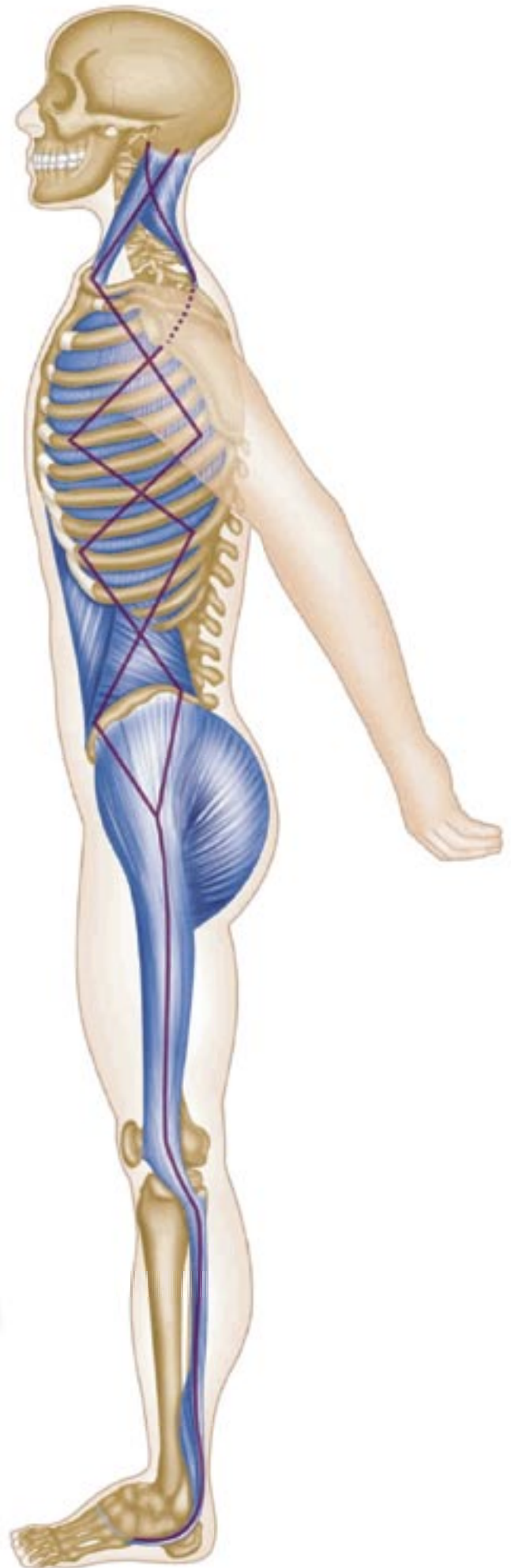


Anatomy Trains

Thomas Myers explains
myofascial meridians



What do massage employers really want?

STT eMag finds out

Functional stability

Rob Granter begins at the base

Sustaining business in a downturn

Andrew Simmons gives his view

Government recognition of massage industry

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Editor's note



The internal debate on regulating our industry continues in Australia with little outcome or direction as yet. There are discussions occurring within at least two of the associations but a coordinated national approach seems well off into the future. While we debate the necessity for regulation, the NSW Government has decided we do need some form of regulation and issued a NSW directive on what entities we as an industry need to have achieved and what we need to display within our clinics (see STT homepage, www.softtissuetherapy.com.au, for link). This has been legislated in NSW, hence we must abide by these rules. The private health insurers have welcomed this mild form of regulation and some (see www.mbf.com.au) have issued letters suggesting only those abiding by this NSW law can provide a redeemable service to their members. So while we debate the necessity of regulation, the bodies around us are implementing them for us. One might argue that if we don't design our own regulation, it will be eventually designed for us, leaving us vulnerable to uneducated opinions on our industry. Time to act.

The STT conference date has been set for 2009 – it will be held 29-30 August on the shore of NSW's Cronulla. The conference schedule will be available soon. To whet your appetite, the conference will focus on the pelvis this year, with speakers from many disciplines presenting their skills and views. For those wishing to reserve a seat, please contact admin@softtissuetherapy.com.au. The conference is limited to 80 participants.

I hope you enjoy this issue of the *STT eMag*. Thank you for your support and involvement.

*Yours in Soft Tissue Therapy,
Brad Hiskins*

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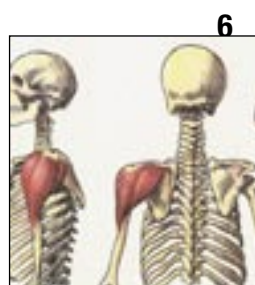
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Anatomy Trains: myofascial meridians for the manual or movement therapist

The 'Anatomy Trains' is a revolutionary way of analysing soft-tissue patterns, and developing dynamic and holistic strategies for unwinding these patterns via fascial, myofascial, and movement work. Tom Myers details this approach.

The 'Anatomy Trains' scheme offers a language that most hands-on therapists, regardless of their modality, can use to communicate clearly to colleagues and clients how the neuro-myofascial web is configured by their 'acture' (posture in action – Feldenkrais coined this word to indicate consistent patterns of stance and movement). Currently, Anatomy Trains is being enthusiastically endorsed worldwide by athletic trainers, chiropractors, massage therapists, Pilates instructors, PTs, and yoga teachers.

As soon as one understands that the fascial web begins is one seamless network, beginning from the reticular webbing that forms in the second week of embryological development, folded and refolded in the complex origami that turns a bolus of cells into a human being, then new insights begin to form concerning the interaction of nerves, muscles, and connective tissues (see image 1).

Because we started our study of anatomy – back in early Renaissance times – with the tools of the butcher, we have naturally focused on the structure and function of individual parts. This has led inexorably to modern understanding of muscle function that I describe as the 'single-muscle theory'. Each muscle is analysed, in text after text, in terms of its action

from origin to insertion. Though occasionally the fixation/stability or eccentric function of a muscle is included in the description, most often the muscle is defined as if working in isolation on an otherwise denuded skeleton (see image 2).

In fact, no muscle ever works in isolation. In the body, even the idea that there are individual muscles is misleading. Without pushing this metaphor too far, it is more accurate to say that there are about six hundred pockets of electrical jelly (muscle) suspended within a single overall fascial bag, which in turn surrounds and suspends the skeleton. In other words, there is one muscle. One mind, one muscle (see image 3).

The Anatomy Trains define the warp and weft of the myofascial tissue within this network. To define some terms, Anatomy Trains is a system of myofascial meridians. Each Anatomy Train is one myofascial meridian. Each myofascial meridian (which have some overlap, by the way, with the Oriental meridians, but are based totally on Western anatomy) consists of a series of myofascial continuities. So, in the simplest terms, the Anatomy Trains system simply shows how the muscles are strung together longitudinally to form a supporting tensile network for the skeleton. What we look for is an even tone along these meridian lines, because isolated areas of high tone and slackness will produce compensatory strain patterns

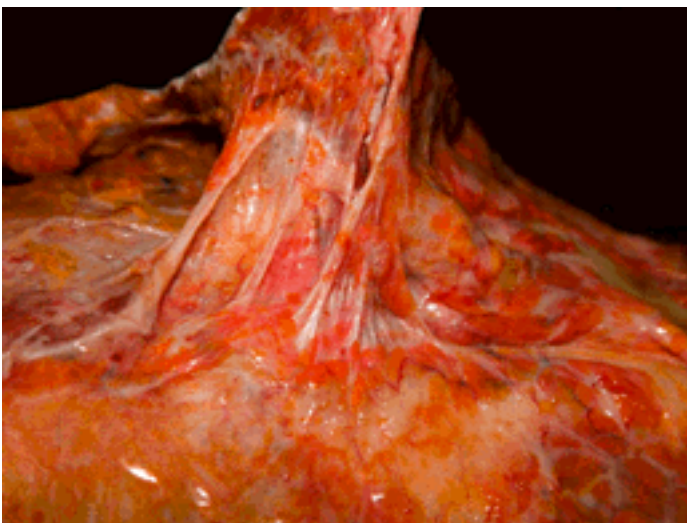


Image 1: Despite the awful gloopiness of this picture of a fresh tissue dissection, this combination of collagen fibers, glycoproteinous 'glue', and the wide variety of connective tissue cells constitutes the 'medium' in which manual and movement therapists act as 'sculptors'.

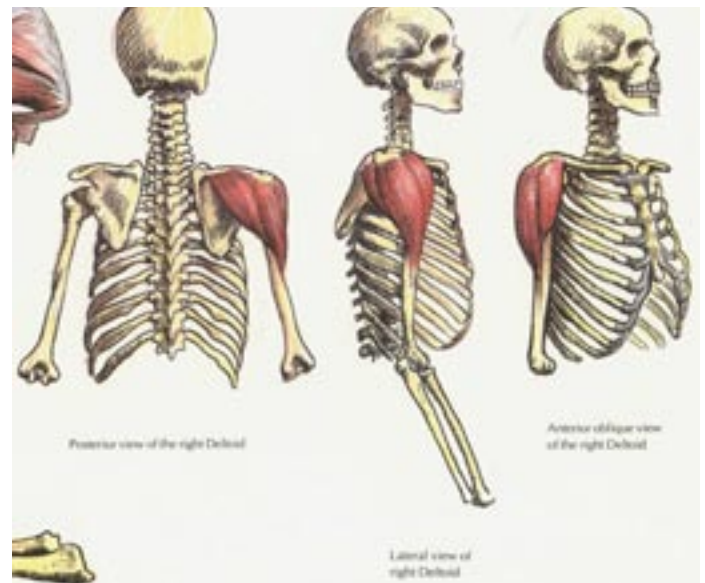


Image 2: Why are all muscles shown in isolation like this? Structural isolation is the opposite of structural integration.



Image 3: A more integrated view of the musculature.

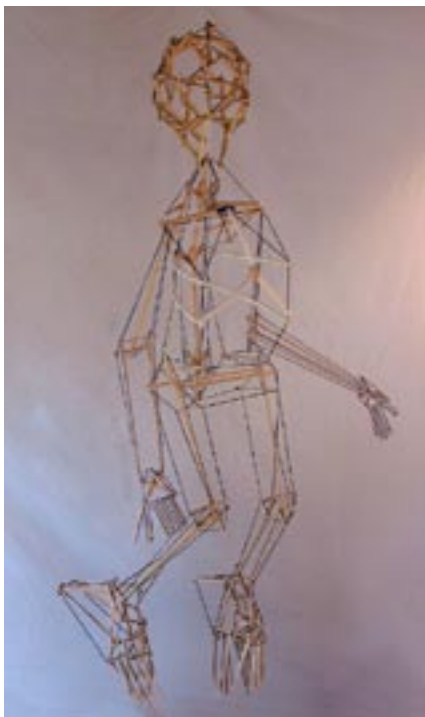


Image 4: An illustration of myofascial meridians.

that pull the skeleton out of line and lead to pain (see image 4).

When the bones and myofascia are in balance, the body approaches a tensegrity structure (for more of these models, see www.intensiondesigns.com).

If you look at the muscles that could be considered to be linked in a 'string of sausages' fashion via the fascia, we find about 12 of these meridians, though other, shorter ones can be found also. Trace the musculature up the back of the body, and you will trace the Superficial Back Line from the bottom of the toes to the brow ridge over the eyes. Similar continuities can be found up the front of the body – the Superficial Front Line – from the top of the toes to the back of the skull.

Similarly, the Lateral Line goes from ankle to ear up the side of the body, and the Spiral Line wraps the body in a double helix. There are four separate lines in the arms, and two lines that connect from each arm to the opposite hip – across the front and across the back.

Finally, there is a line that connects from the inner ankle to the bottom of the skull, the core of the body's myofascia, which we call the Deep Front Line.

One might well question: we have 500 years of very smart people looking at anatomy, and they have never come up with these ideas, so, Tom, are these just functional connections, or actual anatomical entities? Unequivocally, we can now

Continued on page – 8 ↘

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...continued from page – 7

state that these are anatomical entities, and I am glad to present these pictures to you my readers, in advance of their appearance in the new edition of the Anatomy Trains.

Here, for instance, is a dissection of the Superficial Front Arm Line, a myofascial continuity that runs from the trunk to the tips of the fingers along the front of the arm.

Why has no one dissected the body this way in the last 460 years since Vesalius? I don't know, but I suspect that what we needed was a more Einsteinian, relativistic systems view of anatomy, instead of the Cartesian, Newtonian biomechanics which have predominated physical medicine for the last century. I remain totally convinced of the critical importance of this point of view in developing comprehensive strategies for unwinding total body patterns.

And here is a dissection of the Superficial Back Line, going from the plantar fascia to the scalp fascia, covering all the primary and secondary curves of the body in the process (see image 6).

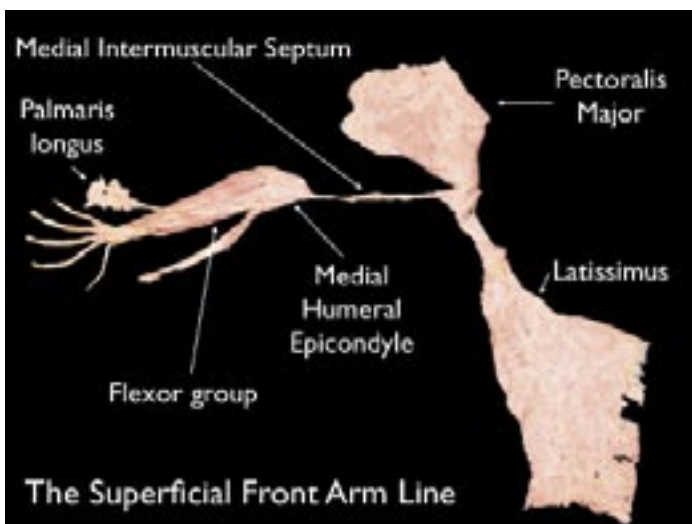


Image 5: A dissection of the Superficial Front Arm Line.

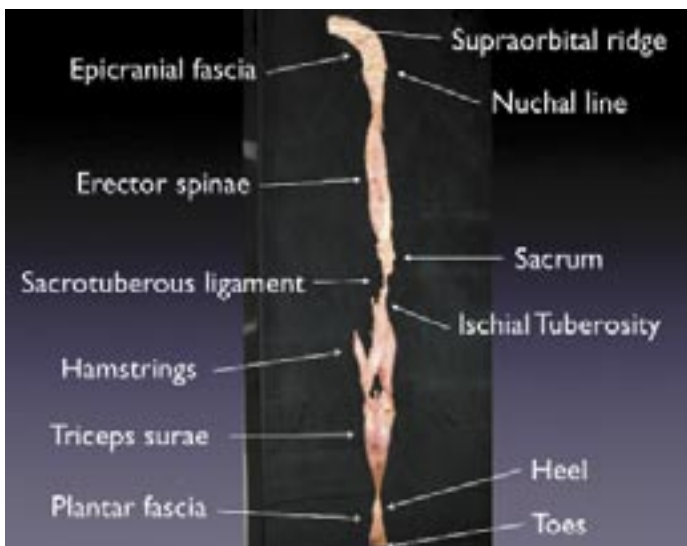


Image 6: A dissection of the Superficial Back Line.

If you consider this young girl, pre- and post-treatment, you can see how the balance of the Superficial Back Line has been disturbed, and she has changed a 'secondary' curve – the knees – into a 'primary' curve (convex posterior) by hyperextending her knees. This affects both the lumbar and the cervicals, both posturally and functionally. But look at the Superficial Back Line post-treatment – it now looks like a regular set of 'waves' traversing these primary and secondary curves in a balanced way from bottom to top.

In the growth from the primary foetal curve into the balance of primary and secondary curves that marks a balanced human plantigrade stance, many things can go wrong. Frequently, for instance (and in this little girl too), the hips fail to open fully, and many compensations occur north and south of the primary developmental fault (see image 7).

This brings us to the final point for this article: regardless of your treatment modality, your practice will be enhanced by the ability to see and recognise these lines, and the patterns of compensation. This type of visual analysis, which we call BodyReading, is an essential skill for the somatic therapist. Some of this skill is intuitive, but it can be learned.

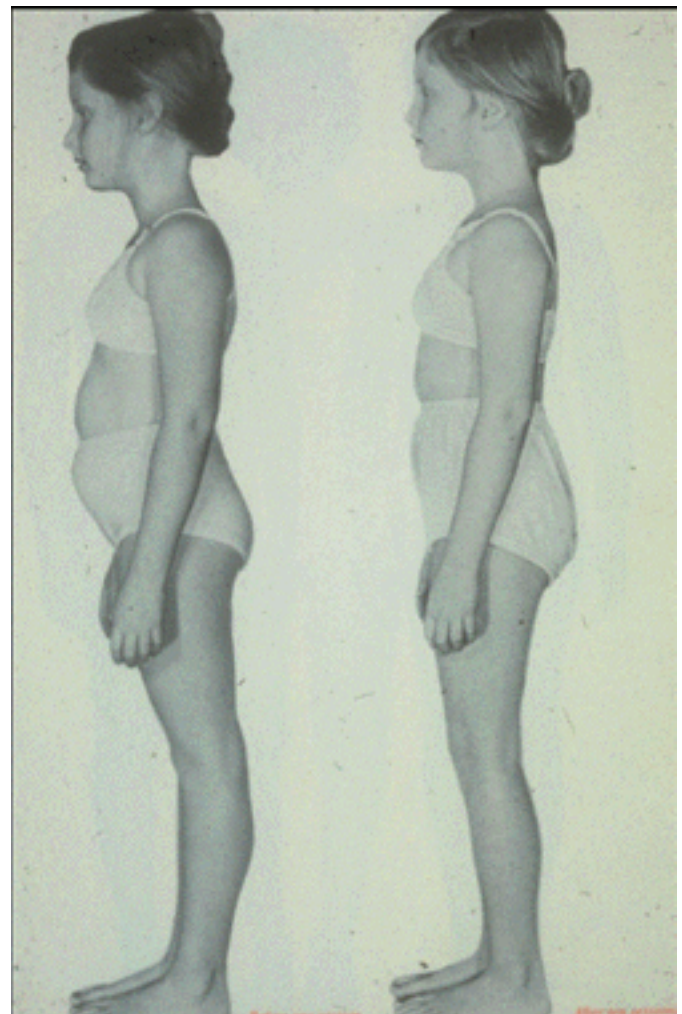


Image 7: The girl's Superficial Back Line has been rebalanced through treatment



Image 8: A short Superficial Back Line is stretching the Superficial Front Line.



Image 9: The Superficial Front Line is pulled down relative to the Back Line.

The first part of this skill is the ability to see the skeleton within the body, and to describe the intra-skeletal relationships. Once you can see these relationships, you can make a hypothesis about which soft tissues are creating or maintaining that position. The soft tissues could be individual muscles, but of course our prejudice is to see these compensatory patterns in terms of the Anatomy Trains lines, as this gives you a better idea as to how the body relates all these patterns together.

In this model, the Superficial Back Line is surely short between the heel and the head, and that is pushing the Superficial Front Line into a stretched position (see image 8).

In this model, the front line is pulled down relative to the back line (see image 9).

In this picture, by contrast, the front line and the back line are very much more balanced with each other – the front is lifted to counterbalance the back. (see image 10)

Of course, this BodyReading can get very much more refined, but this will do for this short introductory article. We are on the threshold of a new era where palpation, vision, and theory can come together in a new systems view of the actions of the musculo-skeletal system, or more accurately, the neuro-myofascial web. The worlds of manual therapy and movement are coming together into a ‘unified field theory’ of the body. The Anatomy Trains is a small step in that direction. We look forward to unfolding more of this point of view ‘down under’ in our courses, as well as in the supporting books, videos, and website.

More can be found at www.anatomytrains.com.



Image 10: A body on balance.

What do employers want from their employees within a remedial massage practice?

The remedial massage profession in Australia has only a handful of multi-therapist clinics in comparison with other health professions such as chiropractic, osteopathic and physiotherapy. Considering our education institutions produce thousands more remedial massage therapists in any one year than in to these professions, wouldn't you expect the opposite? For those clinics that do fly the flag for our industry, we decided to ask the owners why they thought there weren't as many multi-therapist clinics and what employees could do to make our current clinics enjoyable and sustainable.

By Brad Hiskins

The following points represent the most common responses to various questions. Each clinic reserved their right to remain anonymous. These points are not in any way prioritised nor representative of the *STT eMag's* opinion on the matter.

So why do clinic owners think there is a void of remedial massage clinics?

Historical culture

- Most clinic owners viewed the history of remedial massage as a 'third bedroom' or 'cottage' industry. The tendency to move out of one's house and into the commercial real estate world was still a new concept to the industry, therefore the number of mentors that are available to pass on knowledge regarding clinic set-up and maintenance are minimal.
- Limited access to major clinics simply isn't there for graduates, so they turn to the cheapest option to start their careers – their third bedrooms.
- There were a few comments regarding the tendency of remedial massage therapists to rely on other professions to provide rooms, administration and clientele. Hence, many therapists look to work for osteopaths, chiropractors and physiotherapists. The suggestion by some clinic owners was that this created an "I'm not worthy" attitude among remedial massage therapists which decreased the likelihood of working

independently of these other professions.

Education curriculum

- Clinic owners remarked on the comments made by many of their staff towards their education. Young therapists suggested that they were quite specifically told to look for work with other professions rather than established remedial massage clinics.
- Clinic owners suggested it was difficult to establish working relationships with remedial massage education institutions. There was a single but very aggressive comment made by one clinic owner that their local school treated their advances towards current students as "predatory". Their suggestion was that schools should encourage local clinics to visit and build relationships with students for future employment. Moreover, the schools should be asking local clinics what they want from students so schools can adjust curricula for more objective student outcomes.

Health system

- Not being a Medicare approved profession reduced the amount of referrals that could be coming from GPs, which in turn reduced the sustainability of clinics.
- Not being a recognised profession by many within the health system reduced referrals and therefore sustainability.
- The connotation that 'massage' was only for relaxation dramatically reduced referrals from GPs and other health professionals, which again reduced sustainability of remedial massage clinics.
- GPs are conditioned to refer immediately to physiotherapists rather than to remedial

massage. In fact some GPs would refer to physiotherapy for remedial massage, completely cutting remedial massage therapists out of the loop. This needs to change to make more large remedial massage clinics viable.

Pricing per hour

- All clinic owners suggested that our 'hourly rate' was not enough to make a reasonable profit in a commercial property in some centres. Chiropractors and physiotherapists raised considerably more money per hour due to their shorter treatment times and larger pay scales. Considering commercial properties do not take this into consideration, a remedial massage clinic had markedly reduced capacity to sustain high commercial rents.
- Hourly appointments reduced the capacity to pay therapists decent wages to keep them interested in the industry in the long term.

Career mentality

- Clinic owners suggested that remedial massage therapists were quite transient in nature, so sustaining adequate numbers of employees/contractors was very difficult.
- Many remedial massage therapists believed that other professions made more money and preferred to go back to further study.
- Many therapists were only interested in part-time work, which reduced the capacity of the clinic to raise enough money to make ends meet.

The above points are only a summary of comments made, but they are certainly

comments that were made regularly and with some vigour!

What do employers want from an employee?

Again, these points are not in any way prioritised nor representative of the *STT eMag*'s opinion on employee/employer professional relationships. The answers were:

Competence in their ability to assess and treat musculoskeletal conditions

- Every employer wanted their employees to be skilful enough to independently assess, treat and set treatment protocols. This was fundamental to an employees' worth. Many employers expressed their concern over schools not producing what they deemed as competent employees and moreover, the marked discrepancy in students from different schools. It was a headache they didn't want to deal with and believed they shouldn't have to deal with, considering the national competency standards are supposed to suggest to schools what has been deemed a minimum by the industry. Employees simply must have all the necessary assessment and treatment skills to deal with everyday clients. This seems an obvious statement but some or many therapists are not meeting employer's minimum standards. The employer then has to spend extra time with those therapists to further educate them to a 'useful' standard. Although all employers suggested that further education was a must for all their employees, a basic entry level is fundamental that should be reached within the education system. Study your school, ask if it reaches ALL the national competency standards and ask the local clinic owners if they recommend that school as a viable option.

Ability to work independently and also be an integral part of the overall clinical group

- o Employers regularly commented on the absolute need for a therapist to work independently of the more experienced therapists and administrator within a clinic. That is, they did not have to be observed to 'do the right thing' in treatment or be watched over when administering receipts. Therefore in



situations where the therapist may be alone in the clinic, they were completely competent in all areas of treatment and clinic administration. If they didn't have the ability to do this, it was pointless to hire them, as rosters would have to be designed around them.

- o Moreover, if a therapist did not show any ability to communicate with the other therapists and administrator within the clinic (within tutorials, mentor sessions, administrative necessities, general social sense), then that therapist would eventually cause "rifts" and clinic unrest. The word "team" was mentioned on numerous occasions. If there was a weak link in the team, the team suffered and therefore the employer and business suffered.
- o Never, ever, ever whine, whinge, or gossip about any therapist in the clinic, the administrator(s), manager or the owner. Always, always raise the issue in a formal manner to avoid the rot that gossip can create. Understand each other's strengths and weaknesses and be a part of each other's growth and development, not their demise and turmoil.

Be punctual, neat and helpful

- o These seem absolutely obvious but all

employers suggested that there were always a couple of therapists who were renowned for their tardiness with timeliness and neatness. If they are late or untidy, it puts pressure on the admin staff and other therapists to cover for them. Again, this diminishes the relationships within the clinic. Overall, clinic harmony is a major key to success for most workplaces. One or two therapists not pulling their weight was a major factor in clinic breakdowns. When you have your clinic shirt on, you are a representative of the clinic in many ways. Your actions, language, demeanour, behaviour all reflect the clinic. Basic timeliness is fundamental to a clinic's reputation. "Therapists who do not respect this are limiting their work potential and the clinic's reputation," employers remarked.

Understand the clinic philosophy and be able to portray it and express it

- o The clinic's philosophy is one developed over years by the employer. Referral networks are developed, types of treatment are administered and the clinic develops a successful reputation based on these. Employers desperately want their employees to learn, understand, express

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and implement these philosophies. If they don't, then the reputation is lost and the clinic's sustainability is in jeopardy. If the clinic struggles, so do the employers and so do the employees. This statement was integral to the long-term growth and sustainability of any clinic. It was also an aspect that employers suggested was very difficult to integrate into a therapist's mind and day-to-day delivery, both physically and mentally.

- o Respect the short- and long-term goals of the clinic and try to be an integral part of its growth and durability.

Keep clinical notes competently and perform other administration duties adequately

- Employers often raised their voices when asked about clinical notes. Some mentioned therapists who wouldn't do notes for two weeks and then would forget treatments when finally getting around to them. Hence, when the next therapist attempted to treat the client, the previous treatment regime was obscure and therefore unacceptably unprofessional. Employers wanted the very fundamentals of treatment, which includes notes, to be performed adequately without exception.

Be an integral part of the clinic, partaking in tutorials and meetings, opening and closing when necessary, developing relationships with referral bodies

- All employers would like to be confident in and trust their employees. They want their employees to be proactive about ongoing learning and to be an enthusiastic participant in all aspects of the clinic. This means knowing many administration aspects of the clinic so if the situation arose, they could complete the task adequately and the clinic maintained a good reputation. Furthermore, the employers would appreciate their employees contacting and developing personal relationships with referring health practitioners.
- Fill in where necessary – answering phones, cleaning, laundry, new client forms, appointments, receipting. Employers understand that this may be

horribly boring but admin staff may not always be at hand. A one-minute effort to keep the clinic operating well is most appreciated and even expected.

- Try to understand what needs to happen within the clinic to make it run smoothly and effectively for everyone. Help one another where and when possible – at all times.

Understand the financial, social, personal and family sacrifices an employer makes to provide the opportunity the employee gets

- This statement was either made with a degree of frustration, hope or fatigue. Although employers were very aware that it was their choice to take on the risk of running their own business, they believed that an understanding of the sacrifices/compromises made by the employer would inevitably help the longevity of the clinic. That is, if an employer was to ask an employee to complete a certain task that may be outside the employee's immediate job description, they would more likely complete it enthusiastically when understanding and appreciating the employer's efforts and sacrifices to create and sustain the employees job.

Employers want their employees to be proactive about ongoing learning and to be an enthusiastic participant in all aspects of the clinic

Be aware of the nature of the industry and your growth within it

- Employers suggested employees would complain about having to come to work for only one or two clients. Understandably this can be an inconvenience and one that doesn't pay well. However, as employers will recommend, building a clientele takes time. Employers will do everything within their power to get clients for their employees. This makes obvious sense as both parties benefit. But building a client base takes time and early in a therapist's career it is simply necessary to endure the blank sections of your day. This will change with time depending on your ability to treat successfully and to complete all the above tasks within a clinic.

Does this list ask too much of an employee?

Most of the 'needs and wants' of an employer are basic moral and ethical traits that we ask of any person in society. An employer will argue that any good clinical setting is the result of a cumulative effort of the employees to create a harmonious environment. Add the necessary aspect of the employer creating a safe and well catered-for clinic and the group will motor along.

So where does it break down? Judging from the list above, if the employees are decent human beings, then it would be difficult to fail. Surely if all involved demonstrate socially acceptable behaviour then the clinic should boom. But many don't. Why? Many struggle due to basic clashes in personalities and the individual's inability to have patients and develop a workable relationship. Not everyone has to be the best of mates, but common courtesy is essential. Many other clinics fail due to the poor systems developed by the employer or poor ability of the employees to follow them. A true understanding of the clinic's philosophy and basic systems by the employees is an absolute must for success. Simply not filling in your schedule before leaving work on any single day can cause a nightmare for those left to clean up your mess.

Now it's the employees turn. Any employees out there are asked to send in their wants, needs and expectations of their employers. Please send to admin@softtissuetherapy.com.au for the next issue of the STT eMag.

Beginning from the base

Rob Granter continues his series on functional stability.

In the October edition of *Soft Tissue Therapy* mag, I discussed the concept of balance, a vital component of functional stability. Balance can be easily learnt through a systematic approach, which I outlined in that edition, provided that the other essential components are functioning optimally. One such vital component is the presence of a functionally stable and well functioning foot.

“Balance, pelvic stability and posture are all heavily influenced by sensory information from the foot.” (Elphinston, 2008, p 70)

The foot is a sensory “organ” providing information to the central nervous system (CNS) to allow unconscious adjustments to the body’s alignment (Roll et al. 2002). A well functioning foot is often described as a “listening foot”.

“The listening foot is one of the most important components of functional motor patterning. You will not achieve good transfer of gluteal activation and strength into your sport if the information coming up from the foot is poor.” (Elphinston, 2008, p 71)

How can you assess for dysfunction that might be attributable to an unstable foot? The following tests will provide valuable information in relation to adequate foot function or dysfunction.

1. Static foot structure

Assess for a balanced, standing, foot position.

Is the talus sitting in the centre of your ankle mortice?

Is the longitudinal arch well maintained on both sides or is there signs of excessive pronation?

Are there signs of an excessively high arched foot? These feet are often rigid, thus too stable.

Is one foot clearly better than the other at maintaining a balanced foot position or are they both dysfunctional?

2. Active foot control

In a seated position with the knee

flexed to 90°, can your patient easily control shifting weight from the lateral side of the foot to the medial side, keeping the knee stable (not moving medially or laterally)?

If the patient has ideal functional motor patterning around the foot, this motion will be smoothly controlled and they will be able to disassociate active movement of the ankle and mid foot from movement at the knee.

Is one foot clearly better than the other in controlling active movement or are they both dysfunctional?

3. Single leg balance

Stand and balance on the right foot, assess the performance.

If OK, introduce some challenges in the frontal plane – that is, abduct and adduct one arm then the other.

Stand on the left and repeat the challenges.

Is one foot clearly better than the other in maintaining balance or are they both dysfunctional?

It is undesirable to see the foot becoming excessively stiffer in response to the imposed forces (Elphinston refers to this dysfunctional response as functional rigidity). Signs of insufficient foot functioning can be overactivity of tibialis anterior (Brownrigg), toe gripping (especially from the great toe) or lifting of the plantar surface off the floor (Elphinston, 2008, p 78).

4. Controlled landing – jump to one foot from two

Starting from a position of standing on two feet, shoulder width apart, jump to land on one foot approx 3/4 metre out in front.

Repeat jumping to the other foot from the same starting position.

Is one foot clearly better than the other at absorbing and controlling load or are they both dysfunctional? Is the noise of landing excessive? This is a great indicator of function and so relevant to

many lower limb pathologies. After a few patient examples, you will quickly be able to recognise efficient from inefficient function.

Do the knees stay in alignment (centre of patella over the second or third toe)?

Does the pelvis maintain a stable position?

Of course there may be dysfunctional issues further up the body than just the foot, for example in the knee, hip or pelvis; however it is important to evaluate the contribution of function or dysfunction at the foot.

Having assessed functional stability of the foot with the above tests, how can you promote increased function? How can you promote a more optimally functioning “listening foot”?

There many ways to address this but let’s examine two important components, from a soft tissue therapy perspective: A. restoring functional mobility; and B. restoring optimal functional motor patterning and neuromuscular control.

A. Restoring functional mobility

1. Assess and address inadequate passive range of motion of the dysfunctional side.

Ankle joint: dorsi flexion, plantar flexion, inversion and eversion.

Mid-foot mobility: especially the ability to adequately evert to allow the great toe to contact the ground unimpeded.

Metatarso-phalangeal mobility: especially extension of the great toe.

If restricted, apply appropriate soft tissue therapy to the obvious tissue restricting joint movement and reassess to monitor efficacy of treatment.

2. Assess available passive mobility of the inferior and superior tibio-fibular joints. From the ‘resting position’, assess available anterior to posterior (AP) movement and available posterior

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to anterior (PA) movement.

If restricted, apply appropriate soft tissue therapy to the obvious tissue restricting joint movement and reassess to monitor efficacy of treatment.

B. Restoring optimal functional motor patterning and neuromuscular control

Task 1: In a seated position, practice shifting weight from the lateral side of the foot to the medial side, keeping the knee stable (not moving medially or laterally). Endeavour to make this movement as smooth and controlled as possible.



Task 2: Return and hold the foot in the centre, subtalar neutral position. If you can do this without overactivating tibialis anterior then you are successfully facilitating your medial plantar flexors: tibialis posterior, flexor digitorum longus and flexor hallucis longus. If you can't do this without activating tibialis anterior then you have a dysfunctional motor pattern.

To 'switch' tibialis anterior, off or to reduce its dominance, aim to maintain a small degree of flexion at the great toe.

Progressing the challenge, Task 3:

Once you are able to maintain your



foot in a neutral position with the correct 'form', progress the exercise by maintaining this position while the patient performs a heel raise (still in a seated position). Aim to perform 3 sets of 15 reps on each foot. If possible, don't allow the heel to touch the floor on the eccentric lowering phase until the final rep. If the patient is obviously struggling to maintain ideal form, then rest at that point and begin again.

Progressing the challenge, Task 4:

Once the patient has achieved competency with the above exercise



repeat with the patient leaning forward with their elbows resting on the right femur just superior to the patella.

All you are doing here is to increase the load on the foot thus increasing the challenge to the medial plantar flexors maintain a balanced foot, position while under a greater stress. Aim to perform 3 sets of 15 reps with ideal form. Repeat on the left if dysfunctional.

Progressing the challenge, Task 5:

Once the patient has achieved competency with the above exercise, repeat with the patient standing, thus now increasing the stress to at least half body weight, again aiming to perform 3 sets of 15 reps on each dysfunctional side foot with ideal form.

Always gain self-competency before teaching others

So the challenge is issued to you. Implement the process yourself and carefully monitor the positive changes. I look forward to hearing about you and your patient's responses.

References and acknowledgements

Elphinston, J. 2008. *Stability, Sport & Performance Movement*, Lotus Publishing Chichester UK. I highly recommend Joanne's work and this cited book is an exceptional resource. It is available through the Australasian College of Soft Tissue Therapy at <http://www.acstt.blogspot.com/>

Roll, R., Kavounoudias, A. & Roll, J.P. 2002. Cutaneous afferents from human plantar sole contribute to body posture awareness. *Neuroreport*, 13 (15): 1957 – 1961.

Foot & Hand Specialist Physiotherapist Philip Brownrigg, Strathmore Health Group, Victoria Australia, has also been a major influence in shaping my clinical understanding of ideal foot and hand function. Watch for Philip's soon to be published work.

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Warming up

There is little doubt that we live in interesting times. Both late 2008 and the remainder of 2009 are times in history that tested and will continue to test us all. Like many industries around the world, ours is particularly vulnerable to the whims of cash-strapped consumers. While we as an industry struggle to identify who we are and what we do, others forge their paths with determination and positive leadership. One such demonstration of this leadership in the fitness industry is from Andrew Simmons, director of Vision Personal Training, who writes here about how to tackle the crisis.

“Economic crisis, global credit crunch, financial catastrophe, potentially the worst recession of our lifetime, market meltdown”.

These are just some of the phrases used in recent months by the media and ‘experts’ to describe the state of economy. While we should treat this situation seriously and tackle it head-on, unfortunately headlines like these instill unnecessary fear in the minds of many people, including both clients and fitness professionals. In a recent article in *Business Review Weekly* (BRW), it was suggested that consumer spending on fitness will halve in this new financial year. Similarly, an article on domestic budgeting in the *Herald* newspaper in New Zealand recommended people to “give up the gym membership” as a way to reduce household spending.

During a presentation I gave at the 2008 National Franchising Convention in Sydney, I was asked what impact I thought that the “economic crisis” would have on the fitness industry. My response was straightforward. “It will sort out the men from the boys. It will establish which clients/gym members truly value the level of service provided by their personal trainers and/or other fitness providers and those who do not. If clients do not receive outstanding service, they will use the ‘economic situation’ as a convenient excuse to either cancel their gym membership and/or terminate the services of their personal trainer”.



***Our society
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and stressed out
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meaning that our
services have
never been more
needed.***

Recently one of our franchise owners was confronted with such a situation. A client, spooked by what she read in a paper, suggested that she needed to cease training due to the economic downturn. When asked how it has impacted her, she indicated that she only wanted to use the money to pay off her mortgage. After the franchise owner pointed out that interest rates had actually fallen significantly as a result of the crisis, leaving more money in her bank account at month’s end, and established that her job situation was not affected at all, she ‘came clean’ and confessed that the real reason for wishing to cease training was that she felt de-motivated by a lack of goal-setting provided by her trainer. Subsequently, the franchise owner was able to help her establish some more compelling goals which lead to her

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actually choosing to increase the amount of personal training that she does at the studio.

The Australian fitness market is still relatively immature and untapped. Our society is more deconditioned and stressed out than ever before, meaning that our services have never been more needed. However, unfortunately like many clients make excuses for their failures, I have recently heard many fitness professionals too use the “credit crunch” as the excuse for their lack of their success.

I believe that a fitness professional’s success is largely determined by their self-belief during such times. In my opinion, it is professionally unacceptable to allow most clients to stop exercising during times like these. As previously

mentioned, they need it now more than ever, as I see healthy eating, exercise and personal training as a necessity, not a luxury. Those who view it as a luxury will unfortunately allow themselves to be swept up by all of the media hype.

The opportunity for success even in this climate is made apparent by number of large overseas fitness chains that already have or are planning on entering the Australian market within the next five years. I believe that the landscape of the fitness industry in Australia will change dramatically shortly. I don’t wish it was easier, I wish I was better. I am looking forward to tackling these times head-on and forced to become better. By doing so, imagine how fast we can grow when we turn the economic corner once again. Those leaders who possess positive attitudes to these times, are committed to outstanding customer

service and are focused on constant improvement, will rise to the top and achieve greatness in the most rewarding industry in the world. I can assure you that Vision Personal Training will be amongst them.

Andrew Simmons B.Sp.Sc. is the Director of Vision Personal Training, Australia’s fastest growing personal training studio franchise. Currently Vision has 31 studios spread throughout Sydney, Wollongong and the Gold Coast. He is currently a Board Member for Fitness NSW and has also spent time as a member of the Personal Training Council for Fitness NSW. Simmons is also the author of the book Fat Loss Take Control, sales of which have exceeded 30,000 throughout Australia.

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AMT focuses on government recognition

AMT Secretary, Rebecca Barrett, outlines the association's strategic direction.

Recently, I had the privilege of addressing delegates at the AMT conference on the subject of advocacy and leadership in the massage therapy industry. This was a rare opportunity to speak directly to AMT members about the strategic directions being taken by the AMT Board and the reasoning behind them.

Much of my presentation revolved around the issue of identity, something that I believe forms the crucial subtext for any advocacy work that the association undertakes on behalf of the membership and the industry at large. Forming a coherent identity will underscore our rite of passage from being labelled just an 'industry' to becoming a fully-fledged profession.

In order for us to make this transition, there is an enormous amount of work to be done, both at an association level and at the level of individual responsibility. The transition must occur at both ends of the advocacy spectrum. If we expect to be taken seriously as a profession, every single person working within our professional community must commit to thinking and working like a professional: regardless of whether our client base consists of 10 people or 10,000 people, we are all advocates.

The regulatory agenda is gaining enormous momentum in Australia. This is in no small part due to our success as a community in reinventing our image and promoting massage therapy as a health intervention rather than an indulgence or luxury item.

Thus far, however, the process has been largely consumer driven and somewhat ad hoc. Mainstream government recognition has eluded us.

Obviously, AMT has had enormous historical success in its advocacy work with third party payers like WorkCover and the private health insurers. (Our submission to the Department of Veterans' Affairs is still being considered by the Commission, 20 months after the original approach was made!)

There is no doubt that these sorts of hard-

won, third party payment arrangements have helped significantly in repositioning massage therapy as a health service rather than a leisure service. The establishment of the Health Training Package and National Competency Standards in 2002 was another gigantic leap.

But until we have conquered the hurdle of formal government recognition as a health service, we are still only part way along the path to professionalism.

Which is precisely why mainstream government recognition is the centrepiece of AMT's strategic plan.

The four pillars that will form the foundations of our approach to government are where the serious work will be done over the next few years. We'll be relying on you to get engaged with the activities of the AMT Board and play your part in the glorious evolution of our chrysalis industry into a mature profession. We really can't get there without you.

So what are the four pillars of our advocacy plan?

The 1st Pillar: Our clinical evidence base

Evidence-based practice is firmly entrenched as the primary rationale behind health

policy-making. It would be nice to think that this was purely driven by an admirable and noble desire to ensure optimal health outcomes but it is also largely driven by economic rationalism – when there are limited dollars to disburse, governments need an evidence base to justify their health spending.

If we ignore this bottom line, we'll fail at the first hurdle. Our research base is our greatest ally in the advocacy universe. Synthesising our research base and presenting it in a digestible form will be critical to the task of convincing government to treat massage therapy as a health service. Whether government policy-making is motivated by economic imperatives or health outcomes is largely irrelevant to us, as long as our own professional motivations are clear and unequivocal.

So if any of you still believe that the research agenda is irrelevant, please think again. The outcomes we achieve in our clinic should be based on sound, clinical reasoning and research is an inseparable piece of the equation. Research should support our clinical experience, instincts and insights.

How can you help to support your industry's research agenda? Walk outside your comfort zone! Next time you see an item on our conference program relating to research, don't reflexively assume it will be boring and irrelevant. Don't assume that research negates your ability to respond dynamically and instinctively to your clients. Assume, instead, that you may discover the answers to the great mystery of why an approach you took with a client worked. Assume that your confidence as a practitioner will be enhanced, not compromised. Know that you are helping your community to make the transition from industry status to professional status. Research literacy and basic engagement with the research agenda is crucial to that process.

The 2nd Pillar: A National Code of Practice for Massage Therapists

A Code of Practice is a set of written guidelines issued by an official body or

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professional association to its members to help them comply with ethical and professional standards. From an advocacy perspective, a Code of Practice signals to government that a profession has reached a sufficient level of maturity and self-determination to define, set, promote and monitor specific policies and standards.

As an industry, we really don't want a bunch of government bureaucrats doing this job on our behalf. We are the obvious experts here so we are best positioned to set the standards for our own work practices. If we don't, we run too great a risk of having standards imposed on us by people who have scant or no understanding of what we do and how we do it.

Establishment of a National Code of Practice for Massage Therapists not only signals to government that we are serious about our professionalism, it also provides a framework for both the public and other health professionals to better understand our professional scope, skills and boundaries. It will help us promote a clear and coherent distinction between professional/ethical treatment and the many suspect or even marginal practices that continue to attach themselves like barnacles to the bow of the good ship massage therapy.

How can you support the establishment of a National Code of Practice for Massage Therapists? Visit the AMT wiki (www.amt-ltd.org.au/wiki) and read the introductory pages on the current state of regulation. Ask yourself if you can name the Federal Minister for Health. If we want to play a

more mainstream role in healthcare delivery in this country, each and every one of us needs to take some responsibility and develop at least a rudimentary understanding of the regulatory environment in which we operate.

The 3rd Pillar: A National Code of Conduct for Massage Therapists

A Code of Conduct is a set of rules outlining the values and standards of behaviour expected of an individual or an organisation. Establishment of a nationally-endorsed Code of Conduct for Massage Therapists would enable us to promote our profession as safe and ethical to government, allied health professionals, the general public and other key stakeholders such as the private health insurers. The principles enshrined in a code of conduct should contribute to the welfare of all stakeholders and respect the rights of all parties affected by its operation.

Formulating a National Code of Conduct is a key advocacy task for our profession, especially in light of the work program of the Australian Commission on Quality and Safety in Health Care. The Commission has been charged with a government mandate to lead and coordinate the establishment of national accreditation schemes across the health care sector. An endorsed Code of Conduct sends a clear signal to government that we are serious about setting and monitoring ethical and professional standards of behaviour and we are ready to take our rightful place in the mainstream healthcare sector.

How can you help support the

establishment of a National Code of Conduct for Massage Therapists? One of the key ways you can support AMT's work in this area is by supporting our continuing education program and philosophy. Ongoing education is a key part of our ethical framework, as it gives us a precious opportunity to continually reassess our strengths and weaknesses as practitioners and feel 'safer' within our scope of practice. A practitioner who has stopped learning and interacting with his/her peers at workshops and meetings is a practitioner at risk. Benchmarking our performance against other practitioners is one way we can regularly flex our ethical muscles, as well as demonstrating our commitment to professional excellence.

The 4th Pillar: Industry profiling

We need to be able to tell government who we are and how we work. To do this, we need survey data. How many of us work full-time? Part-time? How many of us charge GST? How many of us earn more than the GST threshold of \$75,000?

Many of us would like to see massage become GST-exempt. But the first thing that Treasury will need to assess is how much revenue would be lost. We cannot answer that question without collecting the necessary data. We cannot advocate effectively until we have compiled our own industry evidence base.

How can you assist us in the task of compiling an industry profile? When we start surveying you next year, please respond. Your data is immensely valuable to your professional community.

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The Occurrence of Injuries in Ice Hockey: an investigation into an English Premier League Team

Hannah Boardman, lecturer in Sport Therapy at University College Birmingham, analyses the type of injuries most commonly experienced by ice hockey players.

Introduction

The origins of ice hockey are yet to be confirmed, and the exact date of the game's birth and country of origin is often debated. One thing, however, which is often confirmed, as Vaughan (1999) states, ice hockey is the fastest and most exciting winter game in the world.

It is a fast paced game which involves both finesse and controlled aggression, with high puck velocities, aggressive stick use and collisions being as much a part of the game as scoring goals, it can only be assumed that injuries are of frequent occurrence (Daley et al. 1990; Norman et al. 1980; Villasenor et al. 2006).

This investigation looks into the occurrence of injuries in ice hockey, and will pay particular attention to the English/British game. The hope is to create a datum point allowing for the development of further research in the area of English ice hockey, which appears to be under-represented within the literature. It is apparent that research in this area is essential in creating preventative strategies to aid in the development of the game, which has been recorded by the Cassidy Coventry Blaze as the fastest growing spectator sport in the United Kingdom (UK).

Methodology

Both primary and secondary research has been collated in order to investigate the occurrence of injuries in ice hockey, starting with a look at the existing literature.

The secondary research collected initially indicates a distinct lack of recent research with some articles or data being recorded as early as the end of the Second World War. The most recent research utilised data collected from the 2004/05 season, but even this was prior to the recent stricter rule enforcement generated by the International Ice Hockey Federation (IIHF), nicknamed by fans according to The Hockey Forum (2007) as zero-tolerance. The research presently available also has its relativity questioned as none of the articles investigated contained data regarding English or British teams/players – thus highlighting the demand for primary research to be employed.

Research was carried out which looked at the occurrence of injuries from within one English Premier League (EPL) ice hockey team. The EPL is the second tier hockey league within the UK and consists of 12 teams (EIHA 2007). During the period that the research was carried out, the teams within this league compete for three items of silverware; the league, cup, and the play-offs. During the 2006/07 season, the team in question finished third from bottom in the league, and did not make the cup or the play-offs. They have subsequently folded, thus ceasing to participate at this level. The creation of the modern EPL followed the demise of the British National League (BNL) which in turn led to an increase in the number of teams and quality of players. The number of non-English Ice Hockey Association (EIHA) trained players dropped from eight in the BNL to four in the EPL, creating more competition for the roster spots and raising the standard of play.

The injuries recorded were taken from data collected from the

2006/07 season, and were documented from the beginning of the season to the end of the calendar year. Limitation of the study was required due to time restraints on access to the players, and in order for the data to be collated and analysed.

To increase the internal validity of the data amassed, the first two games of the season were excluded to rule out any pre-season injuries. Data was collected over a period of 15 weeks and included 26 games and 26 training sessions resulting in a total of 52 contact points. This team in particular trains twice a week for a period of an hour, and generally plays two games a week, one at home and one away. The majority of players also participate in additional off-ice training. In England the season runs from September to March excluding the play-offs, where only the top eight teams in the league are invited to participate.

The sample of players used within the research was the entire population of the team that was selected, as recorded on the team roster on the first day of the season. Subsequent signings or releases were excluded. The sample included 18 players from varying positions consisting of eight defensemen, 10 forwards and two netminders from an age range of 15 to 18 years old. The sample included both EIHA and non-EIHA trained players, with all four of the non-EIHA trained players being native to Eastern Europe. This would appear anecdotally, according to interviews with players, coaches and fans, to reflect the majority of teams competing in this league.

Injuries that were included in the study were those that caused a player to miss all or part of a game or training session.

Data was collected via a table containing the names and positions of the players, against the games played or training sessions attended. The chart also recorded how many training sessions or games that a player missed as a direct result of the injury received. Any injury that was assessed or required treatment by the team sports therapist were included in the study. As all injuries were assessed by the team sports therapist it ruled out any differentiation in the knowledge, ability or experience of the person(s) reporting the injuries.

By the end of the study, the number of participants had decreased to 16, leaving five defensemen, nine forwards and two netminders. Reasons for the decrease in population of the study include long-term suspension as a result of an assault of an official, and transfer to another team.

Literature review

Ice hockey is a fast-paced game involving finesse and controlled aggression with some players skating faster than 25mph, unleashing shots around 90mph to 100mph; it seems inevitable that injuries will occur (Daly et al. 1990; Musashi 2006).

The literature regarding injuries within the sport of ice hockey resides in two main areas; that of data collected from players

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competing in the North American/Canadian leagues, and that utilising data from players competing in the European leagues, mainly the Swedish and Finnish leagues.

The majority of the studies which were discovered were located in the journals, with the data being collected after the regeneration of ice hockey after the Second World War and up until the 2005/06 season. Many of the articles followed the same methodology (Flik et al. 2005; Emery & Meeuwisse 2001; Molsa et al. 2000) of studying an ice hockey team over a set period of time and recording the injuries that occurred. This research was normally carried out by an off-ice official, with the main differences between the studies being the length of time that they were continued over. These studies are in stark contrast to studies such as the one completed by Wennburg and Tator (2003), which were completed by evaluating the injuries that were reported by the media. This difference in methodology made them difficult to compare because the reliability of the Wennburg and Tator (2003) is questionable, as the teams in question may not disclose all the injuries suffered by the players to the media. An alternative methodology used was in the study compiled by Hagel et al. (2006), who recorded the numbers of players admitted to the accident and emergency departments. Again the results could be questionable as players may not always seek medical advice, or may play for a team with its own medical support staff. It also seems more likely that minor injuries such as strains/sprains would not require medical treatment from an emergency department, in comparison to the more severe injuries such as concussions.

Throughout all the secondary research differing standards of play were considered, from junior and recreational players through to professional National Hockey League (NHL) players, with large amounts of the research taking place regarding junior players, which relates to the primary research carried out, as according to the official team website, 16 is the age of the youngest players.

None of the articles located investigated the injury rates in English or British ice hockey players within the UK, even though there are several leagues and a national team. According to the EIHA (2007), the number of teams within the UK has risen to 257, with over 8,000 licensed players and coaches. The lack of research also appears slightly surprising as in its past the UK has gained great success, with Drackett (1987) stating that ice hockey is of British descent and according to Crawford (2007), Great Britain was the first nation to win the triple crown containing the Olympics, World Championships and the European Championships.

Although many articles were located regarding players from the North American/Canadian leagues, many of these articles lacked specificity to injury occurrence, and the age of many of the articles lower their validity, as every year the rules are evaluated and sometimes changes are made – for example the introduction of visors on helmets and neck-guards. The lack of specific research regarding injuries seems surprising. Boden (2005, pp. 445-54) even goes as far as to state that “ice hockey has the highest incidence of catastrophic injuries for sport in which males participate”.

At first glance it appears much of the European research has more relevance to this project than the North American/Canadian research, primarily because all of the non-EIHA trained players in

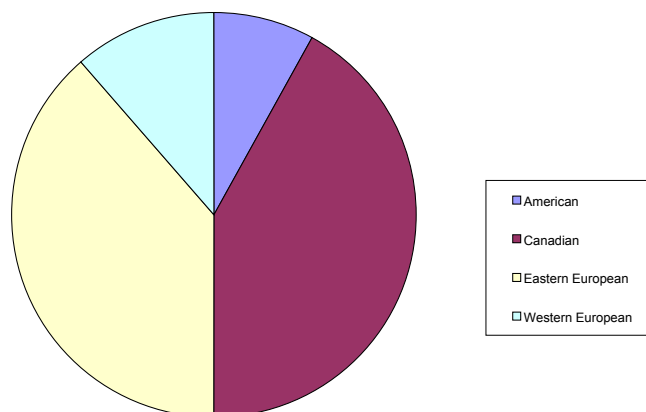
the team are from Eastern Europe, with the team possessing two Slovaks, a Lithuanian and a Pole. It is also thought anecdotally by players and coaches alike that the European style of play is becoming more apparent in English/British game, which could be as a direct result of the increase in use of Eastern European players within the EPL. According to each of the 12 EPL teams’ official websites, there are 57 non-EIHA players registered on the rosters. Figure 1 shows this non-EIHA trained player representation, with 24 of the players coming from Eastern Europe, 15 coming from Slovakia alone (26%). This increase is thought to be largely due to the wage difference between those of Eastern European dissent in comparison to the more expensive North Americans, Canadians and Western European counterparts. Another reason behind this increase could be the increase in member countries to the European Union (EU), meaning that there is no requirement for them to obtain work permits. According to Ice Hockey UK (2007), no players requiring work permits are allowed to play for the EPL.

The rink size in the UK also correlates with the European rink sizes, with the exception of the Isle of Wight, which links furthermore the study compiled by Wennburg (2005), which found that there was significant inverse correlation between rink size and collision rates, and found that the use of larger rinks could reduce the risk of injury. The IIHF (2006) states that a rink should be a maximum of 61m by 30m and a minimum of 56m by 26m.

The new ‘zero-tolerance’ rules are suppose to bring about a reduction in the number of ‘slashes’ when a player swings his/her stick hard at the opposition, ‘hooks’ when a player tries to impede the progress of the opposition by hooking them with their stick, ‘cross-checking’ when a player holds their stick in both hands and drives the shaft into the opposition, or ‘charges’ when a player takes more than a few steps to skate into a opposition player, to name just a few techniques (First Base Sports 2007). This is of obvious significance because as much of the evidence suggests, the primary mechanisms of injuries in secondary research was body-checking, followed by stick and puck contact (Benson & Meeuwisse 2005; Molsa et al. 2003).

It has been considered by authors such as Hostetler et al. (2004) that injury rates have increased in recent times due to the increase in size and change of somato type of the modern day players. According to the Solihull Barons official website (2007), the mean height of a player is 5ft 11ins, with a mean weight of 188lbs.

Figure 1: Player representation



Many of the authors researched agree with Daly et al. (1990) that “injuries are related to direct trauma (80%) and overuse (20%)”. It would seem apparent that research within this area is significant in identifying injury patterns, and will therefore help to bring about preventative strategies.

Discussion

It has been reported by McIntosh and McCrory (2005) that any sport involving body contact, projectiles, and/or high speeds is associated with injuries, thus making ice hockey a sport involving high risk of injury. Whiting and Zernicke (1998) found that in many cases musculoskeletal injuries occur as a result of one object on another, coinciding with the primary research that found impacts being the major cause of the injuries recorded as shown in Figure 2. It was found that 66% of all injuries recorded were as a direct result of an impact, whether from a stick, puck, skate or opposition player. These figures can be supported by Daly et al. (1990).

As shown in Figure 3, the majority of the collision injuries were a result of impact with either the opposition (42%) or the puck (42%). The puck has been known to reach speeds of 200kmph (Groger 2001), therefore it is not surprising that it can cause vast amounts of damage. These results are echoed across many of the articles located in the secondary research (Daly et al. 1990; Flik et al. 2005; Juhn 2002; Molsa et al. 2000). Weinburg (2004) even went as far as to suggest that body impact or collision is the main risk factor underlying all sports-related concussion.

It was found during the primary research that the head/face were the areas of the body most frequently injured in ice hockey, followed closely by shoulder, trunk and upper leg, as shown in Figure 4. This results are different to previous studies compiled, including the studies by Biasca et al. (1995) and Flik et al. (2005), who both found that the most common injury was damage to the medical collateral ligament, however even this is in comparison to the study by Molsa et al. (2003), which found upper extremity injuries the most common. While this leaves this area open to debate, these differences could highlight the differences between the North American/Canadian style of play and the European, or even the implication of the ‘zero-tolerance’ enforcement.

Concussion was the most common single injury during the study, as shown in Figure 5. These results relate to the much earlier study of Castaldi (1991) who acknowledged that prior to 1975 craniofacial injuries were the most frequent of all ice hockey injuries, and it would have been thought that these findings would have been changed drastically due to the introduction of different protective equipment and associated rules. Controversially, Rampton et al. (1997) reported that the risk of receiving a craniofacial injury was the same while wearing a half-visor (Perspex shield covering half the face) as wearing no facial protection at all. During the primary research, craniofacial injuries included a broken nose as a result of impact from a butt end, lacerations from either contact with the puck, player visor, or skate blade, and five concussions, although none of the players included in the study play without a half-visor. Out of all the secondary research, craniofacial injuries were most commonly reported by Rampton et al. (1997), which was the study conducted through emergency department admissions. This is most likely to be as a result of stitches being required or the seriousness of an injury like concussion.

Also in support of the secondary research compiled by Rampton et

al. (1997) regarding the mean age of the injured hockey player being 23.9, the primary research found the age group 18-24 as the most frequently injured, as shown in Figure 6.

With regards to exposures missed as a result of injury, the primary research found that the mean number of exposures missed was 4.2. It appears that the majority of injuries resulted in a missed exposure of approximately 1 or 2. The greatest number of missed exposures was 12, which was a result of a dislocated shoulder.

With the exception of two concussions, all injuries occurred during a game exposure as opposed to training. The majority of secondary research studies also concurred with this, including the studies by Daly et al. (1990), Flik et al. (2005) and Molsa et al. (2003). In the primary research, game exposures accounted to 50% of all exposures, this is in comparison to the Flik et al. (2005) study where game exposures only accounted for 23%.

Controversy also arose with studies including that by Daly et al. (1990), Tator et al. (2004) and Groger (2001) finding that the introduction of improved equipment and stricter rule enforcement has reduced the risk of injury. However Biasca et al. (2002) found that the number of cerebral contusions has increased and that this injury risk cannot be eliminated by any kind of equipment. It was however suggested by Murray and Livingstone (1995) that maybe this is due to the players adopting a false sense of security when wearing protective equipment, thus leading them to taking excessive and unwarranted

Figure 2: Mechanism of injury

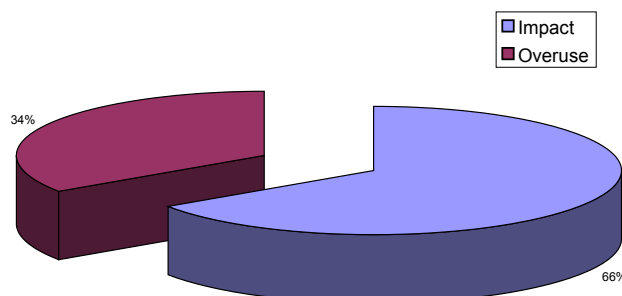
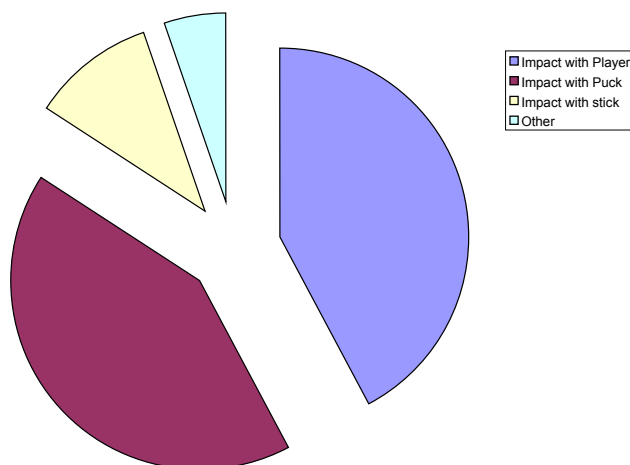


Figure 3: Impact injuries



Continued on page – 22 ↘

risks. The risk of gaining a concussion was also found to increase as the standard of play increases (Honey 1998).

Another interesting finding in the primary research was that 25% of the injuries occurred on the home ice, in comparison to away ice rinks (75%). There could be many reasons for this, including a different size rink, additional nerves, length of journey to the rink, being confined to a small area whilst travelling, or whether it's the first or second game of the season. Figure 7 shows that the majority of injuries occurred on the smaller ice surfaces of the Isle of Wight, supporting evidence put forward by Weinburg (2005) who found that the numbers of injuries on small, intermediate, and large ice surfaces were 295, 258 and 222 respectively.

The primary research collected highlighted the defence position as the position most likely to sustain an injury, however many of the previous studies including that by Groger (2001) stated the forward was at a higher risk. This difference again could highlight the differences in the style of play. It is also common for teams in both North America/Canada and Europe to play with seven or eight defence players, however in the EPL it is often common for a team to play with five defence, thus increasing the exposure time.

The final finding from the primary research was that the non-EIHA trained players were more commonly injured, even though they only accounted for 24% of the team. No secondary research was located to support this; however results show that it is 1.5 times more likely for a non-EIHA trained player to be injured. Reasons for this could be that their positions are usually the higher paid, more

sought-after, placing a higher demand on the player to perform, also they tend to have increased ice time, or maybe even that they are more visible threats for the opposition as they are usually the higher scoring, more skilled players within the team.

With its mix of players from Canada, America, Western and Eastern Europe and coaches from Canada or England in the EPL, the influences on the English game must be significant, and it is findings like the ones highlighted in the primary research that indicate a need for further research to be carried out.

Conclusion

This research has highlighted differences between English/British hockey and the research carried out in North America, Canada and Western Europe. Unfortunately it will be difficult to ensure that these differences are due to the different style of play and not the introduction of the new 'zero-tolerance' rules, as no control group exists. This could however be made clearer with continued research into the area.

There are flaws with the primary research carried out and this could be improved greatly by extending the time scale in which the team was studied, so that it was investigated over the period of a complete season(s), or that the same period was used over a period of years. Another method could have been to investigate the second half of the season and compare the results with the first. This in theory could allow more injuries to occur, thus increasing the reliability of the research. The validity could have been improved by increasing the population size and maybe including more teams from within the EPL.

The clear lack of relevant research in relationship to injuries in ice hockey in the English game must highlight that the comprehensible recommendations must lean towards further research in this area, to enable any form of understanding the risks of the game, or to create preventative strategies.

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Figure 4: Occurrence of injuries in relation to body part

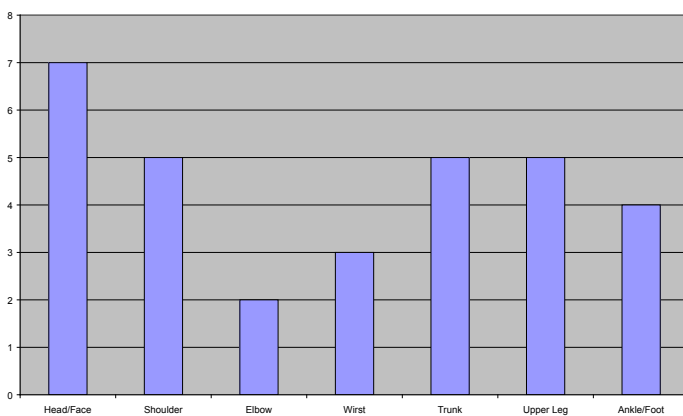
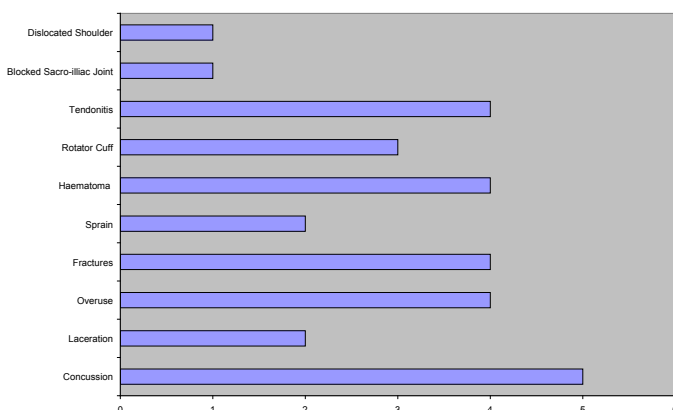


Figure 5: Types of injuries



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Figure 6: Injuries occurring what age of player

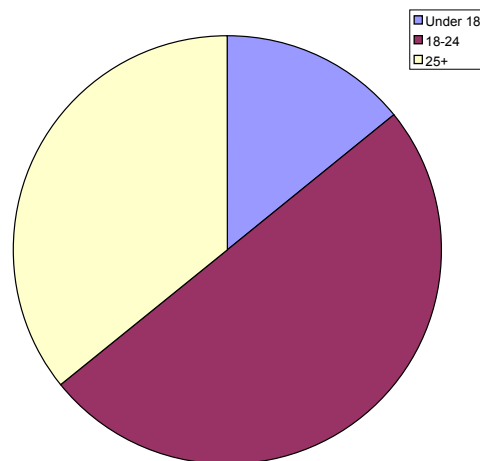
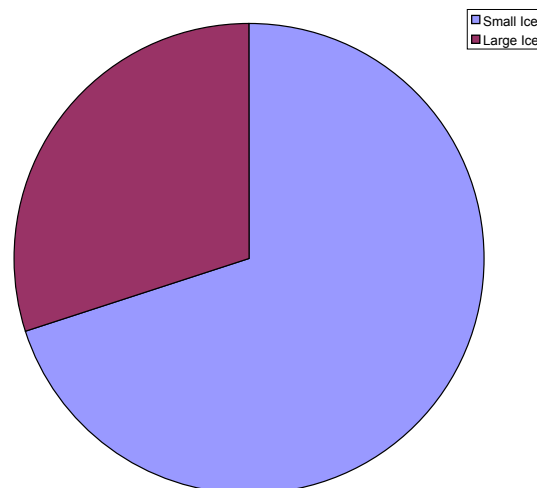


Figure 7: Injuries in relation to rink size



My experience as a Soft Tissue Therapist at the Beijing Olympics – a UK perspective

UK therapist Paula Clayton shares her contrasting experience at the Athens and Beijing Games.



STT Paula Clayton with gold medal winning athlete Christine Ohuruogu

This was my second Olympic cycle and my approach to this one compared with Athens was like chalk and cheese.

Five years on, I am a much better soft tissue therapist. Four years of increasing my expertise makes me far more experienced and looking after 63 athletes in Macau and Beijing was not as

intimidating as it may sound. I know most of the athletes I work with now really well and my relationship with the rest of the medical staff has also developed into a close-knit 'team' in every sense of the word.

Prior to 2003 I hadn't spent much time travelling with athletes where we ate, slept and breathed the same air in the

same space for extended periods of time. I was nervous on my first trip (Olympic training camp in Paphos/Aphrodite Hills) and felt like a fish out of water. The intensity of the athletes, coaches, camp and treatment schedules was completely alien to me and I had a few tears!

The lead-up to Athens progressed at such a pace, the pressure and intensity increased daily. I found that I revelled in it – that this was where I should be. I gained confidence in my ability and in the team around me.

By the time Athens descended on us I had been on several international trips and it was all second nature to me. I fitted in and my skills were being perfected for track and field.

The medical team as it stands has now been together as a unit for the past three years. We regularly travel together so any challenges were ironed out early on and we now have relationships that are strong enough to deal with any differences we may face.

This makes for an extremely comfortable and supportive environment, which is paramount when you are away from home for an extended period of time and will experience a range of emotions along the way.

I, for one, have been told of the death of a family friend while away at the world championships in Osaka in 2007. In any other environment, this devastation would have sent me spiralling into an emotional wreck. Instead I was given the time, space and support that enabled me to continue to do my job in an already highly charged, emotional, competitive environment. This was done without hesitation, I was a person first and an employee second.

All this lays down a foundation which is strong and certain. Having no concerns about who you might be working with or what type of athlete you might come across or having a difficult member in your team allows you the space to do your job to a very high standard. Not that should those things arise you wouldn't perform to the absolute best of

your ability, but it makes it easy and this enables you to cope with other potential problems along the way.

Working and living in the Olympic Village is like being in a bubble. In Beijing, everything was so fantastically organised that life and daily activities were effortless. Athens was similar, but how can you compare to a country who can throw inordinate amounts of money at organisation and a nation so proud of who they are and how they are seen by the outside world. Unfortunately, for those stationed outside the village this was definitely not the case. Taxi drivers who were brought in from surrounding villages to help with the load, didn't know where the village was and how to get to the different gates with all the security and one-way systems that had been put in place. This made for an inordinate amount of time being taken just to travel from A-B. Then not having accreditation and only having day passes produced its own set of nightmare processes which had to be followed.

Luckily for us, we had none of these problems. Having full accreditation meant that we could travel freely and easily from A-B without so much as an after-thought.

Buses were always on time and as soon as one left, there was another. Food was excellent and there was so much variety I would challenge anyone not to be able to find something to eat, and this is coming from a very fussy eater!

Our apartment was one floor above our treatment room, which was adjacent to the BOA treatment room. So it took all of 30 seconds to walk to work-tough times!

I am very lucky to be a part of a team which trusts my abilities without reservation. All of the specific soft tissue issues which arose were directed to me and as always, there was continued and unwavering best practice behaviour. Regular discussions with the whole team ensured that each athlete was getting the best from all of us. Regular cross-referral and follow-up was a fundamental rule.

Post-comp 'rubs/flushes' were shared by the whole team to avoid athletes waiting around unnecessarily so they could go off to continue with their recovery strategies (refuelling, ice baths, resting, sleeping).

All of these things combined with a strict directive of treatment times

and recurrence to keep things running smoothly and efficiently.

Organisationally I couldn't fault how easy things were – right down to how the laundry worked. You were given a blue zipped bag for colours and a pink one for whites. On the top of the bag was a bar code. When you checked your laundry in (which was free and returned less than 12 hours later), they scanned both the bar code and your accreditation. This not only identified you, but the block, floor, apartment, room and actual bed you were staying in, making it almost impossible to lose your clothes. This is just a very small thing, but it highlights how they thought of everything.

One of the highlights of my trip was being able to watch the whole of the men's triple jump final. Working very closely with jumpers in general, I found this both valuable personally but also professionally.

Another would be one of the days it was my turn to stay in the village and 'man' the treatment area. It was the day Chrissie [Christine Ohuruogu] won gold. There were three apartment blocks assigned to the Great Britain team and you could hear them shouting and

**Regular
discussions with
the whole team
ensured that
each athlete was
getting the best
from all of us.**

screaming all around you as she passed the finish line. You could also 'almost' see the blocks shaking as with windows open you heard the heartfelt, passionate belting out of the National Anthem as she stood on the rostrum to have her prize placed around her neck. I still get goosebumps thinking about that.

Being right next door to the BOA treatment room with their huge flat-screen TV, we were able to see or hear while we were treating all of the other huge successes of the British team. We would then see them personally as they dripped in one by one to the treatment room to be assessed or treated and sometimes watched with them as the repeats came up on the screen – quite a surreal experience.

All in all it was a positive experience both professionally and personally. I have to thank the rest of the medical team for trusting in me and for making my job easy as I know I have high expectations.

First Athens, then Beijing, now roll on London in 2012, where I know again I will be an even better practitioner with another four years' experience and expertise. (It's not all about the technical skills which I now take for granted, it's about being part of the team and doing everything you can to help that team fulfil its duties, right down to making cups of tea and having someone cry on your shoulder.) This time round we will be on home soil. Awesome!

If I had any advice for therapists hoping to be part of London 2012 whether it be as a volunteer or with a team, I would simply say:

- Know your stuff and know it well.
- Don't skimp on the amount of information you should be constantly reading, sourcing and discussing.
- Work in an interdisciplinary way-cross-referral/feedback is paramount for best practice.
- Forge your relationships with the physiotherapists and doctors you work with, you have a lot you can teach each other.
- Team, team, team... support each other.

Paula Clayton is EIS Sports Soft Tissue Therapist (six years) and Senior Sports Soft Tissue Therapist, UKA, GB Athletics team (since 2003).

G'day from the Host City 2012 – London

It is not often Team Great Britain is in a position to claim bragging rights (and blow its own trumpet), but the Beijing 2008 Olympics were, as we have all been told in the UK, our most successful in 100 years – admittedly with some help from various coaching friends from overseas. If that is not enough, London is now the host city for the 2012 Olympic Games. So the next challenge begins, to be ready for the Games, especially with the realities of the rapidly spreading worldwide recession.

One consolation for London is that it rained, heavily, at times in Beijing (and as I recall, also in Sydney in 2000). Thus it was appropriate that during London's eight-minute presentation at the Beijing Closing Ceremony the organisers featured not only an iconic red bus, or was it a green hedge, but also umbrellas, definitely in keeping with the UK weather, and possibly a warning to all for 2012. As ever, we managed to include soccer with the appearance of the well-travelled Londoner David Beckham.

The flag was passed from Beijing to London, and London Mayor Boris Johnson, affectionately nicknamed BoJo by *The Times* newspaper, strutted his stuff with the flag waving.

The handover party in London was held in the Mall outside London's most prestigious address, Buckingham Palace, with a capacity 40,000 in attendance. I cannot confirm whether the Queen was amongst them. It was beamed on big screens around the country as we celebrated both the handover and the 19 gold, 13 silver, and 15 bronze medals, and the party included personal appearances from Bradley

Wiggins (two golds), Philips Idowu (silver), and the USA's Michael Phelps (more golds than most countries), along with many past British medal winners. As a sportsman and coach, apart from also being a soft tissue therapist, I am still waiting for someone to pinch me so I can wake up and find out what really happened in Beijing.

So what of the future? The preparations have started, we have knocked buildings down, dug holes, and laid foundations, and even completed the sailing venue on the south coast. The rest is to come, although with the aforementioned global recession there is already talk of cancelling some venue building and rescheduling the location of events. Not even the Olympics can hide from a world downturn.

But I sense the spirit has changed and there is an enthusiasm for 2012 and to be ready to welcome the world, continuing our newfound success.

What of soft tissue therapists, sports masseurs/masseuses? Well the winning of the Games contributed to an acceleration in the review of the National Occupational Standards in our profession, the standards were due to be finalised in October 2008 and implementation due in early 2009. I look forward to providing an outline of their content in a future edition. We should then be able to finalise plans that will prepare STTs in the UK to staff the Polyclinic that will be part of the 2012 London Games.

We look forward to seeing some of you and your teams in London 2012.

Stephen Cluney, MSMA L4

Results of recent polls on www.softtissuetherapy.com.au

Should soft tissue therapists be prescribing foot orthotics?

Why not? What could it hurt?	0%
Definitely. We need to broaden our horizons	6.6%
Podiatrists do this, why should we?	44.3%
Maybe, with adequate training	49.2%

Where do you work from?

Home	29.8%
Remedial massage clinic (STT, Myo etc)	46.8%
Mobile	8.5%
Multidisciplinary clinic (with physio, osteo, chiro, doctor, other)	14.9%

Do you think a degree would enhance or hamper our industry?

Enhance	78.6%
Hamper	21.4%

Do the modalities of Kahuna, Thai and Lomi Lomi massage belong in our membership?

Yes	15.7%
No	84.3%

Are Australian education institutions producing competent remedial massage therapists?

They are doing a great job of meeting the competency standards and producing excellent students	4.7%
Only very few schools produce employable graduates	39.1%
The difference between schools' teaching levels is vast and students differ immensely	53.1%
I don't know any school that produces an RMT that I would employ with confidence	1.6%
I don't know what a competent RMT is anyway	1.6%

Are Australian associations adequately promoting massage therapy versus remedial massage therapy?

No, they all ignore the difference	50.0%
Some try but are lost in the crowd of associations	27.6%
They wouldn't know the difference	15.5%
They are doing a good job of promoting	

the difference 6.9%

Should we regulate our advertising?

No, it's a free market to advertise what you like	11.1%
No, but there should be some basic rules on what you can define yourself as	44.4%
Yes, all should advertise to Cert IV and Diploma only with no advertising of add-on techniques	5.6%
Yes, there should be regulation on how you define yourself (via undergrad and postgrad education) and what you offer as a service (association approval only)	38.9%

How much of your STT work is injury management (in comparison to general massage)?

0-25%	14.3%
25-50%	15.9%
50-75%	28.6%
75-100%	41.3%

To have your say in future polls, visit www.softtissuetherapy.com.au

So long, Stewart Condie

By Gough Alker

As we begin 2009, we have lost a valuable member of our community. No, we have not lost him to the heavens, but he has decided that enough is enough. The sad, sad fact of the matter is that this man cannot, and does not want to continue to function, in this, our confounded industry. While it saddens many of us, and he is a great loss to our industry, we respect his choice and know that it was a multi-faceted decision.

Many people in our industry have passion. Stewart had another quality that very few of our industry have – that is, guts. He says it exactly like it is. His character and spirit is one that is an absolute necessity, though not necessarily welcome, on any management-type committee or executive board. He would, as Greens' leader Don Chipp once said: "keep the bastards honest". Stewart was never one to enjoy any free rides on any gravy train.

Stewart has a long history of excellence in his academic endeavours, his clinical practice, and in his educational career. As the now former Program Coordinator of the Myotherapy course at the Royal Melbourne Institute of Technology (RMIT), Stewart was very well-regarded across all healthcare industries. In his time at RMIT, Stewart steered and influenced countless students. He always had high expectations for and of his students. He jealously protected them and would never see any of them used as fodder by charlatans from our or any other industry.

So why is he moving on?

He was well-revered, well-educated, loved his work, and was great at his job. We, as an industry, need to examine the reasons why one of our great industry leaders who had a very prestigious and rewarding career has chosen to leave the industry.

Is Stewart's leaving merely a symptom of our systemically sick industry?

For years now, we have looked on, numb, as thousands of our graduates and therapists abandon the industry. It is a sad and demoralising fact that we are all

immune to the fact that our students often graduate, practise for a short while in our industry, then move to another profession like chiro, physio or osteo, where they can feel confident and secure in the future of that profession. Our proactive, inspired, enthusiastic massage, remedial massage, and soft tissue graduates want more than our industry has to offer – this is an ominous position for our industry to exist in.

Until we can offer our best and brightest massage, remedial massage, and soft tissue graduates genuine career prospects and career pathways, our industry will continue to haemorrhage. With no direction, no further training, no research opportunities, or career options, why would they hang around? These people need to be inspired – they want to be exceptional.

Of course, this is not the sole reason that our graduates and therapists move on to greener pastures. Nonetheless, we need to learn all the reasons why they leave and then systematically address each of those reasons. We cannot afford to lose great therapists. Many therapists who have left our industry are now shining lights in other healthcare disciplines. Their skills, which they developed in this industry, are strengthening the position of their new chosen healthcare discipline. As a consequence, our industry's position grows weaker in the eyes of the healthcare sector, the community, and the government bodies that we seek to influence. We're having our own weapons turned on us. We're helping to build the reputations of rival industries.

These are defining moments in history for our industry.

Living in these circumstances, as it exists now, our industry is threatened with extinction. Imagine 'what if' the leaders of other healthcare industries like chiro, physio, or osteo determined that they, not us, ought to control massage, remedial massage, and soft tissue therapy. Far-fetched? Not likely. These healthcare disciplines are well-armed, well-financed, and hungry to broaden and consolidate their market share, and their position in the healthcare system. Let's face it, what chiro, physio, or osteo does not have some form of massage or soft tissue therapy

in their practices? They have us there because they know what we do gets great results.

If our industry continues to be ineffective politically and passive in developing career options, it is only a matter of time before our industry is mauled, vandalised, and exterminated by other healthcare disciplines.

Rest assured that out of this, our associations will spend most of their energy defending their inadequacies, rather than doing anything positive. The usual rebuttal is: "well, why don't you all join a committee and help out"... but, we are not all here to function on committees, some of the membership gather intelligence for the associations. It is still vitally important for members to look, see, find, and shout to the associations things that they clearly cannot see because they are so caught up managing the membership. In reality, they cannot see what we see 'at the coal face'. If we were all on association committees, who would be left to point out these oversights in our industry's management? We would probably all be as blind as they are to the obvious flaws in their priorities and methodologies.

It is a true fact. We do need genuine leaders who will get in, take a sincere and honest interest in the industry, take some tough decisions, implement those decisions, and then assess the efficacy of those decisions. We do have the personnel in this industry to turn things in our favour, but, unfortunately, the great leaders all reside in different associations. So what do we do – keep waiting for destiny? Sadly though, waiting for our destiny to arrive has cost us Stewart Condie. Yet another year passes while our other great leaders remain firmly seated in their association bunkers... still waiting for our industry's destiny to arrive – whatever it may be.

I'm sure, however, Stewart will remain a man ever willing to give of his time and expertise to those who ask. So, to finish as we began, we pay homage to a great teacher, a great mentor, and a great professional... thank you for your contribution to this industry, your teaching, and your friendship. Farewell and all the very, very best to you, Stewart Condie. Come back soon!