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ON THE COVER:
The Ontario Legislature at Queen’s Park in Toronto.
Taking the high road

THE IMPENDING LEGALIZATION of marijuana for recreational use in Canada – which is expected to take effect by next summer – is causing anxiety among many in the health-care profession, and for good reason.

The jury is still out on the long-term effects of marijuana use. Although many people use marijuana for chronic pain and relieving other symptoms of certain illnesses and conditions, the evidence are still largely insufficient to determine what the actual risks and implications are with long-term use – or how effective it really is in helping certain medical conditions.

Health-care practitioners are reminding the government to keep the focus on public health as the legislation rolls out. According to the Centre for Addiction and Mental Health, marijuana is the most commonly used illicit drug in Canada, with almost half of Canadians having used it at least once in their lifetime.

The biggest concern about pot legalization is its consequence on young people and on their developing brain. About a third of Canadians aged 18 to 24 years report using marijuana in the past year, according to 2012 data from Statistics Canada. A New Zealand study showed that teens who heavily smoked marijuana lost an average of eight IQ points between age 13 and 38. Other studies point to a deterioration in cognitive thinking and learning among teen pot smokers.

As legalization of marijuana draws closer, front-line health-care providers will be faced with questions from patients about whether marijuana might benefit them. The true medicinal benefits of marijuana is still up for debate and it would require many more clinical trials on hundreds of thousands of human subjects before a scientifically conclusive answer can be provided.

For now, it’s incumbent upon the health-care providers to start educating themselves on this subject for the benefit of their patients. How the legislation will be implemented across jurisdictions is still unknown at this stage. One thing is certain: as marijuana gets more accessible to the public, patient education becomes even more crucial.

Health-care practitioners need to prepare and help their patients safely navigate this new paradigm of public health.

“As marijuana gets more accessible to the public, patient education becomes even more crucial.”

MARI-LEN DE GUZMAN, Editor

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**MODALITY**

Researchers explore massage therapy as muscle builder

**TOUCH POINTS HUMAN FACTOR**

An illness, an accident, or even just getting older can limit a person’s capacity for exercise. Rest is an essential component of healing, but it also atrophies muscles.

“People who are unable to exercise due to, for example, a recent surgery or illness, lose as much as three percent of their muscle mass per week,” said Dr. Esther Dupont-Versteegden of the University of Kentucky’s College of Health Sciences (CHS). “That doesn’t sound like much, but it can make recovery much more difficult, especially for the elderly.”

Dupont-Versteegden and her UK CHS colleague Dr. Tim Butterfield have been testing an inexpensive, non-invasive treatment that appears, in preliminary studies, to aid in the recovery of muscle mass and reduce muscle atrophy: massage therapy.

“Don’t run out and get a massage when you read this,” she laughed. “It might make you feel good, but it won’t turn you into a body builder.”

Proteins are the basic building blocks of all of the body’s tissues, especially muscle. The complicated metabolic process that turns protein into muscle, called protein synthesis, increases muscle cell size, which in turn strengthens muscle fibres. But one of the crucial ingredients for muscle growth is exercise.

“However, there are times and circumstances in which exercise is not possible, because of a severe illness or surgery, for example” Dupont-Versteegden said. “Our research proposes that massage may stave off atrophy, even if you aren’t able to get up and move around.”

According to Butterfield, it appears that massage mimics the effect of exercise by sending signals to the muscle to begin protein synthesis. But perhaps even more tantalizing: massaging one limb seems to confer benefit to its corresponding muscle on the other side as well.

“We’re not sure why yet, but if we could understand the mechanisms for this crossover effect it could have real healing benefits for patients with wounds to one limb – for example, car accident victims or wounded soldiers,” Butterfield said.

Their initial work is promising enough to garner a five-year, $2.1 million grant from the National Center for Complementary & Integrative Health to further their study in conjunction with Drs. Benjamin Miller and Karyn Hamilton from Colorado State University.

The loss of skeletal muscle mass and the inability to recover from atrophy are major contributors to disability and a major factor in the elderly’s loss of independence, Dupont-Versteegden said.

“If we can identify new, cost-effective ways to reduce disability and improve overall health, that’s an all-around win.”

– Newswise

**WHAT’S ONLINE**

Trending items on MassageTherapyCanada.com

**JOB POSTING**

Whether you’re looking for new opportunities or in search of RMTs to join your team, our online Marketplace section is a great resource.
It’s great for pasta sauce and repelling vampires, but the jury’s still out on how effective garlic is at lowering blood pressure.

Dr. Peter Jones is the principal investigator in a new study at the University of Manitoba’s Richardson Centre for Functional Foods and Nutraceuticals. He and his team are looking into the age-old question and hoping to get a more definitive answer.

Jones told CTV Winnipeg there are studies indicating that garlic works to lower hypertension, but other studies have failed to confirm the findings. He’s looking for 40 participants to take part in his own study on the issue.

It’s open to non-smoking men and women aged 40-70 years old who have elevated blood pressure but are not currently taking any blood pressure lowering medication.

Participants will randomly take two rounds of pills – one is a placebo and the other contains aged garlic extract. Participants will also wear an ambulatory blood pressure cuff during the day that takes readings every few minutes and saves the results on a chip.

Jones said this piece of technology will allow for more accurate data sharing and eliminate the need for participants to go into a clinic for testing.

He said many people have a reaction in clinical settings commonly known as “the white coat effect.”

“You blood pressure spikes,” he said. “So it’s an inaccurate reading.”

The findings certainly warrant further investigation to determine how helpful non-LCD screens could be to specific PCS patient populations,” Tator said. “We are already planning other research projects to evaluate this further.”

The study was made possible with funding from the Queen’s University Entrepreneurship Competition, the Ontario Brain Institute, and the Toronto General and Western Hospital Foundation.

For more information visit https://www.massagetherapycanada.com
Canadian certified sport massage therapist, Aurel Hamran of Edmonton planned his vacation to Hungary in July. What he was not planning for was a call from the Hungarian Swimming Federation by Fodor Szabolcs, leader of the open water department. Szabolcs asked him to help their swim team as a full member at the FINA 2017 Aquatic World Championships, in Hungary. He didn’t hesitate, and accepted the invitation.

“They know me for my 28 years with the Canadian Swim Team and I met the Hungarians at five Olympics. I was surprised by the call and found it interesting that a Canadian therapist would help the Hungarian swim team at the World Championships. The open water competition was not unknown to me for I worked with the Canadian team at the 2015 Pan Am Games, in Toronto. However, the uniqueness was that instead of working with the Canadians, now I will be with Hungarians,” Hamran said.

Being born and raised in Hungary, Hamran is fluent in that language and had no problem fitting in with the team. He had to be at Balatonfüred by July 12th, three days before the 10-day competition started, to meet and get to know the four women and four men on the team with their coaches and support staff. Balatonfüred is one of the famous vacation towns of Lake Balaton, the largest lake in Central and East Europe.

Amran related his experience: “Our accommodation was at the glamorous Anna Grand Hotel for all teams. You may guess how busy and loud the restaurant was when many of the teams were together. Needless to say, the Canadian team was very surprised to see me there – in Hungarian team attire. Massages took place in my large room, usually in the afternoons and evenings. Every afternoon team meeting was throughout the 10 days and in the morning on non-competition days training in one of the town’s indoor pools.

To get to the fenced race area, we had to go through the security gates where the bags were x-rayed and accreditation ID cards were scanned. Sometimes we noticed heavy police and army presence around the area, but no incidents.”

The huge tent, where all teams prepared for the races, always holds some excitement, Hamran recalled. “Securing the time recognizing ‘wrist watches,’ sensed by the Omega time measuring system, requires special knowledge and experience.”

It is also important for the therapists to know how to apply the waterproof, greasyointments around the edges of the swimmer’s shoulder, armpits, chest and back area to help avoid skin rashes, or abrasions. All these activities take time, Hamran said. Often, swimmers were called to get immediately to the adjacent “ready tent” for last-minute race instructions and regulations.

When the race started, boats with officials, judges and emergency personnel followed the swimming group on both sides all the way to the finish line. Others on boards were paddling along the way, so the last swimmers can be taken care of, in case they experience difficulties.

There were “feeding stations” on elevated platforms along the course, where coaches were holding cups on long sticks, offering water to swimmers, who were turning over on their backs to take a few sips, then continue swimming. Some racers won’t stop at all at these stations, except during longer races, as they didn’t want to lose their position and time.

Thousands of spectators from the tribune followed the races on huge screens, cheering for the swimmers and crews when they reached their area.

The competition started on July 15th with the men’s 5-km and on the 16th with the women’s 10-km races, followed by a rest day after. On the 18th and 19th the men’s 10-km and the women’s 5-km race caused excitement for swimmers and spectators, not to mention the mixed team competitions on the 20th. The last race on July 21st was the 25-km race, where the women’s event started after the men’s.

“I think, the 25-km is strictly brutal. It is hard to imagine for a recreational swimmer that someone can swim that distance without stopping and still staying above the water,” Hamran said.

The organizers and volunteers were praised by participants and spectators as they were all impressed with the beautifully arranged environment and the smooth operation of the competitions. You could hear comments, like, “I’ve never attended a better displayed and organized competition, ever.”

The weather was perfect for the 10 days with beautiful blue skies. Interestingly, after the last day of the competition the rain took over as if it was saying, “now it is my turn,” Hamran said.

In all, Hamran said, it was a nice experience with many memories to be thankful for.
CONTINUING EDUCATION

Free mental health classes in Manitoba

PORTAGE LA PRAIRIE, Man. – A new program is bringing Manitobans back to school with lessons in understanding mental health.

Enrolment at the new Recovery Education Centre at the Canadian Mental Health Association in Portage La Prairie started this September.

The college-style model is new to Manitoba, free to attend, and open to anyone.

Jordan Friesen, executive director of the association’s central region, said he had seen this done at a few locations in Ontario and wanted to bring it to a rural setting.

People who are interested in taking classes will meet with a CMHA staff member who has had their own experience with mental illness and together, they will put together a learning plan that meets the student’s needs.

There are close to 20 courses to choose from – many are taught by facilitators with lived experience.

Brad Burrell is one example. He is running a course on dealing with addiction, using his own story of recovery from alcohol and drug addiction.

“The best help I got was from people with the same situation that I was in, you know?” he said. “From the people who have been there.”

His class is focused on teaching students how to share their story in a healthy way.

“Which a couple (of students) have, and it’s helped them so much, because they’ve gotten it out and they’ve talked about it with someone else and it’s a very therapeutic thing to do.”

Some of the classes have been offered over the summer, and Tyson Psoch has taken a few of them.

He said he was diagnosed with a mental illness as a child and was often teased or bullied because he felt people didn’t understand him.

“Not only are you dealing with the illness, but you’re suffering from the stigma attached to it too,” he said.

One of the courses on his schedule is focused on managing a group. Psoch hopes to use the skills he learns to one day teach a class himself.

– The Canadian Press

HEALTH NEWS

Cannabis in the workplace

QUEBEC’S LARGEST LABOUR FEDERATION and a major business group said the provincial government needs to pay particular attention to the workplace consequences of cannabis use.

The Quebec Federation of Labour and the group representing Quebec’s chambers of commerce made the comments as public consultations continued on the repercussions of legalizing pot.

The head of the business group said in an interview that studies in jurisdictions where cannabis is legal have shown a drop in employee productivity, increased absenteeism as well as mental health problems.

Stephane Forget also fears a spike in the number of work-related accidents against the backdrop of imperfect screening tests.

Forget says certain tests will allow employers to determine that someone has used cannabis within a certain time frame but will not enable them to pinpoint the level of impairment.

The Quebec Federation of Labour, meanwhile, fears employers will adopt zero-tolerance policies which will encroach on workers’ private lives.

– The Canadian Press

BACK CARE

Back-to-school should not be a pain in the back

Each year, millions of children return to school struggling under the weight of an overstuffed backpack. Heavy backpacks can put children at risk of injury, according to Dr. Joshua Hyman, orthopedic surgeon at New York Presbyterian/Morgan Stanley Children’s Hospital.

Hyman offers the following guidelines to help prevent potential back injuries from overweight backpacks:

A backpack shouldn’t weigh more than 15 per cent of the child’s weight, or about seven pounds for a child who weighs 50 pounds. If textbooks are making the bag too heavy, parents should speak with the teacher — sometimes books can be left at school.

Children should wear their backpack over both shoulders to spread weight evenly. Alternatively, consider a wheeled backpack.

Be sure that the backpack is the correct size for your child. The backpack should not be wider or longer than the child’s torso, and should not hang more than 4 inches below the waistline. A backpack that hangs too low increases the weight on the shoulders, causing the child to lean forward when walking.

Be sure that the backpack has wide, padded shoulder straps and a padded back. The shoulder straps should be adjusted so the backpack can be fitted to your child’s body and a padded backing provides increased comfort and protects the child from being injured by the sharp edges on some school supplies.

“Parents should inspect their child’s backpack from time to time. They often carry much more than they should with extra shoes, toys, electronic devices and other unnecessary items,” Hyman said.

If the child experiences persistent pain, parents should consult their pediatrician, who may recommend physical therapy to strengthen the back muscles. Some indicators of trouble include changes in the child’s posture while wearing the backpack, difficulty putting on the backpack, and pain, tingling or red marks.

– Newswise
MS Society of Canada shares wellness toolbox

As people settle back into the routine of school and work, the MS Society of Canada is reminding Canadians that multiple sclerosis is anything but a routine disease. MS affects each person differently and treatment options can vary drastically from person to person.

“There are as many treatment plans for MS as there are people with MS,” said Dr. Karen Lee, vice-president of research, Multiple Sclerosis Society of Canada. “Everyone’s journey with MS is unique, as is their choice for treatments. Today, people living with MS have a variety of options, from diet and exercise to pharmaceuticals...We want to provide the best information and support that we can on all topics that are of interest to our community.”

A little over 20 years ago, there were no disease-modifying therapies or classes of drugs that impacted the underlying disease of MS. Now, there are 14. It’s up to each person and their health-care team to determine which, if any, is right for them. To help from a wellness perspective, the MS Society reached out to those living with MS to determine common threads in managing – and thriving – with this disease. A few wellness themes emerged:

1) Move your body – Exercise is key. For most people (with or without MS), eight hours a day in the gym is not realistic, but that doesn’t mean you do nothing. Pilates and yoga are emerging as new ways to be active and can be tailored for people living with MS. A variety of other activities can be adapted to provide beneficial aerobic and strength training. Just do as much as you can, as often as you can. For guidelines on physical activity and living with MS visit www.mssociety.ca

2) Feed your health – While there is a vast amount of research about diet and wellness, the general rule of thumb is to eat healthy. For some that means cutting out dairy, gluten and sugar, for others it can simply mean increasing your whole foods intake. Find the personal balance that feeds your body and soul.

3) Look beyond the traditional – While having a traditional health-care team is a must for most MS protocols, you don’t have to stop there. Many people living with MS take a holistic approach to healing and incorporate nutritionists, naturopaths, massage therapists, or acupuncturists. Just ensure everyone involved in your health-care is aware of all treatments.

4) Share – Most people living with MS find it helpful to talk about their experiences. While support groups are very popular, they are not for everyone. Some people living with MS choose other avenues like writing a blog; keeping a diary; confiding in a close friend; or attending therapy sessions.

5) Cut yourself some slack – You are going to have bad days. Allow yourself to be down for a day, and then work to make tomorrow better. Just always know that you are not alone on this journey, and that help can be around the corner or a phone call away.

Montreal scientists tout ‘open science’ movement

MONTREAL’S WORLD-FAMOUS brain research centre, McGill University’s Montreal Neurological Institute and Hospital (Neuro), has been transforming into what is touted as the first research centre of its kind in the world dedicated to the principles of open science.

Along with the city’s artificial intelligence (AI) community, the Neuro is helping to make Montreal a world leader in the international push toward democratizing scientific research.

“To say you’re the first is pretty ambitious, but for all the evidence we have, we are the first,” Guy Rouleau, director of the Neuro, said in an interview.

Open science is broadly understood as a movement to make scientific research and data open and accessible to researchers around the world.

The Neuro’s open science ambitions are threefold.

It is currently building what it hopes will become the world’s largest library of brain imaging, clinical, demographic, genetic and cellular data, as well as biological samples from patients with neurological disorders.

The Neuro is also creating what it calls an open drug discovery platform, which will run tests on nerve cells from sick patients in order to explain how neurological diseases manifest and to help develop cures.

Thirdly, the centre is building an informatics system in order to share its large-scale research data. All three planks of the project are to be open and accessible to researchers anywhere on the planet.

Rouleau said the Neuro’s project is still in the building phase and it’s too early to measure its impact. But he and the project are getting attention from governments around the world as well as the Bill and Melinda Gates Foundation and the Chan Zuckerberg Initiative, a philanthropic organization started by one of Facebook’s creators.

“The Neuro has secured $45 million for its three-pronged mission and Rouleau said it needs another $45 million over the next seven years.”

– Giuseppe Valiante, The Canadian Press
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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. Ken Ansell, RMT, Regina, SK

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The portrayal of massage therapists in Hollywood has often been a thorn in the industry’s side. Stereotypes and misconceptions abound. An online search for “movies about massage therapy” pulls up all sorts of fantasy and porn that continue to taint our reputation. Memorable, loveable (but not exactly accurate) characters, who double as masseuses on TV (like Phoebe from Friends) easily become synonymous with the profession as a whole.

Sometimes, Hollywood gets it right. Although we are infrequently portrayed in dramatic roles, we’ve had some intense debuts. Check out this list and garner a few CEUs by hosting a screening with colleagues. Start your own niche massage movie club and host at your home, clinic or local library.

Now showing
Julia Louis-Dreyfus’ portrayal of a “masseuse” in Enough Said, proved that serious research had been conducted by the writer. From oversharing clients, bad breath exhales, on-the-table marriage proposals and internal debates about client confidentiality – it hit home. Just as lovelorn Dreyfus begins to fall for James Gandolfini, her newest client, Catherine Keener, inconveniently happens to be Gandolfini’s ex-wife. For anyone who works as a massage therapist in a small town, client crossovers either in the waiting room or within client loads (i.e. ex-wives) are an unavoidable situation.

In Touchy Feely, Rosemarie Dewitt’s role as a massage therapist who becomes averse to touching skin is a startling career changer. She suddenly can’t connect with her partner through touch without being repulsed, jeopardizing both her relationship and job in one frightening spiral. Reiki healer Alison Janney becomes a sounding board and saviour, illuminating the importance of healing ourselves before others.

David Cronenberg’s Maps to the Stars features a creepy John Cusack as Julianne Moore’s massage therapist. Their intersected lives go beyond the petrissage in the twisted plot of an aging actor (Moore) desperate for recognition and continued fame. Her needy relationship with Cusack demonstrates how clients sometimes rely on their therapists as an emotional outlet more than the physical outcome.

At First Sight introduced audiences to a blind massage therapist (Val Kilmer) and invisible client/therapist boundaries. Mira Sorvino plays a wound-up New Yorker who is instantly seduced by Kilmer’s confident hands and independence. She pushes him toward a procedure that could restore his sense of sight with unexpected consequences.

Tui Na (Blind Massage) is based on the book by Bi Feiyu (Massage, available on Amazon) about Wang Daifu, an agitated blind practitioner of Tuina in Shenzhen, China. Daifu loses his life savings on the stock market and is forced to return to his provincial hometown. Career frustration, his brother’s gambling troubles, a demanding fiancé and colourful co-workers take drama to the next level.

Set in Toronto, The Five Senses revolves around touch, taste, hearing, smell and vision, “and the impact that each has on a group of individuals searching for an intimate connection.”

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.
human connection.” Touch is represented by Gabrielle Rose, a grieving massage therapist who is reminded of her deceased husband with every client that she touches. The technical importance of touch and emotional resonance are powerful forces in this film.

In The Client List (inspired by a true story), Jennifer Love Hewitt is desperate for money when faced with the foreclosure proceedings of her family home in Texas. Though she is trained in shiatsu and deep tissue massage, the money that offering “a little more” pays becomes too attractive, until the doting mom is charged with prostitution.

Red carpet treatment
On the flipside, what if you’re the massage therapist to the stars? What if the A-listers come to you? Depending on where you are employed, hotels where celebrities are regular guests may ask you to sign a confidentiality agreement and social media policy.

Julie Simcox, spa director at Langdon Hall Country House Hotel and Spa in Blair, Ontario mindfully suggested this: “I think for celebrities we have to be mindful of what name they book in with us under, as it could be a pseudonym and we have to go by that name.”

It’s about respect for their experience and satisfying the same need that brings each client to a spa: anonymity; sanctuary.

Regardless of where you work, there’s an obligation to protect the confidential information of clients. Social media policies like those at Langdon Hall remind employees that they “are prohibited from referencing guests by name or divulging details, both explicit and implied, of their stay.” The restrictions are serious and disclosing contact information, address, occupation and business have consequences for not only employment, but professional misconduct within the College as well.

Though it may be tempting to brag about who you treated in casual conversation, or, “accidentally” on Instagram, just remember, “The College of Massage Therapists of Ontario is committed to protecting the privacy and confidentiality of information it receives or creates in the course of fulfilling its regulatory functions.”

The College fulfills this commitment to privacy and confidentiality by complying with its statutory obligations under the Regulated Health Professions Act and the Personal Health Information Protection Act and by voluntarily adopting the practices set out in its Privacy Code.

Whether you use social media platforms on an official or unofficial basis, be certain your posts are constructive and responsible.

Even if you haven’t signed a social media policy, be mindful of sharing information that could be detrimental to the company you work for, even after termination of your employment. If you rub authority the wrong way, you might just find yourself with time on your hands – instead of massage oil.
Massage therapists frequently provide progressive care, addressing acute spasm/strain and pain (and the anxiousness which accompanies these symptoms) to improve function and provide a sense of well-being. Our eventual goal is to instill agency in our patients, providing self-care techniques they can apply themselves to ameliorate symptoms.

But what if a person suffers acute muscular pain when they are between office visits? What if onset is sudden, perhaps in the middle of the night? The common recommendation is pharmaceutical, which comes with possible side effects, doesn’t address the mechanism of pain or retrain pain-generating habits. As practitioners, we can provide our patients with tools to foster body awareness, a sense of control over pain and suffering, that can be self-applied at any time of day, and improve pliability of soft-tissues until the day we do get our hands on them again. Patients need a self-applied method that addresses muscular pain and stiffness in between office visits.

Dr. Michael A. Cohen, a chiropractor and acupuncturist in Toronto, was looking for a way to teach patients how to intervene in their pain and suffering. He wanted patients to reduce their dependence on him for immediate relief, while teaching them to explore and affect their own bodies when pain arises.

Cohen initially experimented with tennis and golf balls, but they had inherent limitations. This led his to eventually develop the acuBall - a firm but compressible baseball-sized object with nibs to penetrate tight muscles, and heat-ability to quickly release tight body areas with minimal discomfort. The acuBall contains water at its core, and when heated in a microwave for 60 seconds it provides firm compression and penetrating heat.

The acuBall helped him with another inherent problem – running late for appointments. “I typically took too long treating, and that made me late getting to other patients,” Cohen says. “Patients would sit in my waiting room, expressing annoyance to my poor receptionist. (My receptionist) decided to put patients in treatment rooms early, and provide them heated acuBalls.” Patients were not instructed how to use the acuBall in the session room, they were simply told to “go play.”

When Cohen arrived to provide care, he noticed patients were already loosened up, responding faster to his interventions. “Patients self-identified their chief areas of complaint and had begun the process of working it out, before I even laid my hands on them. I now use acuBall as a diagnostic tool.”

Cohen wanted a tool specifically designed for the curves and structure of the human body. After his invention of the acuBall, Cohen went on to design the acuBall mini for small, specific areas like the hands and feet, the roller-type acuBack – which incorporates a groove for the spine – and the oval, flat-shaped acuPad to influence sitting posture. These products are transportable and durable, and when heated in a microwave or boiling water they retain heat for a considerable time.

The acuBall has yielded quite a following, including converts from Toronto Raptors, Toronto Maple Leafs, Blue Jays, Montreal Canadiens, Edmonton Oilers, Washington 

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**PRACTICE POINTS**

**Between office visits**

Helping patients learn to help themselves  
**BY DON DILLON**

DONALD QUINN DILLON, RMT is a practitioner, speaker and practice coach. Find him at DonDillon-RMT.com.
Nationals, National Ballet of Canada, and over 1,000 practitioner clinics. Cohen reports, “We have a wide range of users from Air Canada pilots to Richard Branson. Who doesn’t need self-care?”

Cohen provides instructional videos online and a smartphone app for acuBall users. “Practitioners love the app,” Cohen laughs, “because they don’t need to train patients – patients train themselves.”

Cohen believes we’ve underestimated people in their ability to incorporate self-healing methods. “Patient self-explorations with acuProducts generate information that is important diagnostically, providing the practitioner with clues to issues she may have missed in the initial examination. Using acuProducts on the table during treatment relaxes and releases tight areas, saving the practitioner’s hands while teaching patients how to use the tools – a valuable take home!”

Cohen mentions the facility of the app again, “Over many years of experience I developed proprietary approaches to self-healing which are featured in the app. For instance, we guide patients through relieving their low-back pain by working on six specific areas, including the symphysis pubis while lying prone.”

I asked Cohen if any patient populations have difficulty incorporating the AcuBall at first. “People with high pain levels understandably don’t want to induce additional discomfort, so they need to be gently guided through the first 30 seconds of use. This is when the initial tissue resistance is highest as it may be more painful. I use simple deep breathing techniques to get patients to relax through the process. Other than that, it’s quite easy to get people ‘acuBalling’.”

I asked Cohen about the business model. Can the acuBall be effective for patients, and financially viable for the practitioner? Practitioners can become distributors and, “Busy therapists sell 25 to 30 units per month generating $500 to $600 in profit,” Cohen reports. Patients are quite receptive to using the acuBall themselves, and in his experience, a third of them will purchase acuProducts after directly experiencing their use in the treatment room.

Cohen states he has learned a lot from the practitioners that incorporate acuProducts. “We had a Yoga therapist who came up with a technique using the acuBack for calf release. We now teach that very same technique to health professionals worldwide.”

Cohen provides training to practitioners who wish to infuse the acuBall into their practice operations. There are two trainings available: an inexpensive one hour online course and a more intensive five-hour certification course that covers the best uses of acuProducts.

Common conditions treated include plantar fasciitis, rotator cuff syndrome, neck pain, upper and lower back pain. “Massage therapists, as you can imagine, love the trainings because it teaches them how to save their hands, get better treatment outcomes and earn a revenue stream,” Cohen reports.

In this groundbreaking work on ethics, Ben Benjamin and Cherie Sohnen-Moe directly address the difficult, confusing, and seldom-discussed-but-often-troubling dilemmas confronting touch therapy practitioners.

By honestly describing the issues, identifying clear principles, naming specific resources and using stories straight from the treatment room, they have written a book to guide, support and inspire both students and seasoned practitioners.

Reflective exercises and questions allow the reader to personalize each chapter. With love and respect for the field and for clients everywhere, Dr. Benjamin and Ms. Sohnen-Moe articulate high expectations and outline practical steps to meet them.

Most chiropractors, massage therapists, acupuncturists, physical therapists and other somatic practitioners do not receive adequate ethics training in school. This book supports hands-on professionals in expanding their knowledge about the field of ethics, to better manage boundaries, and to run ethical practices.
Zero tolerance
Breaking the cycle of sexual abuse of patients

BY MARI-LEN DE GUZMAN

When a sexual abuse complaint against Ontario massage therapist Fernando Vigon-Campuzano in 2016 led him to surrender his RMT licence, it opened up a can of worms that went back as far as 2014. He has since faced three counts of sexual assault charges, as two more patients came forward. A report by the The Star indicates that Vigon-Campuzano had been the subject of an investigation by the regulatory college for allegedly groping a female patient in 2014 – that patient was an undercover investigator for the College of Massage Therapists of Ontario (CMTO).

Although the circumstances surrounding the 2014 incident and why it never made it to a formal disciplinary hearing are not clear, this story – and several other similar stories involving other health care professionals – shone a light on what the provincial government believed were gaps in the legislation that allowed for sexual abuse cases involving health-care professionals to go unpunished.

That will soon change.

The Ontario government is ramping up its crackdown on sexual abuse of patients by health-care providers with the passage of Bill 87, which institutes amendments to the Regulated Health Professions Act, “strengthening and reinforcing” a zero tolerance policy on sexual offences by a regulated health professional.

Ontario’s Ministry of Health summarizes the amendments outlined in Bill 87, The Protecting Patients Act, as follows:

- Expand the list of acts of sexual abuse that will result in the mandatory revocation of a regulated health professional’s license
- Remove the ability of a regulated health professional to continue to practise on patients of a specific gender after an allegation or finding of sexual abuse
- Increase access to patient therapy and counselling as soon as a complaint of sexual abuse by a regulated health professional is filed
- Ensure that all relevant information about regulated health professionals’ current and past conduct is available to the public in an easy-to-access and transparent way.

The new legislation was enacted last spring and already, the CMTO has drafted a new “Standards for Maintaining Professional Boundaries and Preventing Sexual Abuse,” in anticipation of the new provisions set out in Bill 87. The draft has been submitted to the massage therapy professional community for feedback.

“The new Standards clearly communicate expectations and requirements for: obtaining client consent for treatment of sensitive areas, appropriate treatment of friends and family members (excluding romantic/sexual partners/spouses – whom RMTs cannot treat); maintaining professional boundaries; as well as explaining post-termination relationships and mandatory reporting requirements of RMTs,” the CMTO states on its website.

Sensitive matter
According to Andrew Lewarne, executive director of the Registered Massage Therapists Association of Ontario (RMTAO), Bill 87 has been a long time
The sexual abuse of patients really transcends the borders of the different health professions, so something needed to be done.”

coming. “The sexual abuse of patients really transcends the borders of the different health professions, so something needed to be done.”

Bill 87 applies to all regulated health professions in Ontario, and the various professional associations have publicly weighed in on how they believe this new legislation could impact their practices. The Ontario Medical Association (OMA), in a statement issued in May when the bill was still in deliberation, said the proposed legislation will “negatively affect the delivery of patient care and compromise the privacy of individual physician’s personal health information.”

There is no doubt the intent of the legislation – eliminating sexual abuse in health care – is sound. However, as Lewarne puts it, “the devil is always in the detail.”

The individual colleges are expected to roll out new or updated regulations and standards of practice to comply with the provisions of Bill 87. The CMTO’s draft new standards have been released for member feedback, and the RMTAO’s board has responded with its comments.

In particular, the RMT association’s board wants clarification on the CMTO’s draft standard pertaining to the treatment of sensitive areas and obtaining written informed consent for the treatment of sensitive areas of the body.

“We’re looking for clarity in what the CMTO is meaning in the particular standard because there is nothing actually in the Act – in either the Massage Therapy Act or Health Care Consent Act or Bill 87 – that indicates that you have to have separate consent,” Lewarne explains.

Under the draft new CMTO standards, treatment of sensitive areas of the body is considered a “high-risk” activity, requiring that any treatment of sensitive areas must be clinically indicated; that proper draping of these parts of the body must be discussed with the client prior to treatment; and treatment of these sensitive parts must be discussed with the client in advance and written informed consent must be obtained.

Lewarne says this provision must be clarified. “For a very long time it’s been standard practice for many massage therapists that if they are going to be treating a sensitive area they would get a separate consent that is written down, and that particular consent has to do with the initiation of the treatment plan. It’s only when there is a substantive change in the treatment plan or a reworking of the treatment plan that a new, fully informed consent needs to be obtained.

“There’s nothing in the writing – in any of the legislation – that says you need to get a full and separate consent each time that you see an individual for a treatment.”

Having clear communication and understanding with the patient about their treatment has never been more important for a health-care practitioner now that Bill 87 looms over the horizon. Having a written record of those communications is also key, says Tracey Tremayne-Lloyd, a Toronto-based lawyer specializing in health law.

She says blanket patient consent just won’t cut it anymore.

“They have to explain to the patient exactly what they are going to do and why,” Tremayne-Lloyd advises. She adds health practitioners can no longer take for granted or assume that a patient is fully aware of the expectations or treatment plans every time they come in to the clinic.

When treating sensitive areas of the body, the Toronto lawyer says the massage therapist should...
tell the patient and ask for permission.”

“They ask for permission, they make a note in the chart that they explained the nature of the procedure and that the patient consented and understood. They have to mark it in their record,” Tremayne-Lloyd says. Permission does not necessarily mean a signed consent by the patient every single time a treatment is administered, she adds, as long as there has been a clear conversation and explanation, and that the patient understood and consented to it – and the practitioner makes a note of the exchange on the patient record.

Too far
Lewarne views Bill 87 as a re-affirmation and clarification of what the expectations of conduct are for all regulated health professionals.

Unlike the medical community, he does not believe Bill 87 will negatively impact patient care “providing there is communication between the health professional and the patient.”

Tremayne-Lloyd, however, thinks Bill 87 had “gone too far,” particularly in broadening the list of acts that would be considered “sexual abuse,” which she says may impact the way health professionals deliver care.

Prior to Bill 87, sexual abuse under the Regulated Health Professions Act included only sexually explicit acts. Bill 87 expands the list of sexual abuse acts to include “touching of a sexual nature” of the patient’s sensitive areas.

Tremayne-Lloyd relates a real case of professional misconduct, where a dermatologist had diagnosed melanoma on a patient’s skin, and proceeded to inspect other parts of the patient’s body for signs of skin cancer. The patient misconstrued this examination as sexual in nature and lodged a complaint against the dermatologist.

“So what happens with this kind of legislation, I think, is that health-care providers are going to be terrified about having their regular professional service misconstrued by a patient as having some kind of sexual connotation.

“Especially with all the publicity, patients today are overly sensitized about the idea that health professionals are going to assault them or sexually abuse them,” says Tremayne-Lloyd, who has practiced health law for more than 20 years.

This broad definition under Bill 87 may leave health professionals more open to more disciplinary proceedings because patients may potentially misconstrue a treatment as being inappropriate.

The Ontario Medical Association shares this concern and its concern about another Bill 87 provision that allows the suspension of a health professional’s licence upon the regulatory college’s receipt of a complaint – even before a finding of guilt.

Tremayne-Lloyd explains this kind of power by the professional regulator used to be enforced only in extra-ordinary circumstances, when the facts of the case warrant such penalty – it is considered an “emergency power” of the regulator.

“The way they’ve done the amendments makes the access to that provision by the regulator easier than it has ever been before,” she explains. “They are suggesting that these kinds of cases that are considered or will be charged as sexual abuse cases, that (the accused) should be suspended under the emergency power before there’s been a trial. That, I think, is really so overreaching and very frightening for our health professionals.”

Task force
Bill 87 is the government’s response to the recommendations by the Health Minister’s Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act, chaired by Marilou McPhedran.

That task force, Tremayne-Lloyd believes, was formed in reaction to a 2014 report by the The Star highlighting cases of patient sexual abuse by medical doctors that largely went unpunished and allowed the accused physicians to continue practicing.

“I do think that the government was feeling almost embarrassed by the fact that The Star was writing all these stories that it gave the impression that the regulators were not doing their job... and were kind of ‘letting people get away with these things,’’” she says.

In her experience, she adds, nothing could be farther from the truth.

“These stories just don’t understand how our system of justice works. These regulators are very strict on their membership and they take these things very seriously, but they still have to follow the natural justice, they still have to do their jobs properly.”

Bill 87 also evokes concerns that the government’s efforts to impose laws that aim to protect patients from abuse may be inadvertently stepping on the rights of the health professionals.

“I just would prefer that they didn’t keep making it easier and easier to violate our professionals’ rights... like their right to access natural justice, be tried and found guilty before they are sentenced,” Tremayne-Lloyd says.
In clinical practice, communication and trust between the registered massage therapist (RMT) and her patient is crucial to a healthy relationship and partnership resulting in positive health outcomes for the patient.

Miscommunication and distrust may lead the patients in feeling abandoned by their RMT, dismissed in their suffering, disbelieved when describing their symptoms, and/or objectified by impersonal care. On the other hand, the RMT may feel overwhelmed by the patient’s inflated expectations and demands that the care received will reverse years of unhealthy behavior, poor health choices or bad luck.

As RMTs, we may find ourselves in situations where we are unable to understand the true nature of our patients’ health concerns. At times, we are missing important information that would allow us to properly identify the problem and give us the data needed to create a valid treatment and home-care plan for the patient.

When a patient fails to progress, confusion and frustration may set in for both the patient and the practitioner, despite all due diligence, care and attention.

In her book, *Narrative Medicine, Honoring the Stories of Illness*, Dr. Rita Charon describes four different types of divide that contribute to the separation between RMT and patient, eroding the trusting bond needed for a successful health-promoting relationship.

These four divides are described as the relationship to mortality; the context of illness; the beliefs about causality; and the emotions of shame, blame and fear.

Each divide reflects a peculiar dimension of the difference between the sick and the well. These divides are capricious, unpredictable, sometimes reversible, but in the end, they are irrevocable.

It is important that RMTs see the chasms clearly if we want to bridge these divides and allow the patients to get healthier by feeling included among those who are well and those in charge of their care.

ANNE-MARIE CÔTÉ has been a RMT in Vancouver since 1997. She teaches for Langara College and is presently working on her master’s degree at SFU in health education and active living.
This article will focus on these divides and how they affect our clinical practice.

**RELATIONSHIP TO MORTALITY**

The relationship to mortality refers to the difference between how a health-care practitioner may view and experience disease and death compared to the patient’s lived experience.

Although most RMTs have little contact with palliative care and the dying, we can extrapolate some of the concepts of this divide to our injured and ill patients.

The intensity of massage therapy schooling and training reduces other people’s sickness and injuries. RMTs are trained to look upon death, illness and injury as technical defeats, so deeply studied that the RMT is led to believe himself or herself immune to it all.

The patient’s past experience, on the other hand, will help dictate how they relate to death, illness and injury, “…it starts in infancy and so the experiences we had then are likely to orientate us in the patient role.” (Pilgrim, Tomasinì and Vassilev 2011, 37)

Therefore, a patient might view death and illness as both unthinkable and inevitable, and sometimes as a personal enemy or a mere distant abstraction.

The RMT may look at illness or injury with the worry of having caused it, through error, passivity or negligence, while a patient may see it as something to be feared, defied or even desired (Stuart and Noyes, 1999).

Taking the time as RMTs to ask our patients to provide a frank appraisal of their own health, including their opinions and feelings about death, illness and injury, and their healing and re-injury chances, could be very beneficial to the relationship.

However, this demands that RMTs must be ready and able to face their own feelings about these same subjects. Keep in mind that death, illness and injury may separate our patients from those that are healthy, but they also unite us all as universal human experiences.

**CONTEXT OF ILLNESS**

With context of illness we are faced with the difference between looking at the variables affecting illness narrowly – for example, only looking at what anatomical region is involved – or broadly, where we look at the full lives of our patients.

We can see here the appearance of the biopsychosocial framework of medicine, originally introduced by psychiatrist Dr. George Engel in 1977, where it is important to take into account not only the biological changes, but also the familial, community and societal context of the ill patient. Dr. Elliot Mishler, a psychiatrist, also describes this framework as the battle between the world of medicine and the life world, where the health-care practitioner is placing the symptoms on the forefront and in order of chronological appearances, to make biological sense, while patients describe them in the unfolding order of their life, to make personal sense.

It becomes important for RMTs to connect all the factors involved in order to provide a more holistic approach to treatment.

*Health-care practitioners are trained to look upon death and illness as technical defeats.*
to find what permits illness or injury to exist, alter the patient’s behaviour in the face of the illness or injury, and influence the effectiveness of the RMT treatment. RMTs need continual thought and research as to what constitutes health and what signifies an effective response to a lack of it.

Medicine tends to narrow its attention, eliminating the extra elements around the biological phenomena of illness or injury. Therefore, it is crucial to be aware of our own impulse to reduce as it is in direct contrast to the patient’s own impulse to multiply.

**BELIEFS ABOUT DISEASE CAUSALITY**

Beliefs about disease causality is rooted deep in culture, religion, family and education of both patients and RMTs, making discrepancies of beliefs of disease causality, at times, very difficult to mediate. Gaps between what the practitioner believes is causing the disease or injury and the patient’s beliefs can lead to ineffectual treatments, as the patient may refuse self-care advice.

RMTs typically review etiologies and treatment plans every time new knowledge and data is acquired. For us, science is both a rigid and revisable process allowing for the incorporation of new information as it becomes available. Whereas for patients, beliefs are rarely based on up-to-the-minute information, more often rooted in past knowledge and experiences.

Health-care practitioners look for etiologies that apply to more than one patient, to generalize the symptomatology bunching we have created.

Patients have more of a qualitative approach to their health, narrative in nature, and focused on how their condition is singular and therefore needing unique attention.

“Our clashes, in the end, over the causes of disease signify the desperate need for answers, for knowing, for certainty about why disease comes and how to remedy it.” (Charon, 2006, 30)

**EMOTIONS OF SHAME, BLAME, FEAR**

Feelings of shame, blame, and fear among patients are very common and difficult for practitioners to address. Most of what goes on inside the body is, to some, shameful and therefore not to be discussed.

Patients often do not feel comfortable talking to their RMTs about their sexual practices, bowel habits, substance abuse, or emotional problems. Most RMTs are also somewhat uncomfortable hearing about those same subjects, therefore leaving these questions unasked for fear of seeming unprofessional or being branded a voyeur.

Patients can also refuse to share information for fear of being blamed and judged for their illness or injury. The smoker with lung issues might be fearful of being mistreated.

In an effort to make their condition easier to accept than just random unfairness, patients may also irrationally look for their part of the blame for their condition – food they eat or not eat, exercise they do or don’t do – resulting in a grave sacrifice of self-esteem.

Fearful of being blamed for the patient’s condition, health-care practitioners can practice defensively and with suspicion toward their patients. Malpractice and unprofessional conduct complaints and litigation are common, although Levinson et al found patients sue their health-care practitioners when they feel they have not been listened to.

Blaming the patient for causing their own disease or injury or by branding them as non-compliant when they do not follow self-care advice, gives the health practitioner an excuse for failing to cure the disease or injury. On the other hand, to avoid being branded as noncompliant, patients may lie or avoid revealing certain facts of their condition or behaviour.

RMTs also need to keep in mind that patients might be fearful of the diagnosis, afraid that we might recommend rest, or worse, cessation from their favourite activity.

Communicating through patient’s fears may allow for a shared experience of suffering, which in turn lessens said suffering.

**CONCLUSION**

Knowledge and understanding that different notions of mortality, context of illness, causality and emotions exist between health-care practitioners and their patients may allow for a trusting and healing clinical relationship.

Patient-centered care is health care without the presence of the divides, it may be viewed as a partnership that equalizes the ground between the sick and the healthy, helping to see our bodies and lives in time, in relation and in meaning.

RMTs can use charting time to reflect on the patient’s stories and fears, their outlook on life, and relationships with their families and their community. We also need to reflect on our own understanding and beliefs about these divides and how they affect our professional judgement, treatment planning and homecare for our patients.

For a list of the references cited in this article, email the editor at mdeguzman@annexweb.com.
All too often joint mobilizations are dismissed as a modality worthy of being merely a footnote. During RMT schooling they are covered in techniques class. However, they are often relegated to the proverbial back pocket – to the therapist’s and patient’s detriment.

This should not be the case. Used correctly and in the appropriate circumstances, joint mobilizations may be the miracle method of changing the patient’s health status. Key to this is recognizing the indications and following through appropriately.

Massage therapists are rightly recognized as the kings and queens of soft tissue work. Soft tissue work can facilitate a significant improvement in a patient’s condition. However, a fixation on soft tissue can distract the therapist from the bigger picture. This became painfully obvious to me as an instructor of massage therapy students, but this is also a ubiquitous shortcoming for many long practicing massage therapists.

Joint mobilizations are purported to achieve a number of objectives:

• Augment joint function, thereby increasing range of movement
• Re-establishing accessory movements
• Loosen adhesions
• Nourish articular cartilage by stimulating flow of synovial fluid
• Decrease pain by stimulating mechanoreceptors
• Reduce edema in the joint-space by pumping local fluid in/around the joint

My objective is to discuss joint mobilizations in a number of common scenarios where soft tissue work plays a role, but in the absence of articular work, success will be limited.

ANKLE
In our first instance, let’s consider plantar fasciitis. One of the most common causes of plantar fasciitis is a restricted triceps surae – in essence, insufficient dorsiflexion.

The body requires at least 10 degrees of dorsiflexion for normal ankle movement. In the absence of sufficient dorsiflexion, the fulcrum of the movement migrates anteriorly from the talocrural joint to the midfoot. Consequently, the arch collapses upward as the forefoot is forced superiorly in order to attain adequate dorsiflexion. Tissues spanning the arch, in particular the plantar fascia, are stressed, hence, the tearing and inflammatory response to the plantar fascia. Logic indicates manual soft tissue work to the triceps surae, and this would be absolutely correct. However, functional dorsiflexion of the talocrural joint also requires correct arthrokinematics between these bones.

Soft tissue work, regardless of how much, will ultimately have finite results. In order to maximize dorsiflexion, both the soft tissue and articular component must be addressed.
Used correctly, joint mobilizations may be the miracle method of changing the patient’s health status.

In fact, it is true to say that limited range may indeed be the result purely of an articular deficiency, rather than soft tissue. By judging the increase in ankle dorsiflexion by doing the joint mobilization first, this may even obviate soft tissue work.

Talocrural mobilization requires a simple anterior drawer movement. Stabilize the tibia and fibula with one hand, and draw the calcaneus anteriorly. By repeating a few of these we are able to maximize the joint’s movement into dorsiflexion and amplify the effectiveness of the treatment for plantar fasciitis. In this instance, we see how a standard special test protocol also doubles as a treatment modality.

By expanding this concept in an ankle sprain scenario, adhesions and residual edema from the injury may be compromising normal function of the ankle. The Anterior Drawer Test is one of the standard protocols for testing the anterior talo fibular ligament for injury. At the same time, as part of the treatment (at the appropriate stage of healing) it may be employed to help evacuate swelling and loosen the consequent adhesions.

**KNEE**

The second instance we shall discuss is the knee. A common test to ascertain quadriceps flexibility, in particular the rectus femoris, is the Ely Test. For this, the patient is prone, the therapist passively flexes the knee and brings the patient’s foot as close as possible to the gluteals. The patient may feel discomfort or a pulling sensation in the quadriceps (indicative of muscular resistance to further range) or pressure or discomfort in the knee – hence, an articular resistance. It is useful for the therapist to use their fist(s) between the heel and buttock to gauge distance and compare bilaterally.

Regardless of where the patient felt the sensation, if restricted range is a consideration, the therapist should still apply joint mobilization to the tibiofemoral joint. With the relaxed patient prone, grasp the proximal tibia, elicit light traction and gently shift it anteriorly and posteriorly into the resistance five or six times. The difference when retesting with Ely Test may be dramatic.

My commentary is this. With the knee, regardless of where the patient felt the resistance, there is invariably articular involvement. Because it may be symptomless, the patient and therapist may not be aware of it. Doing an Ely Test before and after will disclose beyond doubt that the joint mobilization was indicated. In fact, further comment would suggest that by using patient response alone (i.e. where they feel the sensation) can result in a false positive – that it is incorrectly assumed that the rectus femoris is primarily causing the restriction because that is where they feel the resistance. In fact, range of movement likely increases maximally after the joint mobilization.

It is still prudent to include massage and fascial work to the quadriceps, but not without including the articular component.

**HIP**

A procedure I commonly use to check hip status is known as “scouring the hip.” This involves the supine patient’s femur being moved through all ranges, particularly into the end ranges.

The therapist should get a sense of how much range is possible and the quality of the movement. The patient will indicate if and where pain or discomfort is felt. This may occur in the opposite direction of the movement, likely indicating soft tissue stretch or even articular restriction, or in the direction of the movement, which indicates something being pinched – known as impingement – or possibly arthritis. The therapist should test bilaterally to find out what is normal for that patient.

Once this has been determined, the therapist should then mobilize the hip. If possible, the therapist should raise the
Ensuring mobilizations are part of your therapy regimen will maximize the well-being of your patients.

Scouring the hip involves the supine patient’s femur being moved through all ranges, particularly into the end ranges.

treatment table for this technique. Leaning into the supine patient’s hamstring of the flexed thigh, let the tibia lie over your shoulder and “hug” the thigh, preferably proximally to ensure superior leverage. Using your body for leverage, disengage the hip joint by pulling the thigh toward you. This elicits an inferior glide of the femoral cartilage. You may also adjust by shifting the femur laterally, hence including another direction.

Retest using the scouring motion. The range of movement should have increased, possibly the joint comfort as well, indicating a positive effect on the articular cartilage. There are modalities that are more suited to addressing articular cartilage, but if the patient is arthritic, joint mobilizations will help to a degree. However, the increase in range can be dramatic due to joint mobilizations.

Reduced hip flexion is unlikely a consequence of gluteal restriction. The anatomy of the gluteals clearly indicates that it’s a single joint muscle and built for power movement rather than significant changes in length. Soft tissue work to the gluteal musculature will reduce the resistance to hip flexion, but not change the range of movement since this is largely determined by the anatomy of the hip articulation.

From a practical standpoint, after mobilizations the patient is now able to perform greater hip flexion. To compensate prior to correction the patient may have had to tilt the pelvis posteriorly. This would have forced an upward forward tilt of the inferior pelvis thus allowing the femur greater reach superiority. Clearly, this could potentially stress the lumbar spine, particularly if done regularly and with speed and momentum as with dancers or in certain sports. Clinically speaking, there’s the realization that hip mobilization in this scenario not only improves movement of the femur and the arthrodynamics of the humeral head and acetabulum, but also plays a role in lumbar health.

One final point in this: Joint mobilizations clearly allow greater surface contact of the respective articular surfaces that occur with normal movement. The gentle compression and decompression of articular cartilage with movement is what nurtures the flow of synovial fluid and hence healthier articular cartilage.

Ensuring that mobilizations are part of your therapy regimen will maximize the well-being of your patients in a myriad of ways.
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MH Vicars School of Massage Therapy
has convenient, affordable Advanced Placement options for RMTs who want to enhance their training. If you are a practicing massage therapist, we will respectfully assess both your experience and your previous training and place you in the right class to earn our 2200-hour diploma in less than a year. We won’t waste your time or money by making you re-learn skills and knowledge that you already have.

We are excited that our new 2013-14 curriculum meets or exceeds the Canadian inter-jurisdictional entry-to-practice standard for massage therapists, which will become the new standard in all regulated provinces.

Call us today to learn more.

You deserve credit for the experience you have.

MH Vicars School of Massage Therapy has convenient, affordable Advanced Placement options for RMTs who want to enhance their training. If you are a practicing massage therapist, we will respectfully assess both your experience and your previous training and place you in the right class to earn our 2200-hour diploma in less than a year. We won’t waste your time or money by making you re-learn skills and knowledge that you already have.

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Call us today to learn more.
July 1st, 2017, marked the end of the three-year grace period of the Canada’s Anti-Spam Legislation (CASL), which came into effect July 1, 2014. This means that you now must ensure that your marketing communications methods are on the right side of this law. Failure to comply can result in significant fines.

CASL’s intended effect is to deter and prevent deceptive and damaging forms of spam and Internet practices. The legislation deals with how, when, where and why you are authorized to send commercial electronic messages (CEM) that are intended to solicit any kind of business relationship.

In a nutshell, you are required to:
1. Obtain specific permission from your patients and potential patients before you can legally send them electronic messages about your services.
2. Maintain records of consent to prove you have received permission from them to receive CEMs.
3. Remove patients from your mailing list if you have not done business with them for two years, unless you obtain permission again.

CASL requires that you receive permission from patients before you communicate with them electronically. Within the act, both “expressed” and “implied” permissions are acceptable.

Expressed permission is where a patient or potential patient has formally “opted-in” to receive commercial messages from you. They may check a box on your website, complete a website form or otherwise give you a provable permission to receive your electronic messages. This is the strongest form of consent as it is very clear what your patient’s intent is with respect to you marketing to them.

Implied permission is when consent is not actually stated but it is inferred by another action taken by your patients. For example, when you already have an existing business relationship with a patient it is implied that they expect on-going business-related communications from you. When they book an appointment online with you it is implied they agree to receive confirmations from you. You should ensure your email confirmations include an “unsubscribe” option. Implied permission can also include persons whom you may not even know, but their business and duties are relevant to your business and their contact information has been made publicly available to you (on a business card, website address etc.).

Implied permissions expire two years after your last business transaction with the patient.

Existing patients that book online already have given you implied consent. The concern you have is with new and potential patients. It can be easy for you to obtain and store expressed permission from your patients without deviating from your regular day-to-day practices. Here are a couple of ideas you may want to consider.

1. You are required to obtain signed treatment consent from your patients before you treat them. Why not add a checkbox to this form that asks for permission? Something like, “I understand and agree that as part of my ongoing care, I may receive communications from you electronically or otherwise about my treatment and related services.” Once checked, this would qualify as expressed permission for you to communicate with them about your business and services.
2. An example of implied consent is when a new patient visits your website and requests an online appointment with you. Your online booking system saves and stores this interaction. When the patient attends their first treatment you can enact #1 (above).

There are additional CASL compliance matters that may affect the way you communicate with your patients:

1. All the commercial email you send to your clients must contain the full name of the sender along with valid address and contact information. You are likely already doing this, as it makes sense to provide your patients with a way to get in touch with you. That said, with CASL it is no longer an option.
2. All of your commercial messages must provide the recipient with a working mechanism (automated or manual) for them to opt-out of receiving any further electronic correspondence from you. It is also very important that you monitor, store and honour all unsubscribe requests within 10 days to ensure CASL compliance.

Note: This article is not intended to provide legal advice nor is it a complete analysis of the Act. It is intended to inform practitioners of the potential ramifications to their day-to-day business practices. The full legislation can be viewed at http://crtc.gc.ca/eng/internet/anti.htm.
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