



The body as a soft machine:

Part 3 of our interview
with Thomas Myers

STT and short track speed skating

Life in the fast lane



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what type of therapist are you?

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Functional Fascial Taping, the knee and diagnosing DVT



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Editor's note

Welcome to another issue of the *STT eMag*. In

this edition we have some extensive case studies. Very importantly Rob Granter, a veteran in soft tissue therapy, pushes home the necessity to be ever vigilant with considering DVT as a source of calf pain. Thanks to Rob for his time and experience in writing this article for the *STT eMag*. Check out Rob's new website at www.softtissuetherapyonline.com.

On a sporting note, Scott Smith gives us an idea of what it is like to work with the Australian elite speed skating team. Congratulations to Scott, who has travelled with the team internationally for the past 18 months and will hopefully get a gig at the next winter Olympics. Good luck Scott.

On a political note, we examine the basics of any business – your branding. When it comes to our industry, worldwide, we struggle to grasp any form of unification on our branding. And the terms we do use are poorly defined. Sound like a poor business plan? I would say a resounding yes. What do you think? Have a read and then have your say either on the forum or letter to the editor at admin@softtissuetherapy.com.au.

*Yours in Soft Tissue Therapy,
Brad Hiskins*



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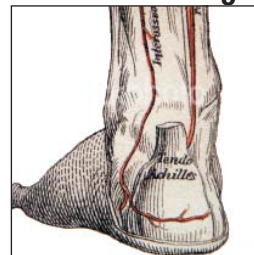
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Soft Tissue Therapy eMag

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STT and short track speed skating

By Scott Smith, STT, Australian Short Track Team

When you think of Australian sport, short track speed skating probably isn't the first thing that comes to mind – in fact, short track has one of the lowest profiles of our sports and is best known in Australia for Steven Bradbury winning Australia's first-ever gold medal at the 2002 Winter Olympics.

Despite not being the most recognisable or well-funded sport in our country, this does not deter the athletes that comprise our national team, who are immensely dedicated world class athletes and extremely competitive on the world circuit.

Short track speed skating at the elite level combines immense power with muscular endurance. The athletes who compete in the sport train up to five hours per day, six days a week which includes ice, land training and weights sessions.

Speed skating, by definition, is a non-impact sport; however the physical demands of both training and racing mean there is immense load placed on specific structures within the body.

As the skaters spend the majority of the time in hip and knee flexion, core stability is paramount in order for them to both

generate power and maintain technique. In terms of treatment, the core and pelvic region is usually a priority.

Depending on whether it is during competition or training, a regular soft tissue treatment for one of the skaters includes lots of work to the pelvic region, in particular glute medius and minimus, TFL, QL, psoas, iliacus and adductor magnus, as these muscles bear the brunt of the load, as they support the bigger more powerful glute max, quads and hamstrings.

I have found manual dry needling to be a very effective treatment tool, particularly in treating TFL and glute medius and minimus. The athletes tend to respond extremely well to this when utilised in conjunction with soft tissue therapy.

The other areas of major concern for skaters are the lumbar and thoracic spine. Again these are usually managed with regular maintenance, but if left untreated can cause major problems. The athletes on the Australian team usually have a minimum of two treatments per week with at least one of those treatments focusing on thoracic and lumbar mobility. The team also travels with and utilises a portable thoracic rack (from Portacoverly.com), which also assists with maintaining their thoracic mobility between sessions.

The majority of significant injuries that occur in short track

Short track speed skating at the elite level combines immense power with muscular endurance.



speed skating are usually from falls or collisions which can cause major fractures, dislocations and cuts, which more often than not will require surgery. This is mainly due to the high speeds that the skaters travel around the rink (around 65km/hour at top speed).

Overuse injuries are not overly common amongst skaters, however given the demands being placed on their bodies, maintenance plays an important role in the athletes' preparation and recovery.

Maintenance also plays a major role in maintaining good biomechanics for the skaters on the ice. As with other sports, biomechanical changes brought about by neural or muscular tension can cause major changes to technique and when you're dealing with differences of a thousandth of a second, it can mean the difference between winning or losing a medal.

I quite often have people ask me what it's like travelling and working with an elite sporting team. Working with an elite team is a fantastic experience and an opportunity that I am extremely grateful for so early in my soft tissue career, however unfortunately it is not all glitz and glamour as some people may think.

Sure, there are loads of benefits that come with it – for instance, you get to travel to some amazing places and see things that you wouldn't get to see in your everyday life. You also get to work with and watch some of the best athletes ply their trade on the world stage from arguably the best seat in the house.

As a soft tissue therapist travelling with a team, you will be called upon to fill many roles on top of the work you do on the table – you automatically become a cameraman and a team manager so you learn to think pretty quickly on your feet in order to make sure everything that needs to be done is being done. This means the coach and the athletes can then concentrate on what they do best.

On the downside though, it is really hard work and can be extremely taxing both physically and mentally. Not all sports have large budgets and many of the teams that you will work with will not be able to provide remuneration for the services you provide for them so you definitely need to be committed.

You spend long periods on planes, or waiting in airports for connecting flights, and when you finally arrive at your destination when everyone else has unpacked and decided it's time for a rest after the long flight, you set up your table and prepare to start work so that the athletes can be ready for what lies ahead.

Probably the hardest thing about being on the road is being away from family and friends for long periods of time, you miss out on birthdays, anniversaries and just spending quality time with those closest to you. Having support at home is extremely important to be able to do this job and personally I am very lucky to have a supportive wife who understands what the job entails. Throughout a single trip, you experience major highs and lows and it can be hard at times, but this is the profession I have chosen, it's something that I am passionate about and enjoy immensely, so personally I'm willing to make the sacrifices to pursue it. Having said all that, it is a choice and it's not for everyone, so if you don't think that is something you could handle, then you're probably best not venturing down that path.

I'm currently in the middle of an 11-week trip with the short track team en route to the Olympic qualifiers in November. So far we have spent time in Beijing and Seoul for World Cups 1 and 2 of the short track season and we are currently on camp in Salt Lake City, where we will stay for two weeks before heading off to Montreal and Marquette for the Olympic qualifiers.

This will be my first trip to an Olympic-qualifying event and with the stakes so high, the pressure to perform will be immense, which is exactly what you would expect and with the reward for success being so great, you can guarantee it will be action-packed.

This is the part I love – what being part of a team is all about. Everyone has a role to play and everyone is part of the result. My role is to make sure that our skaters are in peak shape for these qualifiers and I will be there riding every corner with them as they strive to win their place to something that not many people get to do – represent their country at an Olympic Games.



Are you a **Massage Therapist** or a **Remedial Massage Therapist?**

By Peter Ford

Almost a decade ago in Australia, stakeholders from across our states, including association representatives, were invited to discuss and ratify a set of competencies for our industry. At these meetings, it was decided that our industry needed to exist as two very distinct and very separate vocations – that is, our industry was to have two clear career pathways. They were, and remain:

- Those that practice relaxation based treatment - Massage Therapists (MTs); and
- Those that practice injury and pain management – Remedial Massage Therapists (RMTs).

It was unanimous among the stakeholders who attended these meetings that there needed to be a clear division between these two skill-sets.

So where have we since gone so very wrong ?

There was very little question over the necessity of two clear vocations in our industry. The primary debate was around: (a) distinguishing between the two vocations from a competency-based education perspective, that is, what should each skill-set be capable of in their vocation; and (b) the title of each of these vocational specialties.

Once again, most in the room agreed that the title ‘Massage Therapy’ should be representative of those who practised relaxation-based massage. But this is where the unanimity ended.

What title was to be used to represent those therapists who committed to lengthier terms of tertiary education and those that were more focussed on pain and injury management ?

Essentially, two factions were represented in the room – those who favoured the title ‘Remedial Massage Therapy’ (RMT) and those who preferred the title of ‘Soft Tissue Therapy’ (STT). Various perspectives and opinions were floated. In the end, it all came down to a show of hands. On that day, a decade ago, the title of ‘Remedial Massage Therapy’ was deemed to be a title more representative of our industry skill-set, rather than Soft

Tissue Therapy. It was very close – in fact, a vote of 14 to 13 swayed our destiny.

Personally, I strongly advocated for the title STT, but my views were out voted, and my heart sank. My heart sank even further as one Sydney stakeholder boldly proclaimed that they had chosen the title Remedial Massage Therapy, on behalf of their association, because, and I’ll paraphrase here, “... it would cost an awful lot of money to change all our letterheads”.

To this day, I still have trouble coming to terms with that person’s decision based on that rationale. After all, we were there to influence and steer our industry into the next millennium, not to see how much money we could save on printing.

The competency-based system has been in place for several years now. Most educational facilities that deliver ‘massage’ have stepped into line and have adjusted their educational delivery and content to meet the expectations and intent of the Health Training Package’s competencies. With this, most have adopted the two titles that are suggestive of compliance with the Health Training Package, namely, the Certificate IV in Massage Therapy Practice and the Diploma of Remedial Massage.

Some educational facilities have, however, chosen to overlook the competencies, either partly or completely. This has a sweeping effect across our entire industry. Sadly, some of these educational facilities use the goodwill and reputation of the Training Package competencies to attract students into their courses. This in itself borders somewhere between deceptive and disingenuous. This eventually affects the future graduates of these facilities.

The graduates of these non-conforming educational facilities are left stranded. Without a nationally recognised qualification, they have little chance of enjoying all of the benefits that come with a fully-fledged qualification. Specifically, the graduates of these schools are left without the ability to gain membership with the larger associations, as their education does not meet the minimum standards outlined in the Health Training Package competencies.

Some of these educational facilities have gone to extraordinary

lengths to buffer the inadequacies of their education by manufacturing their own membership criteria and associations. This of course is for the express purpose of bypassing the embarrassment of students realising their education shortcomings.

In a further attempt to ride on the coat-tails of the Health Training Package and, in the process, further discrediting compliant educational facilities, some of these non-compliant facilities choose only to use the titles as determined by the Health Training Package, namely, the Certificate IV in Massage Therapy Practice and the Diploma of Remedial Massage. So, while they fail to teach what is required in the competencies, they boorishly use titles that were developed to co-exist with meeting specific educational requirements.

This is a battle we must continue to fight. We must preserve our hard-fought titles for those who earn the right to use them. Whatever the case, we must move on to more pressing industry matters.

While any school can teach whatever they want and use any title they wish, without fear of recourse or rebuttal, we do have another bizarre monkey on our backs. While we lost the vote 14 to 13 in the debate over Remedial Massage Therapy and Soft Tissue Therapy, almost a decade ago, we still do not have one single Remedial Massage Therapy association in our entire

country. Why then all the fuss to secure this title for our industry?

This is a very peculiar situation. Why then complete a Diploma of Remedial Massage? At this moment in our industry's history, you may only join a Massage Therapy association, not a Remedial Massage Therapy association. Surely graduates who spend twice as long in educating themselves have earned the right to belong to an association that caters to their individual skill-set. Surely, associations who advocate the concept of continuing education ought to target their workshops towards specialist groups within their respective associations. But this is not the case. All workshops conducted by all associations are a free-for-all. More specifically, a Massage Therapist is able to attend a workshop targeted at a Remedial Massage Therapist audience. Why is this?

If we examine the associations in Australia at present, all we see is representation of Massage Therapy, not Remedial Massage Therapy. Again, all that bravado and huffing and puffing to secure the title of Remedial Massage Therapy and it is not represented anywhere in our industry, by any of our associations. What is that all about?

To date, every single media release from our associations has failed to address this aspect of our industry. It is wrong. In fact, in

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recent times one large ‘Massage Therapy’ association delivered a blatantly false and misleading media release extolling the virtues of Massage Therapy in ‘curing’ arthritis. It was a humiliation to our industry on so many levels.

We need to start to educate our society about the difference between our MTs and our RMTs. Our associations should lead this.

Every weeknight there is a lifestyle program depicting holiday-makers having a wonderful, fluffy, relaxation massage on a beach balcony. But what of RMT? Have you ever seen this part of the industry promoted? I certainly have not. And it is my strong belief that the RMT industry suffers heavily from the social and peer health professional connotation that all members of our industry are MTs and only MTs. Hence, we all do relaxation massage and that is all. For all those out there who are sick and tired of trying to explain to people that you assess and treat injuries and dysfunction, and you are not a physiotherapist, you might ask, why haven’t our associations done this for us? We have the education levels, the vocation has been there for decades, we often pay more to get membership as an RMT versus an MT, but no promotion of the RMT skill set can be seen. Why?

I’ll ask a few questions that I really don’t have the answers for, but ask you the reader to ponder:

- Why don’t we have an association called the ‘Australian Remedial Massage Association’?
- Why aren’t the two levels clearly and tangibly defined on our association websites?
- Why do health insurance companies often do a better job of defining the two areas than our associations?

I have some opinions on why these questions are poorly addressed within our industry but would prefer if you, the reader, would submit your opinions on why this is the case, what we should do about it, and how clear delineation between the two areas would benefit our industry.

Those well-versed in the topic might want to consider the movements by both the Victorian Myotherapists and the Canberra Soft Tissue Therapists, both of whom have literally made a name for themselves. More recently, how will ‘Musculoskeletal Therapists’ impact on the MT and RMT industry? Will it be positive or negative? Will it simply confuse

We must preserve our hard-fought titles for those who earn the right to use them.

the consumer and our peer health professionals with yet another name? Will all these names create a hierarchical, behavioural system within our industry with no real definitions to distinguish the apparently different educational systems? And what are our associations saying about all of this? Should they be reining in these schools and promoting a standardised education system (this is what our competency system was supposed to do) or will the schools, through entrepreneurial behaviour, divide our industry into uncoordinated mayhem?

Who are we? If you had to define what an MT was versus and RMT, could you do it? If you then had to define what a Myotherapist was, a Soft Tissue Therapist was, or a Musculoskeletal Therapist was, could you do it? And if you can’t, how do you expect society to know who we are, what we do and where we fit in? How do you expect the local GP to know what we are? Or The local Physiotherapist, Chiropractor, Osteopath, personal trainer?

I’m not sure professionally who I am anymore. I’m not sure which group I belong to. I look for guidance, but I only see ever-growing confusion with no leadership. I see an industry being driven and ambiguously defined by entrepreneurial schools with dollars as their goal.

Who are you? Where do you reside within this industry? Who would you like to be? Tell us at admin@softtissuetherapy.com.au.



This series of articles is designed to provide your clients with extra information about common injuries. Feel free to print this page and leave in your waiting room for clients to read.

Understanding the Achilles tendon

By Brad Hiskins

The Achilles tendon is well known to runners. Most of the time, it is a handy piece of anatomy that allows us to absorb load when our foot hits the ground, and transmit force developed by our calf muscles to propel us forward. Unfortunately this tendon can occasionally become painful. Those who have experienced Achilles pain will know that it can be severe enough to completely stop training. Moreover, it can linger on for months, even years if not managed well in the early stages.

The Achilles is the tendon that attaches the soleus (deep calf muscle) and the gastrocnemius (superficial calf muscle) to the Calcaneus (heel bone). It is a thick, cylindrical, easily palpated tendon just above your heel bone. If you palpate the tendon inferiorly (towards the foot), you will notice the tendon blending into the Calcaneus (heel bone) to the point where it is difficult to tell what is tendon and what is bone. If you palpate superiorly (upward), you will notice the tendon grows thick and flat as it becomes musculotendonis (the transition from tendon to muscle). Eventually the tendon disappears and the only tissue you will be palpating is the superficial calf – gastrocnemius.

The purpose of any tendon is two-fold, each having a nuance of course. The first is to transmit force developed by the attached muscle contraction to enable movement (the two ends of the muscle coming closer together). For the Achilles, this is when the soleus and gastrocnemius concentrically contract (when a muscle shortens via contraction). This contraction causes the heel to become closer to the back of the knee (or toe pointing) as in the exercise heel raises. There is also a mild action to bend the knee via the gastrocnemius (as the gastrocnemius attaches above the knee). The other mechanism is to bear load when a muscle is forced to lengthen. For the Achilles, this is when the foot hits the ground when running (or walking) and the calf muscles eccentrically contract (lengthen as they contract) to soften the heel strike and control movement of the lower leg just after the heel hits the ground.

So what goes wrong with the Achilles? Most runners will have experienced some sort of pain associated with their Achilles. More often than not, it will be an acute episode of inflammation (swelling with inflammatory cells) that occurs due to tissue damage about the Achilles. It is usually associated with (but not limited to) a palpable nodule on the Achilles that is very sensitive, stiffness initially in the morning but warms up as you become active, and it will be painful to hop. Hill running will be very difficult. If treated with (but not limited to) rest, anti-inflammatories, ice and treatment (assessment of possible causes and treatment of these), you will recover. If you ignore the pain, the problem can become chronic. The inflammation will disappear but the Achilles will become degenerative (the Achilles tissue will break down). This can lead to the Achilles becoming very thickened and the calf muscles will become very weak.

So what causes this? There are numerous causes for Achilles pain.

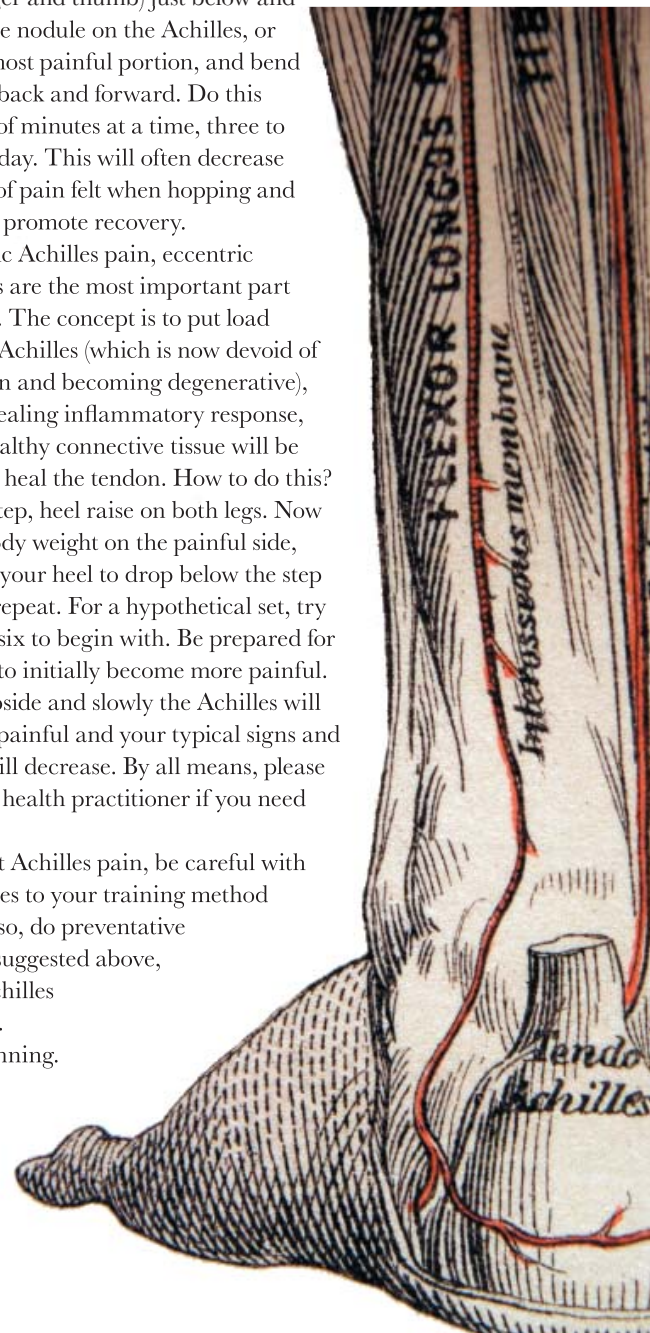
Start looking at the very obvious. Has your training load increased? Do you have very old shoes that have worn? Brand new shoes? Camber running or excessive hill running? Has your dorsiflexion range of motion decreased? Have you changed your type of training (track running, flats instead of joggers, spikes, plyometrics are all examples of what often cause acute onset Achilles pain). You can often self-assess and figure out what is causing your pain. Change these immediately. If you can't see anything obvious, then make a visit to your health practitioner.

What can you do? For acute onset of Achilles pain, try to assess what has caused your pain and change that immediately. For the Achilles itself, ice the affected area, put a heel raise in your shoe for a few days to take the load off the Achilles, cross-train and gently mobilise the Achilles. How do you mobilise? Pincer grip (grip with forefinger and thumb) just below and just above the nodule on the Achilles, or at least the most painful portion, and bend the Achilles back and forward. Do this for a couple of minutes at a time, three to four times a day. This will often decrease the amount of pain felt when hopping and walking and promote recovery.

For chronic Achilles pain, eccentric calf exercises are the most important part of treatment. The concept is to put load through the Achilles (which is now devoid of inflammation and becoming degenerative), to create a healing inflammatory response, and more healthy connective tissue will be laid down to heal the tendon. How to do this? Stand on a step, heel raise on both legs. Now with your body weight on the painful side, slowly allow your heel to drop below the step height, and repeat. For a hypothetical set, try three sets of six to begin with. Be prepared for the Achilles to initially become more painful. This will subside and slowly the Achilles will become less painful and your typical signs and symptoms will decrease. By all means, please consult your health practitioner if you need direction.

To prevent Achilles pain, be careful with major changes to your training method and load. Also, do preventative exercises as suggested above, including Achilles mobilisation.

Happy running.



Interview with Thomas Myers

Thomas Myers is arguably the most influential and pioneering body worker of our age.

You can listen to part 1 and 2 of this fascinating interview via the link to previous editions of the STT eMag – click here now

THOMAS MYERS INTERVIEW PART 3 OF 4 (14:07)

In Part 3 of this wonderful insight into the mind of Thomas Myers, he discusses the revelation that is the Anatomy Trains in the wet lab; why turning the scalpel sideways was so critical in cementing the Thomas Myers hypothesis; the Piezoelectric Effect; how fibroblasts respond to constant load; why exercising and fascial binding don't mix; the 3 Body Wide Networks – Nerve, Fluid, and Fascia; and the beauty of embryology.

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Case study: Functional Fascial Taping

By Geoff Walker

A 51-year-old male presented 10 weeks after extensive neck surgery to remove cancer. He had a portion of tongue removed, a portion of hyoid, all lymphatic structures and all of his right sternocleidomastoid. He had a course of radiation treatment post-operatively. Scarring extended longitudinally from mid-clavicle to the mastoid process and transversely from the chin, along the jaw line, up to the mastoid process. He had been having speech therapy to re-establish motor control of his tongue, as his speech sounded slurred.

He is restricted to a liquid diet for life.

He presented with limited cervical range of motion (ROM) in all planes to 60-70% of normal. Right shoulder ROM in all planes was limited to 60-70% compared to his left. He had 'buzzing/numbness' across the deltoid which often became very itchy. He did not describe pain as being a primary concern. The fascia across the anterior neck was fixated to the underlying structures.

Treatment focused on restoring cervical and shoulder ROM and also on decreasing the buzzing/numbness at the deltoid.

Weekly treatment focused on mobilising fascia from mastoid through to clavicle and all of the anterior neck. This included active and passive tissue tension ROM, with and without shoulder ROM.

Treatment had exceptional positive results in the first 10-12 weeks. Cervical and shoulder ROM were returned to 75-85% of normal. The buzzing/numbness had lessened, but remained.

For the next 20 weeks, treatment focussed on continuing to increase ROM and decrease buzzing/numbness at the deltoid. Treatment also sought to manage a variety of associated neck, shoulder, and back pains that may have been related to changes in posture and altered patterns of muscle use. During this period, negative changes in his posture were noted and corrective exercises and neural tension techniques co-existed in

the treatment plan.

Following a further 20 weeks of treatment, improvements became less obvious. Treatment remained purposeful but more as a management strategy.

At this point, Functional Fascial Taping (FFT) was introduced. This technique had a remarkable effect on structures that had seemingly reached their anatomical and physiological limits. FFT was applied and cervical and shoulder ROM quickly improved to 80-95% of normal. This technique also had an unexpected effect on his speech. On applying FFT, he said that he could feel a pulling sensation very clearly on the back portion of his tongue. He said that this sensation made it easier for him to sound out the letter "G".

FFT was used routinely for several months (see images).

Treatment continued for next seven years. There was no evidence of cancer in this period. Each six months he is required to attend day surgery to have his esophagus expanded using a small, inflated balloon.

Eighteen months ago, he had a headache, which was unusual. Treatment focused on muscles known to refer in that region. There was little improvement. It was recommended that he return to his specialist for assessment. X-rays were inconclusive. His specialist suggested continuing with soft tissue treatment. He was treated a further three times with little change. He was asked to return to his specialist again. This time a C/T scan revealed radiation necrosis of the C1 and C2 vertebrae. He was immediately placed in a neck brace.

This being a degenerative necrosis, he had surgery some months later to fixate the skull to the lower cervical vertebrae.

Presently, treatment continues to maintain what remains of cervical ROM. Right shoulder buzzing and numbness are now at 20% of their original presenting level.

My thanks to this client for his cooperation.



Case study: The knee – structure and common serious injuries

By Charles McGrosky

The knee is a very interesting joint, particularly for massage therapists who do a good deal of sports-related work. Lots of the injuries that occur to the athlete happen at the knee joint, particularly in football:

- Rugby union
- League
- Australian rules
- American football
- Soccer.

Unfortunately many of these knee injuries are career-threatening ones. One only has to watch matches on TV or read one of the daily newspapers to observe this. In this article, I'll attempt to describe some of the basic structures of the knee joint with a view increasing the sports massage therapist's knowledge of the area. When applicable I will refer to various YouTube videos for clarity. I will also describe some of the more serious injuries that occur to the joint and basically outline some of the surgical procedures used to treat them.

A very useful adjunct to the following segment of this article can be found at www.youtube.com/watch?v=fvTMzr3d_3s.

In reality, the knee consists of two joints: the tibiofemoral and the patellofemoral. The tibiofemoral joint is simply the interface between the femur and the tibia. The patellofemoral is the patella gliding on the femur. The tibiofemoral is where the massive weight of the upper body and thigh are transferred to the lower leg. There are three structures that help facilitate this: the medial and lateral meniscus and the articular cartilage. The menisci are half-moon shaped, rubber-like pads that sit on top of the tibia. These:

- Reduce friction,
- Distribute weight, and
- Facilitate movement between the tibia and the femur.

Unfortunately they are very prone to injury, especially the medial meniscus. "It only moves 2-5 mm within the joint and is hence more prone to tears than the lateral meniscus which is more circular in shape and moves 9-11mm."¹ The additional movement seems to give the lateral meniscus more protection from damage than the medial, which is more firmly anchored to the tibia. When an athlete simultaneously flexes and rotates the joint, combined with impact coming from the lateral side, it's a recipe for disaster. In these situations, tears of the menisci often occur. If the tear is slight, the menisci may heal; if the tear is substantial, there may be an operation on the horizon. Because the menisci have a rather limited blood supply (most of the vascularisation is located along the outside perimeter²), the tear does not heal but rolls back on itself inside the joint. In

this case the athlete may experience:

- A popping sensation as he flexes and extends the joint,
- Joint locking,
- Extreme pain in the joint,
- Swelling in the joint, and
- Limited range of motion (ROM).

A picture of a variety of meniscal tears is available at <http://img.medscape.com/fullsize/migrated/408/520/mos5701.ryu.fig07.jpg>.

For the athlete the treatment of choice would probably be an arthroscopy. A good video of this procedure is available at www.youtube.com/watch?v=xYIzlUDz6Nc. In this operation three holes are made around the knee:

- Two tubes are inserted and the joint is filled with fluid so that the surgeon can more easily see within the joint.
- A third tube is inserted with the arthroscopic camera attached. The miniaturised camera allows the surgeon a clear view of the inside of the joint.
- At the end of the tube is a tiny auguring device to cut out any loose material. In this case, the surgeon trims away the loose menisci and thus alleviates the joint locking problem.

This is quite an improvement from the old days, when the surgeon would open up the entire joint from top to bottom, not only leaving a large half-moon shaped scar but also excising both menisci as well. This has changed radically because research suggests that leaving as much of the menisci in situ as possible ensures the long-term health of the joint³. A professional or very active athlete might require more than one 'trim job' during the course of performing in their sport and over the duration of a career, this slowly erodes the integrity of the knee.

After a time and more than one or two substantial knee injuries, the athlete may find that the menisci are mostly gone and the only thing absorbing the friction between the tibia and femur is the articular cartilage. At the distal end of the femur is the articular cartilage. This silvery white substance is:

- Rubbery in consistency,
- Provides a cushioning effect at the joint, and
- Reduces friction in the joint.

With no menisci in place, this cartilage does double duty, thus placing more wear and tear on the cartilaginous structure of the joint. If a piece breaks off, a joint mouse can occur. This in effect acts like a torn menisci and locks the joint if it gets lodged in the right position. At times with certain joint mobilisation techniques, the joint mouse can be encouraged to go back into position. If not, then surgery is the next option. Over time, with no menisci, the articular cartilage has a strong probability of wearing away, especially if the athlete continues to be very active after excessive knee trauma. Then the condition known as 'bone on bone' develops. This is when there is nothing to cushion the effect of the femur against the tibia. It is apparently very painful and allows the athlete only short periods of activity before sharp pain and inflammation develop in the joint. With continued inflammation and wearing occurring within the joint bone spurs and osteoarthritis are likely to develop⁴. This short video may help to illustrate this:

www.youtube.com/watch?v=0dUSmaev5b0.

Also of interest are the ligaments at the sides of the knee.

On the lateral side, we have the lateral collateral ligament and on the medial side we have the medial collateral ligament. Both these structures are integral to both holding the knee together, and provide medial and lateral stability to the joint. In terms of injury, the medial ligaments are about 90 per cent more likely to be injured than the lateral ligaments.

This stands to reason because most tackles, in any code, come from the lateral side and move towards the medial side. A tackle of this sort will sometimes merely stretch the medial ligament and be regarded as a minor injury, however, with sufficient force a tackle coming from the lateral side will tax the medial ligament so much that it will tear, and thus require weeks of recuperation and possibly surgery to repair. Here's another wrinkle. The fibres of the medial collateral ligament intermingle with those of the medial meniscus⁵. Thus an athlete will often tear a medial ligament and then simultaneously damage the medial meniscus as well. An example of laxity produced by a damaged MCL can be found at www.youtube.com/watch?v=_fxKCDkOjJs&feature=PlayList&p=4152876F6ECAF35B&playnext=1&playnext_from=PL&index=50.

Once again, we see that an intimate knowledge of the structure yields a greater understanding not only of how to treat an area with massage, but also in understanding the biomechanics of injury.

The final structures of the knee that we want to focus on are the anterior and posterior cruciate ligaments. These are very important to the integrity of the joint as they hold the joint together at the deepest level, and provide stability for the joint especially with abrupt movements. The anterior cruciate ligament prevents the tibia shifting anteriorly in relation to the femur and the posterior cruciate prevents the tibia shifting posteriorly. Of the two ligaments, it is the anterior cruciate ligament or ACL that is damaged more than 90 per cent of the time in relation to the posterior cruciate.

This stands to reason. The ACL is attached to the inside of the lateral condyle of the femur and to the medial aspect of the top of the tibia. When a side on tackle occurs, the ligament comes under great stress: sometimes straining, sometimes tearing, and occasionally exploding. The video showing ACL insufficiency is not in English, however it clearly shows how much the damaged joint moves compared to the healthy joint. The first joint examined is the damaged joint, the second is the healthy joint: www.youtube.com/watch?v=4u6DK3BINtc.

So, let's say that an athlete tears his anterior cruciate ligament. What can he expect?

- The joint feels loose and unsupportive.
- The athlete is walking along and all of a sudden he falls or stumbles for no reason.
- An audible pop may be heard at the time of injury.
- Pain and swelling around the joint.

A helpful video illustrating this can be found at www.youtube.com/watch?v=uuoj_HFG5Z0&feature=Play

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List&p=0E544D09389BBF6F&playnext=1&playnext_from=PL&index=14.

For treatment, the athlete has basically two options: strengthen the muscles that cross the joint, that is, quads, hamstrings and gastrocnemius, and for sports like skiing, wear a derotation brace, or have an ACL reconstruction. A very active person or professional athlete would probably opt for the reconstruction as it offers more stability and functionality. In this case, a hole is drilled through the knee from the lateral side of the femur to the medial side of the tibia. This hole approximates the path of the original ACL. A piece of the semitendonosis tendon or a strip of the patellar ligament is looped through the hole, fastened at the ends and 'voila'. The athlete has a new ACL.

A good video of this process is at www.youtube.com/watch?v=q96M0jRqn7k&feature=Playlist&p=55A5A946243DFE68&playnext=1&playnext_from=PL&index=31.

Recovery time is approximately six to eight months, until the body has had time to revascularise the new structure. In the meantime, the graft will be kept alive by the nutrition it can obtain from the synovial fluid produced in the joint. The knee will never be completely the same as before, but with proper rehabilitation and strengthening, it will function almost as good as new.

The last condition that I would like to mention is probably

one of the worst an athlete can sustain. It is called the 'terrible triad', or is sometimes known as the 'terrible triad of O'Donahugh'. In this condition, the medial collateral ligament, the medial meniscus and the ACL are all torn at once⁶. A rugby player I know who had this happen said that after he had been at the bottom of a ruck, he looked down and saw his lower leg sticking out laterally at almost 90 degrees to the knee! Obviously this is a serious injury, not only from the massive trauma that occurs but also because of the potential damage to the popliteal artery, vein and the tibial nerve. An athlete with this injury can be looking at eight to 12 months for recovery and will have to endure a knee reconstruction along with extensive rehabilitation.

So there you have it! A short synopsis of knee structure, serious knee injuries and an outline of the surgical procedures used to repair them. Many massage therapists may ask, "How is this pertinent to the soft tissue work that I do?" The answer is that it's very pertinent. Many clients will come to you who have had serious knee injuries in the past and it's very useful to know exactly what they are and how they are treated. Most have absolutely no idea of what their injury consisted of and how it was managed. This constantly astounds me! But as a massage therapist, I know that having this information at hand gives me confidence about working around damaged knees. For example, I really can't do much about an old ACL injury, but I might be able to do a great deal about an old medial ligament injury. If you know and understand the structure, then you'll know what to do.

Bibliography

1. Kate Owers and Fares Haddad, 'Meniscal Tears Treatment Review' from the Sports Injury Bulletin, www.sportsinjurybulletin.com/archive/meniscal-tears.html.
2. Tria, A. J. & Klein, K. S. (1992). An Illustrated Guide to the Knee, p. 95.
3. King, D. MD. (1936; 18). 'The Function of Semilunar Cartilages', *The Journal of Bone and Joint Surgery*, pp. 1069-1076.
4. Grisogono, V. (1988). *Knee Health: Problems, Prevention and Cure*, pp. 111-114.
5. Tria, A. J. & Klein, K. S. *ibid*, p. 9.
6. Lowe, W. (May/June 1997). 'Condition in Focus', *Orthopedic and Sports Massage Reviews*, pp. 1-5.

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Case study: Posterior calf pain

By Rob Granter

HK, an elite womens road cyclist (two World Championships with the Australian team) limped into a Melbourne Sports Medicine Centre with a self-diagnosed calf tear. The physiotherapist she saw didn't agree with the diagnosis and performed a simple test. The test was positive and he alerted one of the doctors. HK was immediately admitted to hospital where she spent an anxious six days.

What was the simple test? And what was the diagnosis?

To help you we will give a little more of the history. She crashed in a race at 50kph, then drove 13 hours through Europe in the immediate two days. Ten days later after an easy recovery ride she developed left calf pain. (First clue – no significant mechanical overload incident.) She normally responds very well to sustained digital pressure soft tissue treatment, however there was no change following this treatment. (Second clue – if soft tissue treatment is indicated, positive change should occur immediately post treatment.) Her leg started to feel heavy and she couldn't squat without compressive pain in the popliteal fossa. (Third clue – no mechanical incident to accompany such a presence of “fluid/swelling”). She felt a loss of balance on

the bike and a change in proprioception, as she had difficulty in clipping into the pedal on the affected side. (Fourth clue – certainly not behaving like a ‘normal’ soft tissue injury.) She had to withdraw from the World Championships after one lap with exhaustion and heart rates that were way too excessive considering she was “in the form of her life”. (The team doctor felt that these signs were the early indicators of a virus, however next day she awoke with no respiratory symptoms). She flew back to Australia (25 hours) and tried to see a doctor, physio or soft tissue therapist at the Victorian Institute of Sport, where she was a scholarship holder, however all practitioners were booked out. Her limping became worse. Self-massage seemed to make the condition worse, she felt overtired then passed out early one evening. Still going with the self-diagnosis of a calf tear, she presented to another Sports Medicine Centre.

Conditions masquerading as soft tissue injuries

Did you correctly arrive at the condition?

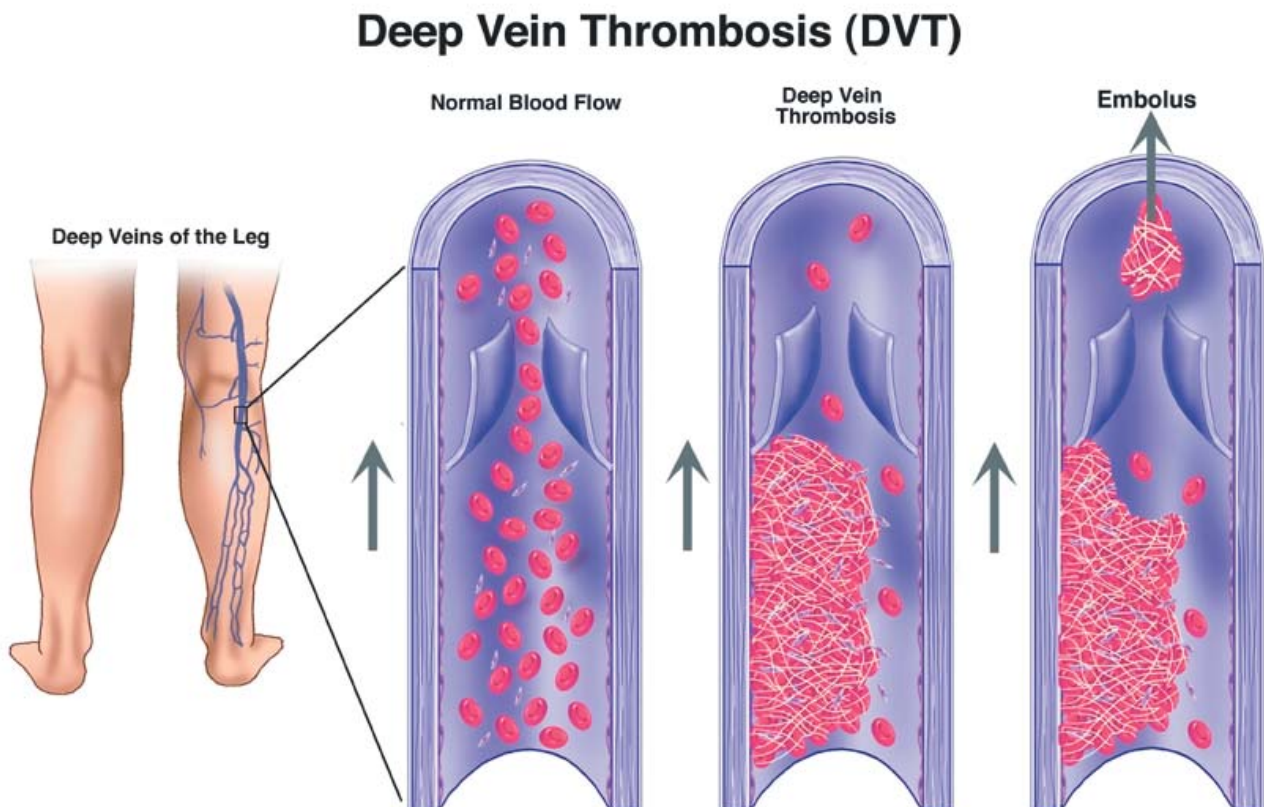
Deep Vein Thrombosis.

Did you arrive at the correct simple test?

Homans test, Passive Dorsi Flexion (which elicited 10/10 pain).

DVT is the most common form of VTE

Diagram 1



Source: <http://endovascularsurgery.com/?q=dvt> ©Society of Interventional Radiology

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ASSESSING YOUR CLOTTING RISK: *What You Need to Know*



HIGH RISK

Blood Clots

Stop!

Discuss with your doctor now!

- Hospitalization
- Major surgery, such as abdominal/ pelvic surgery
- Knee or hip replacement
- Major trauma: auto accident or fall
- Nursing home living
- Leg paralysis



MODERATE RISK

Blood Slows

Caution!

Talk to your doctor next visit.

- Older than age 65
- Trips by plane over 4 hours (car, train, bus)
- Active cancer/chemotherapy
- Bone fracture or cast
- Birth control pills, patch, or ring
- Hormone replacement therapy
- Pregnancy or recently gave birth
- Prior blood clot or family history of a clot
- Heart failure
- Bed rest over 3 days
- Obesity
- Genetic/hereditary or acquired blood clotting disorder



AVERAGE RISK

Blood Flows

Go!

Keep doing what you are doing!

- Active
- Younger than age 40
- No history of blood clots in immediate family
- No conditions or illnesses that heighten clotting risk

(VenousThromboEmbolism). VTE causes over 500,000 deaths in Europe every year (Cohen et al, 2007) (see diagram 1).

Pathology and etiology

Deep vein thrombosis occurs when a blood clot (thrombosis) forms in a deep-lying vein. This usually occurs in the lower leg, but less commonly can be found in the arm and pelvis. This can be a serious condition because the clot can dislodge itself, as shown above, as an embolus, from the vein and travel to the heart, lung or brain. This can lead to permanent damage or be fatal as it can cause a heart attack, pulmonary embolism or a stroke. DVT usually occurs when the blood flow through the vein is stopped or slowed down more than usual. This is why DVT is associated with flying long distances. Watch this excellent animation from nucleus animation on YouTube: www.youtube.com/watch?v=gGrDAGN5pC0&feature=fvw.

The higher the embolus travels, the more severe the possible outcome. Once the embolus crosses higher than the knee, the level of medical concern is very high. Watch the extraordinary video on the Thrombosis Adviser website: www.thrombosisadviser.com/scripts/pages/en/understandingthrombosis/how-thrombosis-develops/index.php?WT.srch=1.

Those at risk

The people who are most at risk of developing DVT are those:

- Over 40 (however it can happen at any age),
- Who are obese,
- People who have prolonged bed rest,
- People who travel long distances,
- People who have surgery or fractures to the leg or hip,
- People who have already had cardiovascular diseases such as a stroke or a previous DVT,
- Varicose veins,
- Smoking can increase your risk because it increases your chances of developing a blood clot,
- Pregnant women, due to the change in hormones that make their blood clot more easily,
- Those on contraceptives containing oestrogen or on oestrogen replacement therapy.

Assessing clotting risk (see graphic on page 16)

Signs and symptoms

A clear diagnosis of DVT is not always obvious so adopt an alert attitude and if in the slightest doubt, refer for clarification. It is very important not to miss the signs and symptoms, as DVT can potentially be a fatal disease.

Some patients may present with very minimal signs and symptoms of DVT so the patient history (S/E) is vitally important. Others will show DVT signs and symptoms very clearly.

In obvious cases, for example, DVT in the lower leg, the affected leg can be swollen and tender to touch (the swelling



Source: <http://drzeze.wordpress.com/2009/06/11/jom-exercise/>



Source: <http://medicine.ucsd.deu/clinicalmed>



Source: www.stoptheclot.org/learn_more/learn_thrombosis.htm

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may be more obvious behind the knee or the ankle). I don't think you would miss the patients in the images (right). The patient may also experience night cramps and pain only in the one leg. Pain increases when standing or walking and ceases with rest.

Assessment

Observation: Measure the girth size of the affected lower or upper limb, the affected leg can also show colour changes.
Homans test: (As discussed before.) The test has fallen out of favour because of a lack of sensitivity (60-88%) and specificity (30-72%) for a diagnosis of deep vein thrombosis (Joshua, et al. 2005).

However, in the case above the test proved to be highly sensitive.

Medical management

Once you suspect a DVT it is important that the patient sees a medical practitioner ASAP. Ring their doctor for them if needed to ensure that they seen immediately. If the doctor is unable to see them suggest that they go to a hospital emergency department.

Diagnostic ultrasound is used to detect blood flow restrictions. Treatment sometimes requires hospitalisation to dissolve the clot and try and reduce the risk of other clots developing. The main treatment is blood-thinning medication administered intravenously and orally. Medications such as Warfarin and Heparin are used. Further tests may include assessing the clotting properties of the blood.

The goals of medical treatment are to:

- Prevent more clotting,
- Prevent complications of the clot, such as a stroke,
- Allow time for the clot to dissolve,
- Prevent more clots.

General preventative advice for patients could be:

- Exercise the legs regularly,
- Maintain a healthy weight, and
- Avoid sitting or lying in bed for long periods without moving.

In relation to air travel, those at risk of developing DVT should seek medical advice prior to travel. They may be advised to begin taking aspirin prior to travel, to wear compression garments in flight and to maintain an ideal level of hydration. Compression garments work by increasing compression around the vein, thus reducing its diameter and increasing the efficiency of returning blood to the upper body.

Considerations, cautions and contraindications regarding soft tissue therapy treatment

If a patient is being treated for DVT or other cardiovascular disease, it is obviously important to identify their current medications before planning soft tissue therapy for a presenting musculo-skeletal condition. Anticoagulants and/or

blood thinners can make a patient bruise more easier. It is important to OK treatment with their doctor first or treat very conservatively.

Any condition like DVT where there is a blood clot that can dislodge and cause significant problems is an absolute contraindication when regarding soft tissue treatment.

What are the signs and symptoms to be aware of in regard to an embolism in the lung, heart and brain?

- Chest pain,
- Cough,
- Rapid breathing,
- Rapid heart rate, and
- Shortness of breath.

Signs and symptoms of stroke

The Australian National Stroke Foundation give the FAST acronym to recognize the signs of stroke.

The FAST acronym stands for:

- Facial weakness – can the person smile? Has their mouth or eye drooped?
- Arm weakness – can the person raise both arms?
- Speech difficulty – can the person speak clearly and understand what you say?



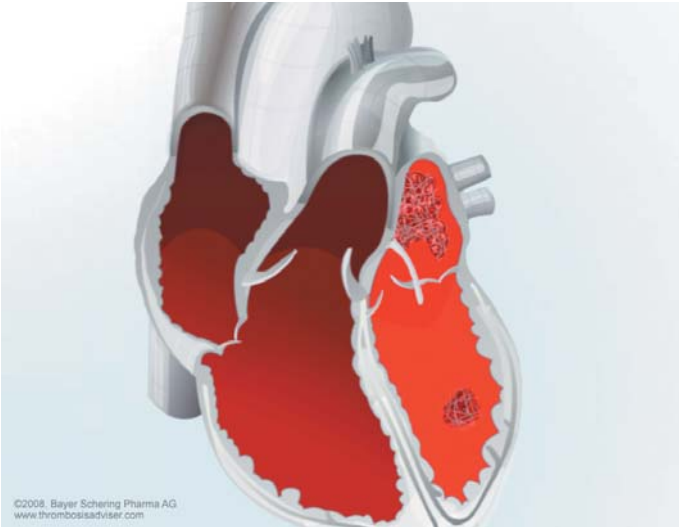
Source: www.thrombosisadviser.com

- Time to act fast – call 000 immediately.
www.strokefoundation.com.au/signs-of-stroke

Signs and symptoms of heart attack

- Chest discomfort – pressure, squeezing, or pain,
- Shortness of breath,
- Discomfort in the upper body – arms, shoulder, neck, back,
- Nausea, vomiting, dizziness, lightheadedness, sweating.

I hope this presentation helps in raising the awareness level in all physical therapists.



Source: www.thrombosisadviser.com

References

Cohen A. T., Agnelli, G., Anderson F. A. et al. (2007). VTE Impact Assessment Group in Europe (VITAE). Venous thromboembolism (VTE) in Europe. The number of VTE events and associated morbidity and mortality. *Thromb Haemost*, 98(4): 756-764.

Dugdale, D. (Jan, 2009). Deep Vein Thrombosis, Medline Plus. Website of the US National Library of Medicine Website and the National Institutes of Health, www.nlm.nih.gov/medlineplus/ency/article/000156.htm.

Joshua A. M. et al. (2005). Beauty is in the eye of the examiner: reaching agreement about physical signs and their value. *Internal Medicine Journal*, 35(3): 178-187.

University of Michigan Health System. (2005). Deep Vein Thrombosis, McKesson Provider Technologies. www.med.umich.edu/llibr/aha/aha_dvthromb_sha.htm.

Useful web resources

www.stoptheclot.org

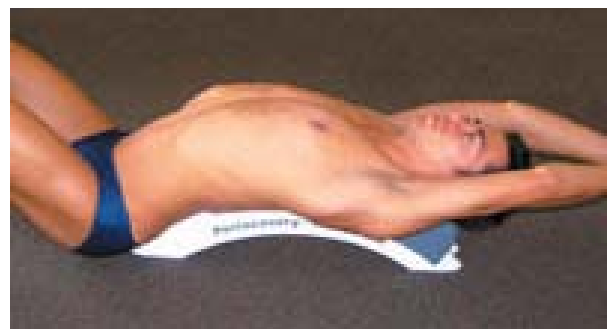
www.thrombosisadviser.com

www.strokefoundation.com.au/signs-of-stroke

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An educator's response to something good, bad and ugly

By Graeme De Goldi

I felt the need to respond to your article on education in the August 2009 issue of *Soft Tissue Therapy*. You expressed an opinion that lacked any overview of where the industry was and where it is now and in doing so downgraded Australia's standing within the worldwide soft tissue therapy sector.

I have had the good fortune to travel throughout the world with elite Australian sports teams and work with the most elite of tennis players. I have been to symposia where, as you would be aware, Australian soft tissue therapists (STT) are held in the highest regard. I would hate to see that damaged by such broad statements about education.

Further, I would hate to think that you would fall back on the old cliché "I just wanted to create open discussion". It's always easy to blame registered training organisations (RTOs). It's easy to call RTOs the "the industry" in fact they are not. To understand where education is heading, you need to reflect on the past. Education has come a long way in a relatively short number of years, from unstructured courses to now advanced diploma levels. Changes along the way have resulted in what we see today, which is competency based training (CBT).

In the 1970s practitioners passionate about massage were running courses from small establishments and were teaching what they believed was the best course for their students at that time. It may not have been complicated or intense, but it gave massage an identity. Unfortunately though, no one recognised any of your training.

But education was taking a turn – curriculum was being developed and schools were starting to introduce anatomy and physiology subjects as well. There were therapists out there starting to make some money in this newfound industry. By the late 1980's and early 1990's, schools were having courses recognised by the appropriate state training boards.

This was a great step forward in education. The actual accreditation of courses gave us, the students, an 'award'. Massage education had something to hang its coat on. In the 1990's education took another turn with the introduction of Training Packages, which, depending on your viewpoint, was for better or worse.

Training Packages came into play particularly around 1993 and every government since then, both at state and federal levels, has been a strong supporter of this system.

Competency based training (CBT) is synonymous with training in Australia. In general terms, CBT can be explained as having a focus on the outcome of training. These outcomes are measured against specific standards and not

against other students (like in curriculum courses) and the standards are directly related to industry.

Education, and in particular competency based education, has divided the mainstream education sector for some time. The argument that curriculum based training is better than competency based training has been debated – and continues to be debated time and time again.

CBT is here for the long term, so let's look at what it is. Is a Training Package the same as a curriculum course? No. A Training Package provides RTOs with a framework for designing courses or learning programs. The qualifications in the Training Package show how competencies can be combined to reflect different roles in the industry. A Training Package describes the outcomes required of training but leaves the detailed decision-making about how training will be structured and delivered to RTOs. What are the benefits of Training Packages for the cultural industries? Training Packages:

- Provide national qualifications that can be recognised across state and territory boundaries;
- Give people the opportunity to have their existing skills, knowledge and experience recognised formally, without having to undergo any unnecessary additional training;
- Give enterprises and individuals more involvement in setting up and providing training;
- Allow more flexible delivery of training and assessment than was possible in the past;
- Provide a consistent framework for vocational education and training, thus reducing unnecessary duplication of courses and resources;
- Provide a means of training and assessing new and existing workers, at times and in locations that suit their needs and those of their employer;
- Offer pathways to further training and career development;
- Provide many possible ways of learning.

Over time, national Training Packages will replace state and territory accredited vocational education and training courses. In Australia, CBT has been legislated to a greater extent than most other countries. Policy directives at the national/federal level in the early 1990s have ensured that competency-based training would become the preferred method of delivery of VET in Australia. At that point in time, having standard nationally accredited qualifications would move the 'industry' away from a huge range of different and

unique school curriculums.

You failed to mention anywhere in your article that Massage and Remedial Massage qualifications fall under the Health Training Package (HLTP). The HLTP was developed in 2002 through industry consultation. The Industry Representative Group (IRG) was comprised of a select group of massage

associations, massage educators and massage practitioners. The IRG, working with the Community Services & Health Industry Skills Council (CSHISC) – developed a list of competencies (learning outcomes) that a Massage Therapist (MT) and Remedial Massage Therapist (RMT) needed to know to work in the industry. The fact of the matter is that the IRG through consultation determine the outcomes of a training package. On reflection, the IRG got it wrong. The first HLTP did not even have any anatomy or physiology units in it.

Under the heading “it’s a ‘no rules’ zone!” you insulted the numerous disabled people who work and study in our industry. An ‘unconsidered’ reading would suggest that people with a ‘physical or psychological learning difficulty’ don’t belong in the soft tissue industry. I hope that you are considering an apology to those people. What about the hard-working Disability Liaison Officers in the TAFE sector? These are the people who have the difficult job of juggling competing student expectations and academic realities to ensure that individuals are neither unnecessarily excluded (when enabling assistance can be ‘reasonably’ provided) nor exploited (by being allowed to undertake programs of study for which they are clearly ill-equipped to complete satisfactorily).

So what does the ‘industry want? Massage therapist, remedial therapist, musculo-skeletal therapist, myotherapist, soft tissue Therapist, tactile therapist, sports therapist, etc? All in all the HLTP confirmed two levels – MT and RMT. We now have RTOs offering Bachelor courses in a myriad of different names. Doesn’t this further disenfranchise the industry? Doesn’t that mean that we are going back to the problems of the 70’s? Different courses, names, qualifications – where will it all end?

The learning outcomes of MT and RMT are determined by the industry. Take steps to influence the Associations, understand what CBT is about, and suggest legitimate changes that improve our profession from a clinical perspective. There are excellent educational facilities teaching massage in Australia. Although there are ‘churn and burn’ schools out there, I want to make it very clear that there are excellent schools that are absolutely dedicated to this fantastic industry. At my Institute I’m proud of the achievements we have made and can stand proud alongside any of our graduates. I’m sure there are other schools that feel the same.

A possible solution

strong association that sets minimum face to face hours (contact) for anatomy, clinical assessment and practical skills would be a great place to start. Perhaps even a membership assessment to confirm the applicant’s knowledge. This is one

Education, and in particular competency based education, has divided the mainstream education sector for some time.

way to ensure that RTOs flaunting the system are brought into line.

So in summary:

- The industry determined that competency based training was the way to go (not the schools).
- BT does not have a minimum level of education.
- The Industry Review Group determines the learning outcomes.
- Disabled people can work in the industry.
- Australia is a great place to learn.
- Let the industry associations work together to forge better learning outcomes.

Let’s work together with what we have and create an opportunity to set a benchmark in the education.

Graeme De Goldi is the director of the Melbourne Institute of Massage Therapy. He has been a massage educator for 17 years and is a member of the National Education Board of AAMT and the Myotherapy Program Advisory Committee for RMIT.