeting place where potential clients first learn about you and your practice. You will want to put your best foot forward.

Introduce yourselves by including professional bios of the practitioners in the clinic and be sure to include their specialties and interests – this will help viewers get to know them.

Your website should provide these necessary elements:

- Logistics of your clinic – hours of operation, the treatments/modalities offered, client intake forms for new clients to download, etc.
- Contact information, with directions on how to get to your practice
- Most importantly, a “call to action” – give readers the ability to immediately book an appointment with you online

Wise investment
A well-thought-out and presented website will ensure that you are noticed and that your clients and prospective clients find what they are looking for. It is an important investment in both time and money; however, it is an investment that will more than pay for itself via increased business for you – if done right. You may want to think about partnering with a professional to work with you. The good news is that it does not need to be expensive.

There are website companies that offer a complete service to massage therapists. They have pre-written relevant website content that will give you a running start that can be fine-tuned to your specific practice. Services include modality pages you can personally edit to appease both audiences – search engine robots and human visitors. They may even offer a complete practice management system as well. The practice management portion may include appointment scheduling and reminders, invoicing, online payments, SOAP notes, financial reporting, and much more.

We have all heard the real estate industry speak about the importance of location, location, location. In the website industry, you are just as likely to hear about the importance of content, content, content.

Until next time, be well.

Jessica Foster writes on behalf of mindZplay Solutions, provider of massage therapy websites and practice management solutions. To learn more, visit www.massagemanaged.com.

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