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REVISING THE SCOPE OF PRACTICE OF BC's MASSAGE THERAPISTS

Submission of the

COLLEGE OF MASSAGE THERAPISTS OF BRITISH COLUMBIA

#103 - 1089 West Broadway, Vancouver, BC V6H 1E5

to the Health Professions Council

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1. INTRODUCTION

In January 1998 the Health Professions Council ("Council") circulated the final draft of its *Shared Scope of Practice Model Working Paper* ("Working Paper") containing a list of seven possible reserved acts available to the various health professions. After reviewing these proposed reserved acts, the College of Massage Therapists of BC ("College") decided to withdraw its 1995 submission and prepared this revised submission.

2. BACKGROUND

The following section presents information on the history and practice of massage therapy in order to frame a discussion of the need to revise this profession's scope of practice.

In support of the College's 1995 submission, the Council was provided with copies of a thirty page book by Dr. John Yates, titled *A Physician's Guide to Therapeutic Massage : Its Physiological Effects and Their Application to Treatment*. The College understands that the Massage Therapists' Association of BC ("MTA") has provided the Council copies of its recent publication, *In Touch: The Practice of Massage Therapy in British Columbia*. Both of these documents are further sources of useful information about massage therapy and should be consulted accordingly.

2.1 A brief history of massage therapy

Therapeutic massage has been practiced worldwide throughout history. Hippocrates himself regarded massage as one of three modalities vital to the practice of medicine and to the treatment of pain and dysfunction, the other two being hydrotherapy and joint manipulation.

Massage and hydrotherapy continued to be regarded as accepted medical treatments in many parts of Europe right up to the present, particularly in Germany, Holland and Russia. In North America, however, emphasis began to shift away from these modalities near the end of the last century with the development of new safe surgical techniques and improvements in drug therapy. Advances in these areas accelerated throughout the twentieth century so that medicine, in the minds of the public, came to be associated almost exclusively with medication and surgery. Meantime, the term "massage" was taken to mean the work performed by masseurs or masseuses.

A particularly unfortunate consequence was the appropriation of the word "massage" by persons offering sexual services for sale.

Manual therapies, however, continued to be practiced by chiropractors and to some extent by physiotherapists (now known as physical therapists), as well as by massage therapists. The next significant shift occurred during the 1980s when the public in North America began to be interested in massage and other manual therapies as alternatives to medication, surgery or electrical modalities for the treatment of pain and musculoskeletal conditions. This renewed interest in manual therapies has had important consequences for massage therapists (with particular reference to British Columbia):

- introduction of new manual therapy assessment and treatment;
- further refinement of traditional techniques;
- expanded curricula for professional training;
- consistent standards for entry-level to the profession (i.e. registration);
- maintaining competence among practitioners through enhanced programs for continuing education.

2.2 The Practice of Massage Therapy in BC : 1946 - 1998

Massage therapists have been a regulated health profession in BC for over 50 years. Massage therapists, physiotherapists and remedial gymnasts were regulated under the (now repealed) Physiotherapists Act passed in 1946. In 1995, massage therapists were established as a separate profession under the Health Professions Act.

Since the 1960s, registered massage therapists have billed the Medical Services Plan ("MSP") for services to patients referred by medical doctors or dental surgeons. Currently about \$12 million is budgeted for massage therapy under MSP.

An important professional relationship has developed between physicians (particularly general practitioners) and massage therapists. There were over 200,000 medical referrals in 1996. Massage therapy treatments are also funded under various insured medical benefits such as those administered through the Insurance Corporation of BC, the Workers' Compensation Board and the federal Department of Veterans' Affairs. Many supplementary health care insurance plans also cover massage therapy treatments. Organizations like the Royal Canadian Mounted Police include massage therapy as part of their medical benefits package. In addition, of course, there are self-referrals where patients are billed directly and pay privately. The MTA estimates about 30% of patients are included in this category.

2.3 Nature and Extent of Massage Therapy

Massage therapists treat patients of all ages, from infants to the elderly, for a variety of different conditions. The nature and extent of the work is affected by outside factors such as a shift in demographics, lifestyle changes, innovations in the workplace, as well as the longer survival of persons with disabilities. All these factors increase the need for quality massage therapy services within the provincial health care system.

Massage therapy techniques are used to treat two main categories of conditions. The first category is primary soft tissue conditions, such as tendonitis or whiplash. The second is medical conditions affecting the body that have a soft tissue or circulatory component, such as Parkinson's disease or fibromyalgia. Massage therapists also see patients who present with acute, as well as chronic problems, commonly the result of motor vehicle accidents, falls and other accidents, sport injuries, and overuse of soft tissues and joints. Most patients referred to massage therapists are sent for soft tissue and joint conditions; however, as soft tissue, circulatory and nervous systems are inter-connected many massage therapy techniques are aimed specifically at one or two systems with the understanding that all systems will be affected.

Common forms of treatment include traditional massage, various forms of manual therapy, therapeutic exercise and instruction in home exercise, postural instruction, relaxation training or a combination of two or more therapies. Hydrotherapy and light therapy, heat and cold may also be employed.

A typical referral from a physician may be for treatment of low back pain following a fall. These referrals often simply state something like "low back pain". The subsequent diagnosis of the cause of the low back pain and decisions about whether or not massage therapy is an appropriate treatment and which therapies should be provided are the responsibilities of the massage therapist.

If the therapist determines that the patient's problem cannot or should not be treated by massage, the therapist will direct the patient back to the referring physician with an explanation of the findings. The therapist may also offer suggestions for further investigations and treatment by the physician or other health care practitioners. (See *In Touch*, for a more detailed presentation of a referral: a more detailed discussion of diagnosis by registered massage therapists occurs later in this document.)

It is not uncommon for acute problems, such as falls, to be accompanied by other, more long-term conditions and some patients referred to massage therapists are seeking relief from one or more chronic conditions. This includes individuals suffering from multiple sclerosis, strokes, chronic fatigue syndrome, muscular dystrophy, osteoarthritis and rheumatoid arthritis. While massage cannot cure these conditions, it can offer patients significant and lasting relief from their symptoms.

Massage therapy is not applicable only to the treatment of trauma. Circulatory problems resulting from lymphedema, lymph node dysfunction and post operative conditions can be treated by techniques including manual lymph drainage which encourages circulation where it has been impeded. (See Appendix "O" for a discussion of manual lymph drainage.)

Some patients, typically those who actively "manage" their health, believe that massage therapy is an important contributor to their well-being. Some also use it as a form of preventive medicine while others turn to massage therapy because they are suffering from deep emotional or mental stress. Therapeutic massage can help these patients cope with their problems and - in conjunction with therapies provided or guided by mental health practitioners - help them develop new strategies.

2.4 The effectiveness of massage therapy

When such a large proportion of physicians in British Columbia refer patients to massage therapists, it is surprising to find that some do not believe that there is any benefit in massage therapy. That said, it is unfortunate there has been relatively little research done on this continent into the effectiveness of massage therapy.

- In the mid-1980s, the Quebec Task Force on Spinal Disorders found that massage therapy is particularly useful in controlling pain and is the most frequently used therapy for musculoskeletal problems.
- The National Institutes of Health, the most established research facility in the United States, is now funding studies on the use of massage for patients recovering from surgery, bone marrow recipients and AIDS patients through the Office of Alternative Medicine.
- The Touch Research Institute at the University of Miami School of Medicine, medical researchers are investigating the effects of massage on premature babies, autistic or abused children, depression and job stress.

The results of a recent survey by the Massage Therapists Association are telling. Seventy-seven percent of massage therapy patients surveyed believed that massage therapy was

"highly effective," while 95% indicate that massage therapy had improved their particular conditions. Slightly less than half said that the massage treatments they received let them stop or reduce drug or medical treatments.

(For more information on the effectiveness of massage therapy see:

- Appendix "A" : *Massage Therapy Research and Facts*, prepared by the MTA;
- Appendix "B" : *An Executive Summary of A Physician's Guide to Therapeutic Massage*.

See also the information in the MTA publication *In Touch*.)

2.5 Qualifications and experience

British Columbia has the highest standard of training for massage therapy in North America. The College's current curriculum sets a minimum undergraduate requirement of 3,000 hours, three years of full time instruction. The educational standards in the United States and elsewhere in Canada are much lower - most American jurisdictions require 500 to 1,000 hours of training while a number of Canadian provinces are still working toward a 2,200 hour minimum.

The core curriculum in British Columbia requires instruction in anatomy, physiology, pathology, kinesiology, nutrition, first aid, ethics and professionalism, business management, communication skills, clinical practice, patient assessment and diagnosis, massage theory, massage techniques, passive motion, therapeutic exercise, hydrotherapy, actino (light) therapy and clinical treatments. Massage therapy schools have clinics where students also perform postural, soft-tissue and joint assessments, massage therapy and hydrotherapy on members of the public. (A copy of the College's current core curriculum standards document is included with this submission as a separate document.)

Registered massage therapists are specifically trained to use the following techniques:

1. Assessment of the patient's musculoskeletal system.
2. Diagnosis of soft tissue and joint disorders, dysfunction or injury.
3. Soft tissue manipulation: manipulation, manually or mechanically, of the patient's muscles, connective tissue, ligaments, tendons, joint structures, circulatory system and other soft tissues.
4. Passive movement: the therapist moves the patient with no assistance from the patient.
5. Active movement: the patient performs an action him or herself under the direction of a therapist.
6. Hydrotherapy: the therapeutic use of water, pharmaceutical or herbal sprays and applications of packs at different temperatures and states (steam, hot or cold water, or ice).
7. Actinotherapy: the therapeutic use of light (infrared and ultraviolet).
8. Patient education about their condition and about self care, therapeutic exercise, posture, ergonomic information, etc.

The focus of these techniques and their purpose can be summarized as follows:

1. Soft tissue: the relaxation, release, healing or strengthening of contracted, lax, scarred, fibrosed or injured muscles, connective tissue, ligaments, tendons, joint structures and

other soft tissues. This aids in returning these tissues to normal function, contributing to freer, more balanced movement and posture and decreased pain.

2. Circulation: improvement of circulation of fluids in the body. This includes blood and lymph circulation into and out of all the tissues of the body to provide nutrition and remove waste products. This contributes to recovery from injury and to all aspects of the patient's health.
3. Nervous system: decreasing excitability of the nervous system caused by dysfunctions of the soft tissues and circulatory systems.

(For further details please refer to:

- Appendix "C" - *Summary of Techniques Used by Registered Massage Therapist;*
- Appendix "D" - *Hydrotherapy and Antinotherapy;*
- Appendix "E" - *Conditions Treated by Massage Therapists.*)

A new, longer curriculum developed by the College contains additional hours in both academic and clinical subjects. The curriculum establishes Grade 12 chemistry and first year university biology as prerequisites for admission to a school of massage therapy. It applies higher entry standards in British Columbia than in any other jurisdiction with the exception of some European countries. In Germany, for example, massage therapy is part of accepted medical practice and is covered by that government's medical insurance plan, as it is in this province.

Under the Health Professions Act, the College must establish a quality assurance program. The elements of this program have been well developed and include a compulsory continuing education program. The College would be pleased to provide details of this program, on request.

The College is also mandated under the Health Professions Act to develop a patient relations program. The College's current program includes workshops and educational materials on patient-therapist boundary issues. Massage therapy is most often provided to patients who have removed their clothes and are covered only with draping. Most massage techniques require direct physical contact between the patient and the therapist. For these reasons, clear patient-therapist boundaries is an essential feature of the profession's practice. Indeed, to quote from Judge Meiklem in a recent criminal prosecution:

Clearly a massage therapist is a paramedical professional in whom clients repose trust by placing themselves on a table partially or in some cases nearly entirely disrobed. The vulnerability of such clients is very obvious. Added to that is the fact that massage is by its broad description not physically unlike the type of repetitive manipulation that, if devoid of therapeutic purpose, might otherwise have only a sexual nature or at least might appear so to inexperienced clients. So in my view, sexual touching of a client by a massage therapist is a particularly acute breach of trust.

3. THE SCOPE OF PRACTICE OF MASSAGE THERAPY

3.1 The current scope of practice definition

The current scope of practice of massage therapy is set out in the definition section of the *Massage Therapists Regulation* ("*MT Regulation*") under the Health Professions Act. It reads:

Massage means the kneading, rubbing or massaging of the human body, whether with or without steam baths, vapour baths, fume baths, electric light baths or other applications, and hydrotherapy or any similar method taught in schools of massage approved under this Act, but does not include any form of medical electricity.

This definition originated under the Physiotherapists Act and is over twenty years old. As noted above, massage therapists, physiotherapists and remedial gymnasts used to be regulated under this Act. In 1995, massage therapists and physical therapists were designated under the Health Professions Act as separate health professions; however, the definition set out under the Physiotherapists Act was continued under the *MT Regulation*.

This definition suffers some serious shortcomings.

1. The description of massage as kneading, rubbing and massaging is insufficient. Kneading is just one of many massage techniques.
2. Rubbing is a popular term for massage that by itself has no basis in clinical practice.
3. Defining massage as "massaging" is redundant and not useful in a legal definition.
4. The current list of specific techniques does not include methods that massage therapists are trained to apply and commonly use in clinical practice. For example, therapeutic exercise and passive motion techniques are not mentioned even though applicants are examined on these traditional techniques during the provincial licensing exams.
5. There is no reference to the therapeutic intent of massage therapy treatments, although this is fundamental to the current training and practice of the profession in BC.

The College believes that this poorly worded scope of practice contributes to disputes between massage therapists and other health professionals: some professions want massage therapists limited to only those techniques listed in the current definition. This places massage therapists in a position where they have to defend their right to use traditional techniques and to grow and change as a profession as new techniques are developed.

3.2 A proposed new scope of practice definition

The College proposes the following new scope of practice definition for massage therapy in British Columbia:

The practice of massage therapy is the assessment and diagnosis of soft tissue and joint disorders and the treatment and prevention of physical disorders, dysfunction, injury and pain of the soft tissues and joints using treatment methods which include but are not limited to manual techniques, hydrotherapy, light therapy, electrical modalities, therapeutic exercise and patient education to rehabilitate, augment physical function, relieve pain, facilitate relaxation, reduce stress and promote health.

This definition is based, in part, on the definition of massage therapy set out in section 3 of Ontario's Massage Therapy Act.

The practice of massage therapy is the assessment of the soft tissues and joints of the body and the treatment and prevention of physical disorders, dysfunction, injury and pain of the soft tissues and joints to develop, maintain, rehabilitate or augment physical function to relieve pain, and to promote health.

The College has added "diagnosis" to Ontario's definition, as that process is an essential first step in providing any form of therapy. The College also added:

- specific examples of the more common massage treatment techniques in order to provide greater specificity than the Ontario definition
- the therapeutic objectives of "to facilitate relaxation" and "to reduce stress" as these are important features of massage therapy generally, and indicate that massage therapists are capable of providing both therapeutic and simple relaxation massage.
- electrical modalities. Currently, massage therapists are prohibited from using any form of electrical medical therapies. The College is proposing that this prohibition be eliminated - in light of the Council's approach to defining reserved acts British Columbia set out in its Working Paper, it is legislatively redundant. (See Part 6, *Prohibited Acts*, for further discussion on this point.)

The proposed, new definition properly limits the field of expertise of massage therapists to soft tissue and joint dysfunction and pain. Within that context, the definition allows massage therapists to adapt to the rapidly changing and growing field of soft tissue and joint therapy.

Patients come to massage therapists specifically for treatment of pain and dysfunction. Massage therapists must be able to provide them with whatever treatment is required for their recovery, whether it be manual therapy, hydrotherapy, home exercises, postural retraining or any of a number of other approaches that they are trained to provide.

The College believes that the proposed definition is more descriptive and easier to understand than the current definition. It fairly and accurately describes the current state of professional practice of massage therapists in British Columbia. At the same time the definition provides patients and the public a better explanation of massage therapy while encouraging the future evolution of the profession.

4. RESERVED ACTS FOR MASSAGE THERAPISTS

The College does not protest the use of simple, non-therapeutic massage by lay people for the comfort and relaxation of healthy persons. However, without complete patient case histories, assessment and diagnostic skills, knowledge of contraindications and competent training in the use of massage therapy, the College believes that lay practitioners can cause serious harm to the public.

4.1 The current reserved act

The current reserved act for massage therapists is too broadly stated. The scope of practice of massage therapy is defined under section 1 of the *MT Regulation*. Section 5(1) of the *Regulation* states that this broadly framed scope also constitutes the reserved acts for massage

therapists. In effect, all acts of therapeutic massage and hydrotherapy are currently reserved for massage therapists. This repeats what was set out under the repealed Physiotherapist Act.

The BC Royal Commission on Health Care and Cost identified this sort of broadly stated reserved act as one reason for recommending a wholesale change in the legislative framework used to regulate the province's health care professionals. The royal commission felt that the reserved acts granted to professions should specifically adopt the approach taken in Ontario and be narrowly focused on preventing harm. The Council has adopted a similar approach in its *Working Paper*.

The College agrees with this approach. Changes need to be made to the reserved acts of many health care professions, including the massage therapists' reserved act.

In addressing this challenging task, we have carefully considered the need to articulate new reserved acts that reflect meaningful risks of harm to the public that can be reasonably attributed to massage therapy, but ones that our members are able to perform safely.

4.2 Possible reserved acts for BC's health professions

In its *Working Paper*, the Council has proposed a list of possible reserved acts that may be granted to British Columbia's various health professions.

- I. Making a diagnosis identifying a disease, disorder or condition as the cause of signs or symptoms of the individual.
- II. Performing the following physically invasive or physically manipulative acts:
 - A. procedures on tissues below the dermis, below the surface of a mucous membrane, in or below the surface of the cornea, in or below the surfaces of the teeth, including the scaling of teeth;
 - B. setting or casting a fracture of a bone or reducing a dislocation of a joint;
 - C. moving joints of the spine beyond the individual's usual physiological range of motion using a high velocity, low amplitude thrust;
 - D. administering a substance by injection or inhalation;
 - E. putting an instrument, hand or finger(s),
 1. beyond the external ear canal,
 2. beyond the point in the nasal passages, where they normally narrow,
 3. beyond the pharynx,
 4. beyond the opening of the urethra,
 5. beyond the labia majora,
 6. beyond the anal verge, or
 7. into an artificial opening into the body.
- III. Managing labour or delivery of a baby.
- IV. Applying or ordering the application of a hazardous form of energy including diagnostic ultrasound, electricity, magnetic resonance imaging, lithotripsy, laser and X-ray.

Prescribing, compounding, dispensing or administering by any means a drug listed in Schedule A-1 or A-3.2 of the Pharmacists, Pharmacy Operations and Drug Scheduling Act. For the purpose of this reserved act, the following definitions shall apply:

"prescribing": the ordering of a drug.

"compounding": mixing ingredients, at least one of which is a drug.

"dispensing": preparing for filling a prescription for drugs.

- V. Prescribing appliances or devices for vision, hearing or dental conditions; dispensing a prescribed appliance or device for dental conditions; fitting contact lenses, or appliances or devices for dental conditions.
- VI. Allergy challenge testing in which a positive result of the test is a significant allergic response; or allergy desensitizing treatment in which there is a risk of significant allergic response.

In its *Working Paper*, the Council observed that is not always easy to determine the precise point at which a threat of harm associated with a particular act becomes serious enough to justify reserving it. The Council, therefore, proposed the above listed reserved acts after first applying the following factors as a general guide:

- the likelihood of a risk of harm occurring;
- the significance of the harm's consequences on individual victims;
- the number of people the harm threatens.

The Council also noted that if an act is dangerous it should be reserved regardless of the number of people it threatens.

The Council did not limit its discussion of risks of harm to only physical risks, and therefore the College understands that the risks to be addressed by reserved acts can also be those that can result in emotional or psychological harms.

4.3 Proposed reserved acts for massage therapists

The following are the methods, procedures or techniques that the College believes should become reserved acts for massage therapists. These are based on the Council's list presented above. Each is focused on a possible risk of harm to the health, safety or well-being of the public. The College believes that for each one, a competently trained and experienced massage therapist can avoid the associated risks.

- 1) Making a soft tissue diagnosis by identifying a disease, disorder or condition of the soft tissue as the cause of signs or symptoms of an individual.
- 2) Manipulation of soft tissues with sufficient biomechanical pressure to cause tissue damage, including microtearing, bruising or inflammation.
- 3) Moving body joints beyond the individual's current physiological range.
- 4) Putting a finger beyond the labia majora or the anal verge.
- 5) Using massage therapy techniques on a patient when a contraindication for that patient exists that would necessitate avoidance or modification of the technique, and the technique to be given

(a) would significantly increase the blood or lymph circulation of that patient,

(b) requires deep pressure or stretch to be applied to the soft tissues of the patient's body, or

(c) would passively mobilize the patient's joint (excluding high velocity manipulation).

6) Using massage therapy techniques on a patient when a contraindication exists that would necessitate avoidance or modification of the technique, including but not limited to

(a) an acute or chronic injury, structural abnormality or disease of a joint, muscle, ligament, tendon, connective tissue, bone or organ of the body,

(b) a circulatory or lymphatic condition that compromises either system, and

(c) a neurological injury or disease.

4.3.1 Making a soft tissue diagnosis

The College is proposing that massage therapists be granted the following reserved act:

1) Making a soft tissue diagnosis by identifying a disease, disorder or condition of the soft tissue as the cause of signs or symptoms of an individual.

In this context, "soft tissue" means muscle, fascia, tendon, ligament, bursae, joint capsules, and other associated connective tissue components.

This proposal is based on the "diagnosis" reserved act that the Council set out in its *Working Paper*. "Soft tissue" has been added to that generic reserved act to make it clear that massage therapists are seeking a narrower reserved act than that described by the Council. The focus would now be on the diagnostic skills massage therapist employ when patients complain to them of soft tissue and related problems.

Soft tissue diagnosis is an essential component of the services normally provided by massage therapists. If this service is not provided, or is provided by someone who is not sufficiently trained and skilled, there is a risk that musculoskeletal injuries and disorders may be exacerbated through treatment that is not of an appropriate type or intensity. There is a risk that injury may occur due to a failure to recognize contraindications to treatment or that systemic disease or other medical conditions that contribute to the presenting signs and symptoms may go unrecognized and untreated.

Massage therapy uses a wide variety of manual techniques, as well as hydrotherapy and other modalities and massage therapists are routinely required to make decisions regarding treatment methods. This involves a diagnostic assessment that identifies as closely as possible the location, nature, severity, and cause of the pathology or abnormality from which pain and/or dysfunction originate.

Differential diagnosis is also required to rule out systemic disease or other causes that may mimic musculoskeletal disorders but are not treatable through massage therapy. A review of the patient's past and present symptoms and medical history may indicate that an unidentified medical condition is causing the patient's symptoms and a visit to a physician is required instead of massage therapy. For example, a patient with chest pain should be asked specifically about both musculoskeletal and systemic origins of present pain and symptoms. Similarly, a patient with a history of kidney infection may experience back pain that is not treatable by massage therapy.

Case history - A massage therapist reports:

A patient came to my office suffering from headaches, dizziness and numbness of the face. His physician had diagnosed the symptoms as a musculoskeletal problem and had referred the patient to massage therapy. The patient had seen two chiropractors previously. During assessment I found that the numbness and tingling patterns were along more than one neural pathway, possibly indicating a brain tumour. Also, the first rib was subluxed and extensive trigger points were found in the neck region. Using muscle energy techniques, I discovered that the C1 occiput was not stable and was probably causing the patient's dizziness since it was incorrectly aligned. While the techniques I employed did improve the patient's symptoms, the result was extremely short-lived. I encouraged my patient to seek further medical attention from his doctor, explaining that I believed his symptoms may be resulting from a condition I could not treat. He was referred to a neurologist, but ended up in emergency due to excruciating pain, prior to learning his test results. The doctors in emergency diagnosed a brain tumor and my patient awaits surgery to remove the tumor located above his occiput.

Identifying causative factors or etiology by the massage therapist is limited primarily to neuromusculoskeletal abnormalities that result in pain and pathokinesiologic problems (disorders affecting movement) and massage therapists may often be able to make a more accurate diagnosis of such conditions than most general practice physicians. Physicians, unless they have specialized in such fields such as orthopedics or sports medicine, do not receive the lengthy and detailed training in soft tissue/musculoskeletal assessment procedures that massage therapists receive, nor are they called on to perform related procedures on a daily basis. (This may explain why general practice physicians in particular seem to consider spending the time required to perform detailed diagnostic procedures not necessary once their preliminary evaluation has indicated that referral to a massage therapist or physiotherapist is indicated.)

In addition to identifying causative factors, massage therapists are also trained to evaluate the progress or recovery of the presenting condition in order to properly gauge the type, intensity, duration and frequency of treatment required. If the type of treatment is not appropriate or the intensity, duration, or frequency of treatment is too great for the effected tissues, there is a potential for harm to the patient.

Pre-existing conditions are also carefully evaluated. These may constitute contraindications to certain types of treatment and may alter the choice of treatment method or necessitate modifications in the application of certain techniques to avoid or minimize the risk of harm to the patient. This is particularly important where the patient has not visited a primary care physician prior to seeking massage therapy; however, even with a referral the patient's physician may not be aware of all contraindications to massage or other modalities.

The College estimates that about 5% of physician referrals state a specific diagnosis. Nonspecific terms, such as "shoulder pain" are common. This requires the massage therapist to identify a disease, disorder or condition of the soft tissue as the cause of the patient's signs or symptoms, and do so before treatment can be considered.

Case history - A massage therapist reports:

A physician referred a patient to me with a diagnosis of "shoulder and neck spasm". My assessment lead me to conclude the patient was suffering from something quite different--a frozen shoulder caused by adhesive capsulitis. Symptoms included acute, sharp pain in the mid deltoid, difficulty moving or lifting arm and a significant weakness in the affected arm. I tested all the shoulder girdle and periscapular muscles and palpated the joint capsule during various ranges of motion and discovered severe restriction of the shoulder during abduction and external rotation. My primary treatment involved trigger point therapy, Swedish massage and joint mobilization techniques. After four treatments, the patient was able to abduct and externally rotate the affected arm without pain, although there was still a significant weakness. Now that the shoulder has proper range of motion, this weakness could be corrected with strengthening exercises.

In all cases it is a skilled physical assessment, palpative examination and accurate and complete history taking and diagnostic assessment performed by the massage therapist that identifies the location, etiology, and other relevant characteristics of the condition to be treated. The therapist differentiates between neuromusculoskeletal problems and systemic disease or other medical condition as the source of signs and symptoms, and identifies the presence of contraindications to certain types of treatment.

Case history - A massage therapist reports:

MM is a middle aged woman who was diagnosed with rheumatoid arthritis by her physician. She was suffering from severe hip pain which limited her active lifestyle by impeding her ability to walk more than a few hundred metres. Her physician considered the hip pain to be a part of her rheumatoid arthritis and therefore, "hopeless". However, my assessment showed a misalignment of the hip joint with soft tissue components. Pelvic stabilization techniques helped to realign her pelvis and hips. After a few treatments, she was able to increase her walking, swimming and general activity level. She now walks a few miles at least three times a week, which has benefited her health. Unfortunately she had been unnecessarily limited for years by a poor soft tissue diagnosis and consequently had no treatment before she saw me for another problem.

(For a detailed description of two different diagnostic procedures, see:

- Appendix "F" : *Diagnostic Procedures for Neck Pain and Referred Arm Pain;*
- Appendix "G" : *Typical Shoulder Dysfunction Diagnosis.*

Examples of typical history and assessment forms are included in Appendix "H" : *How RMTs Are Commonly Employed.*)

A minimum of 150 hours of training is provided to massage therapy students attending British Columbia's two accredited educational programs in history taking, interviewing and physical assessment. However, the education director of the West Coast College of Massage Therapy estimates that, when all academic and clinical subjects and courses dealing specifically with diagnostic assessment are combined with approximately 38 hours spent practicing these methods in the student clinic, massage therapists receive more than 400 hours of training in history taking, physical assessment and diagnostic skills. This is comparable to the number of hours of training that students in similar health professions, such as physical therapy and chiropractic, receive. (Appendix "I" provides examples of the basic case history and assessment forms that are used by the West Coast College of Massage Therapy.)

Case history - A massage therapist reports:

RB is a man in his thirties who was involved in a minor motor vehicle accident in 1993 resulting in back and neck pain which severely limited his physical activity. I noticed a persistent pain and a loss of sensation pattern that suggested nerve impingement. I repeatedly wrote letters to RB's physician, suggesting the patient undergo an MRI. Finally, in 1998, my request was heard. The results indicated a herniated disc in the cervical spine and the specialist scheduled surgery immediately. During massage treatment, RB's condition could have been improved by cervical traction in line with the spine, but severely worsened by lateral flexion over pressure, which an unskilled bodyworker might have performed.

4.3.2 Performing procedures on the tissue below the dermis

In its *Working Paper*, the Council identified a generic reserved act of: "Performing non-invasive but physically manipulative procedures ... on the tissue below the dermis." The College is proposing a variation on the Council's wording:

- 2) Manipulation of soft tissues with sufficient biomechanical pressure to cause tissue damage, including microtearing, bruising or inflammation.

The change the College is proposing focuses on soft tissues while clarifying the type of non-invasive manipulation that should be of concern by including the phrase "biomechanical pressure." It also addresses the specific potential harm that may arise from that type of manipulation with the closing phrase "to cause tissue damage, including microtearing, bruising or inflammation." Once again, this narrows the reserved act suggested by the Council's wording. At the same time, the wording does not proscribe all forms of soft tissue manipulation by untrained persons. Rather it limits to trained professional therapists only the application of biomechanical pressure sufficient to create a risk of harm.

Therapeutic massage often involves working on soft tissues to a greater depth and with the application of more force than recreational massage or massage performed for the purpose of relaxation. Treatment may also focus on isolated structures such as tendons, musculotendinous or tenoperiosteal junctions, ligaments, or joint capsules. This creates the possibility of tissue damage in the form of microtears, and can result in bruising and inflammation, particularly where injury, disease, or other medical conditions are present.

Implicit within the therapeutic intent of massage is the expectation that the tissues being treated are not normal, healthy tissues, and that they are more easily injured. The

manipulation of injured tissue through the application of pressure and stretching, becomes potentially more harmful in proportion to the amount of force used and the severity of the injury or other pathology that is present.

In fact, in the treatment of musculoskeletal injuries, where fibrosis, adhesions, and loss of normal tissue extensibility contribute to pain and reduced range of motion, some carefully controlled intentional tissue disruption does occur. However, bruising and inflammation are undesired side effects of such treatment, and often indicate that the force, duration, or frequency of treatment is in excess of tissue tolerances. The presence of inflammation in particular indicates that tissue damage has occurred to an extent that manipulation may make the presenting condition worse rather than better. Where such damage occurs, there exists a real risk that significant and lasting harm may be done: An otherwise treatable condition may become chronic or disabling.

Professional massage therapists are trained to diagnose the cause of pain and dysfunction, identify the specific structures involved, and through palpation and observation, to evaluate the current state of the tissues and their response to treatment. It is often the case that more than one structure is involved, each contributing in some way to the complaint, and differing in both the type of treatment that is indicated and vulnerability to further injury.

The College does not believe that it is in the public interest to allow inadequately trained individuals to perform soft tissue manipulations with sufficient force to produce tissue damage, particularly in therapeutic situations. Where the treatment involves sufficient biomechanical force to alter tissue structure, inadequately trained individuals may do significant damage.

Massage therapists are trained in a wide variety of treatment techniques and modalities, and are instructed in the rationale for using each, the conditions for which they are appropriate, the risks associated with them, and the contraindications for each. A minimum of 550 hours is spent performing these treatments on patients under the supervision of an instructor. Students examine and palpate numerous examples of soft tissue injuries and disorders, learn to evaluate the condition of the tissues they work on, and observe the effects of treatment over time. This training prepares them to use powerful soft tissue manipulation techniques safely and effectively for the benefit of their patients. Body workers and unlicensed providers are not likely to have received equivalent training.

Case history - A massage therapist reports:

Two of my patients (a husband and wife) went to an unlicensed practitioner for "treatment" of their injuries. They had suffered severe hyperflexion injuries of the cervical and thoracic spines during a motor vehicle accident. The unlicensed practitioner did not use a case history form or interview them, nor did he assess their condition. He simply felt his "massage" would help them. His "treatment" involved walking on people's backs, which he did to my patients. After this "treatment", both patients experience intense pain. During their next massage therapy treatment, I reassessed them and discovered they had reverted to the condition in which I first began treating them a year earlier. Both patients complained of increased pain in the upper back and neck and reported the onset of headaches again. I found the cervical and thoracic paraspinal muscles guarded and hypertonic. Edema and muscle tenderness were also present. These signs and symptoms persisted for many months, causing them to modify their work and leisure activities.

If the Council does not agree with the College's proposed wording for this reserved act, the alternative would be to grant to massage therapist a reserved act of "performing non-invasive but physically manipulative procedures on the tissue below the dermis."

4.3.3 Moving body joints beyond the individual's current physiological range

The College is proposing that massage therapists be granted the following reserved act:

3) Moving body joints beyond the individual's current physiological range.

This wording is based on the reserved act identified by the Council in its *Working Paper*, which reads: "moving joints of the spine beyond the individual's usual physiological range of motion using a high velocity, low amplitude thrust."

The College is proposing to change "joints of the spine" to " body joints" and to remove the qualifying phrase "using a high velocity, low amplitude thrust". The College's proposed change broadens the Council's original, narrower reserved act, which appeared to be specifically directed at chiropractic manipulations.

The College offers this change because massage therapists and physical therapists commonly use joint mobilization techniques which are applied to joints other than the spine, and which are performed at low velocity. The potential for harm to joints is not limited to those of the spine.

Low velocity joint manipulations involving progressively greater amplitude are technically known as grade I through IV joint mobilizations. High velocity, low amplitude thrust is a grade V mobilization. Mobilizations using lower velocity can be potentially as harmful as high velocity mobilizations, in particular if the range of motion of an individual's joint is currently limited due to soft tissue or joint disorders, dysfunction or injury.

A wide variety of musculoskeletal disorders, including trauma and certain chronic conditions, result in a reduction of the physiological range of motion to less than normal due to shortening and/or the formation of adhesions within the connective tissue structures associated with joints. Specific manipulations are used to assess restricted movement and to restore normal joint movement.

These manipulations are therapeutic in nature and are not necessary for the preservation or increase of the physiological range of healthy joints. They are used where a restriction exists due to pathological conditions such as osteoarthritis, traumatic arthritis, meniscal problems, ligamentous sprains, frozen shoulder or adhesive capsulitis. The intent of the manipulations is to restore a normal range of motion, and involve a controlled movement of joint structures beyond their current, diminished, physiological range to encourage elongation of shortened components and to disrupt adhesions that have formed between adjacent structures.

Moving a joint beyond the range that can be performed voluntarily by a patient involves applying an external force, either to overcome mechanical resistance or to produce motion in a direction that cannot be produced through voluntary muscle activity. This creates a risk of damage to joint structures if the force, direction, amplitude, or velocity of movement exceeds the mechanical tolerances of the tissue.

Case history - A massage therapist reports:

DP was a 60 year old woman suffering from back pain. She saw an unlicensed practitioner who did not take a case history and therefore did not know she suffered from osteoporosis and a thyroid condition that was being corrected with medication. The practitioner employed a low velocity, low amplitude technique to "put the spine back in". As a result of this maneuver, DP suffered three fractured ribs. This new condition caused much sharper pain than the original aching low back pain. She was in considerable pain for approximately four months, during which her physical activities were severely limited. When she arrived in my clinic, I did not treat her for the fractured ribs, but provided massage therapy for her lumbar back pain.

Therapists trained in British Columbia receive a minimum of 50 hours of instruction on joint mobilization techniques. These are advanced techniques and, due in part to the risk of injury associated with these techniques, are only taught after students have completed studies in arthrology (anatomy of the joints) and arthrological kinesiology (joint motions), massage, stretching, fascial mobilization, and clinical assessment. Student therapists are required to demonstrate the following competencies before performing these techniques on patients:

1. Identify and employ anatomically and physiologically based principles of joint mobilization techniques including indications, contraindications, precautions, uses, effects.
2. Recognize and practice biomechanical skills necessary for the safe and effective performance of joint mobilization modalities and techniques.
3. Define, describe and develop methods and techniques of joint mobilization including:
 - a) passive range of motion
 - b) "joint play" mobilization (grade I & II)
 - c) sustained glides (grade III) and oscillatory techniques (grade III & IV)

Joint mobilization techniques are an important component of the massage therapists' repertoire of treatment methods. When used correctly they can dramatically increase pain-free movement and improve a patient's ability to perform the activities of daily living. Used incorrectly, these techniques can traumatize joints, damaging the joint capsule and ligaments, resulting in pain and an increase rather than a decrease in joint restrictions.

Case history - A massage therapist reports:

DM was a man in his early forties who was suffering from an upper back ache. He received massage from an unlicensed practitioner who did not take a case history or do an assessment. The practitioner decided to fix DM's back by manipulating the joints of the thoracic spine with a strong pressure but low velocity joint mobilization technique. DM's condition was significantly worsened by these techniques. His upper back pain worsened, headaches appeared and he was unable to sleep on his right side. As a mechanic, DM had to reduce his work load significantly and was unable to perform jobs that involved pulling or lifting. This pain continued for several months. Treatments from a registered massage therapist reduced DM's symptoms, especially the headaches, but did not totally eliminate the symptoms resulting from the unlicensed practitioner's treatment.

4.3.4 Putting a finger beyond the labia majora or the anal verge.

The College is proposing that massage therapists be granted the following reserved act:

4) Putting a finger beyond the labia majora or the anal verge.

This reserved act is simply a narrower version of the Council's own proposed reserved act of putting an instrument, hand or finger(s) into certain body orifices; massage therapists who provide those services do not use an instrument. Massage therapists also do not massage beyond the external ear canal, beyond the opening of the urethra or in an artificial opening in the body, so reference to those is also dropped in this proposal.

While a few massage therapists may insert a finger in the nasal passages to release the connective tissue of the nose, to spread the nasal aperture, to help drain the sinuses of the face or to help release several bones of the face, the College understands that these therapists do not go beyond the point of the nasal passage where they commonly narrow. Therefore, the College is not also seeking that reserved act.

Some massage therapists have been trained to insert their fingers in the mouth or throat to massage the muscles located there for excess tone and for trigger points. The muscles are also massaged to allow for symmetrical, balanced motion of the temporomandibular joints, commonly at the request of a dentist. The lymph vessels in the tissues of the soft palate can be drained by putting a finger in the upper part of the mouth. (See Appendix "J" for more information on the treatment of muscles in the mouth.) In providing these services, however, the College understands that massage therapists do not put a finger beyond the pharynx. Therefore, the College is not also seeking that reserved act.

4(a) Putting a finger beyond the labia majora

A finger may be inserted beyond the labia majora to treat the bulbospongiosus, levator ani, ischiocavernosus, coccygeus, piriformis and obturator internus muscles. With vaginal examination, one can reach farther into the pelvis to treat different aspects of these muscles. (See the following section on inserting a finger beyond the anal verge.) With female patients, this technique is required to treat trigger points in two muscles:

- (i) bulbospongiosus muscle: painful intercourse and aching in the pelvic floor;
- (ii) ischiocavernosus muscle: pain in the pelvic floor.

(See Appendix "K" for more information on treatment of the pelvic floor muscles.)

A good knowledge of anatomy and palpatory skill is required for effective treatment that minimizes discomfort. The patient must be adequately educated about the need for and effect of the procedure. The therapist's approach must be highly professional.

The main risk of harm associated with this reserved act is psychological. The patient receiving treatment in this area feels extremely vulnerable. This is further complicated by the fact that this technique can be painful, increasing the psychological effect.

4(b) Putting a finger beyond the anal verge

A finger is inserted beyond the anal verge to massage the pelvic floor muscles and ligaments. This may be done to relieve conditions caused by motor vehicle accidents, severe falls, and

surgery in the pelvic area, pregnancy, postural deviations and misalignment of the pelvic bones. In such cases muscles may become tight and develop trigger points for referred pain; ligaments can also be sources of pain.

Structures involved include:

- (i) levator ani muscle: pain is referred to the sacrum, coccyx, rectum, pelvic floor, vagina or low back. Sitting, lying on the back and defecation may become uncomfortable;
- (ii) coccygeus muscle: similar symptoms to levator ani;
- (iii) obturator internus muscle: referred pain and a feeling of fullness in the rectum, with possible extension of the pain down the back of the thigh. There may be difficulty with defecation;
- (iv) sphincter ani: pain referred to the anal region and possible painful defecation;
- (v) piriformis muscle: referred pain in the buttock and back of the thigh;
- (vi) sacrospinous, sacrococcygeal and anterior longitudinal ligaments: referred pain in the pelvic area.

(Please see Appendix "K" for a description of the trigger points in the pelvic floor muscles and sacrotuberous ligament syndrome.)

Contraindications to this technique include:

- (i) inflammation: structures could be further inflamed;
- (ii) active hemorrhoids: this condition could be further irritated and blood vessels could be damaged;
- (iii) fracture: healing of a fracture could be disrupted.

Knowledge of anatomy and palpatory skill is required for effective treatment that minimizes discomfort. An understanding of anatomy and pathology is required to recognize and avoid surrounding structures such as the prostate in males, the possibility of hemorrhoids, etc.

A major risk of harm associated with this reserved act is also psychological. The patient receiving this treatment feels extremely vulnerable. This technique can also be painful, which increases the psychological effect. The patient must be adequately educated about the need for and effect of the procedure. The therapist's approach must be highly professional.

Specialty, post-graduate certification

The techniques applied in relation to the above "body orifice" reserved acts are not taught at the undergraduate level in the two accredited massage therapy education programs operating in British Columbia. The College is of the view that these massage therapy techniques requires special post-graduate certification to ensure that the massage therapists who provide those services are adequately trained. (The massage techniques embodied in the other proposed reserved acts are adequately taught at the undergraduate level.)

At the moment, there is no board-approved certification program in place for post-graduate specialty practices. However, if the Council recommends the reserved acts of inserting a finger beyond the labia majora or the anal verge be granted to massage therapists, and government subsequently acts on that recommendation and amends the *MT Regulation* accordingly, the College board would amend the College's bylaws to implement a specialty certification program to cover those particular techniques. On the other hand, if they are not granted to the profession as reserved acts, there would be no pressing need to create the applicable specialty certification program for massage therapists.

4.3.5 Using massage therapy techniques when a contraindication exists

In many cases, the risk of harm from the techniques and modalities used by massage therapists is conditional: it is more difficult to hurt healthy, uninjured people with massage therapy. However, if these techniques are misapplied to people with medical conditions or musculoskeletal injuries, the risk of harm increases.

Unfortunately, this situation does not translate easily into the concept of "reserved acts" granted to professions designated under the Health Professions Act. Reserved acts are intended to be specifically defined and address so-called inherent risks of harm. Furthermore, it is often difficult to know where health ends and dysfunction begins, and thus articulate an appropriate reserved act for massage therapists. The patient, and even the referring physician, if there is one, may not be aware of underlying medical conditions or injuries that might be aggravated by applying manual or hydrotherapy techniques. The massage therapist may be the first contact for patients who do not choose to seek a medical referral prior to obtaining massage treatment. Others may seek therapy for what appears to be a recurrence of a previously treated condition, either without returning to the primary care physician for a referral, or by obtaining a referral from a primary care physician who, based on the similarities to the previous complaint, does not perform a new examination. In these circumstances, the therapist's assessment or the patient's response to therapy may be the only way that these medical problems are discovered.

The next two proposed reserved acts are based on the presence of injuries or medical conditions that are absolute or partial contraindications to massage therapy treatment. They are not based on the Council's proposed list of reserved acts; however, the College feels that the risk of harm from untrained practitioners providing treatment to people with medical conditions or injuries is sufficient to attempt to incorporate this conditional risk into reserved acts. The risks of harm are articulated as specifically as possible to minimize the unnecessarily expansive reach of these reserved acts.

The College is proposing that massage therapists be granted the following two reserved acts:

- 5) Using massage therapy techniques on a patient when a contraindication for that patient exists that would necessitate avoidance or modification of the technique and the technique to be given
 - (a) would significantly increase the blood or lymph circulation of that patient,
 - (b) requires deep pressure or stretch to be applied to the soft tissues of the patient's body, or
 - (c) would passively mobilize the patient's joint (excluding high velocity manipulation).

- 6) Using massage therapy techniques on a patient when a contraindication exists that would necessitate avoidance or modification of the technique, including but not limited to
- (a) an acute or chronic injury, structural abnormality or disease of a joint, muscle, ligament, tendon, connective tissue, bone or organ of the body,
 - (b) a circulatory or lymphatic condition that compromises either system, and
 - (c) a neurological injury or disease.

The risk of harm associated with massage therapy treatment of certain medical conditions and musculoskeletal injuries has long been recognized by massage therapists, and is the reason contraindications are taught in massage therapy schools. The goal is to treat the patient in whom a contraindication exists such that a beneficial response may be obtained without producing unnecessary pain, causing further injury, or adversely affecting other medical conditions. Many contraindications are relative, meaning that certain techniques may be safe, while others are not. The contraindication may also mean that a particular technique may have to be modified in order to be safe. (See Appendix "L" : *Contraindications to Massage Therapy*.)

Although there are many contraindications to massage therapy and hydrotherapy, most pertain to the potential harm from these causes:

- (a) increased blood or lymph circulation in conditions where that may be harmful;
- (b) pressure placed on the joints and soft tissues, including organs, which may be harmful because of injury, inflammation or medical condition;
- (c) stretching of joints and soft tissues, including organs, which may be weak, abnormally shortened, adhered or otherwise vulnerable because of injury, fibrosis or medical condition.

The following are some examples of contraindications to massage treatment, both absolute and relative, together with an explanation of the potential for harm:

1. The effects of massage therapy on the movement of venous blood and lymph are quite potent. Some of the research demonstrating this has been documented in *A Physician's Guide to Therapeutic Massage*. (Appendix "B" is an executive summary of this guide.) Although these circulatory effects are among the best known benefits of massage, they are not always in the best interests of the patient.

An example of this can be found in patients with certain forms of chronic heart and kidney disease who experience massive edema and poor circulation, particularly in the lower extremities. Although massage can be very effective in reducing the swelling by moving this fluid back into the circulatory system, it is undesirable and potentially dangerous to do so: the fluid has accumulated in the legs because the weakened organ, the heart or kidneys, was overloaded and not capable of dealing with the fluid. (See Appendix "M" for a case description of a patient with chronic kidney

disease who was adversely affected by massage received from an unlicensed practitioner.)

2. Prolonged immobilization, such as commonly occurs following major trauma, during serious illnesses, or in the elderly, can result in venous stasis, a condition in which the venous blood flow is sufficiently reduced that blood can coagulate in the vessels. This is described as venous thrombosis. Thrombosis can also occur in varicose veins, and in veins that have been occluded by a tight fitting cast or bandage. If the thrombus is disturbed, it can begin to travel toward the heart and may ultimately pass into the arteries of the lung where it obstructs the flow of blood.

This condition, known as pulmonary embolism, is serious and may be fatal. Indeed, pulmonary embolism following removal of casts is one of the more serious complications of the medical treatment of fractures. A massage therapy patient may be predisposed to venous thrombosis through any one or a combination of the factors described above, and in fact any of these can be the primary motivation for seeking massage and its circulation enhancing effects. However, where venous thrombosis is evident or suspected, massage is absolutely contraindicated in the area or peripheral to it, because of the risk that the massage itself, or the increased venous blood flow it induces, may dislodge the thrombus and cause a pulmonary embolism. (See Appendix "N" for a case description of a patient whose venous thrombosis was first recognized by a trained massage therapist.)

3. Massage is perhaps best known for the treatment of muscular aches and pains, and is used for this purpose by a wide range of people with every conceivable degree of training or lack thereof. Nevertheless, musculoskeletal injury is a relative contraindication to some massage techniques.

For example, recently injured tissues such as muscle, tendons, and ligaments are weakened and are therefore particularly vulnerable to further damage through the application of stretching or pressure. During the repair phase following injury, new connective tissue fibers are laid down in abundant quantities resulting in thickening of the structure at the site of injury and a loss of elasticity. This fibrous tissue can also adhere to adjacent structures in such a way as to limit the normal movement of these structures relative to one another. This condition is described as fibrosis. The new tissue is a form of scar tissue.

Massage therapists use stretching and a form of deep friction massage, among other techniques, to restore normal movement and function to these structures by gently disrupting the cross-links that have formed, and by encouraging a realignment and lengthening of the new fibrous tissue. Stretching is, however, a relative contraindication in that the amount of stretch must be carefully modulated and gauged to the condition of the tissue, otherwise further damage will occur, and a new cycle of repair will be initiated resulting in more fibrosis and further loss of function. Long after healing is completed, particularly if the type of treatment just described did not occur during the repair phase, the loss of elasticity of the structure due to the presence of fibrous scar tissue at the site of the injury will make it more vulnerable to tearing when stretch is applied. This damage primarily effects previously uninjured areas adjacent to the scar tissue, and contributes significantly to a further loss of elasticity and increased vulnerability to subsequent re-injury.

In this example, both new and old injuries are relative contraindications to stretch that require the therapist to have the training and skills necessary to evaluate the condition

of the tissue and adapt treatment accordingly. (See Appendices "O" and "P" for sample descriptions of risks of harm from specific massage therapy techniques when applied in specific conditions.)

The massage therapist is called on with every patient to plan and choose treatment that specifically addresses the abnormality responsible for the patient's presenting condition. The therapist is responsible for identifying as closely as possible the origin of the pain and/or dysfunction in terms of location, nature, severity and cause of the pathology or abnormality that has produced the complaint. Differential diagnosis must be performed to rule out systemic disease or other causes not treatable through massage therapy, and pre-existing conditions must be carefully evaluated as potential contraindications.

People not formally trained as massage therapists (or as health care practitioners) typically do not take case histories from their clients, or do so inadequately. Usually, they lack the knowledge of anatomy, physiology and pathology required to ask the right questions or interpret the answers. Nor do they learn the contraindications to massage, how to identify them through history taking, or how to manage them. Their assessment skills are also often inadequate to help them either to closely identify the cause of the presenting complaint or the existence of contraindications. (See Appendices "M" and "N" for an example of the need for proper case history taking and competent assessment skills. See Appendix "Q" for an illustration of massage assessment and treatment of a condition.)

The two proposed reserved acts set out above address the risk of harm for patients with contraindications, each from a different viewpoint. The first looks at specific techniques that are most likely to harm a person with a contraindicated condition. The second looks at conditions that are most likely to be harmed by any and all techniques. The two reserved acts overlap somewhat, but between the two, they capture risk of harm as specifically as possible.

4.4 Other legislation

In preparing this revised submission, the College contracted with a consultant to survey other jurisdictions that regulate massage therapy to ascertain if any had granted reserved acts (or their legislative equivalent) to massage therapists. The consultant did not identify any jurisdiction that had granted reserved acts to massage therapists. The College is not surprised by this finding, for two reasons.

First, we now understand that Ontario and British Columbia are probably the only two jurisdictions in North America which have adopted the reserved act approach to regulating the practice of health professions generally. (Alberta, we understand, is moving in that direction.) Legislatively speaking, therefore, reserved acts or their equivalent do not exist in other jurisdictions.

The second reason is based on the fact that therapists in British Columbia and Ontario are better trained and may do more medical procedures than their counterparts elsewhere in North America. Further, massage therapists in this province appear to be more directly involved with and integrated into the British Columbia health care systems and, in particular have access to public health care insurance funding for the services they provide. As a result, British Columbia massage therapists may be the only therapists in North America capable of being granted reserved acts.

The College believes that British Columbia is on the leading edge in its legislative framework for governing the practice of massage therapists and in the way that massage therapists have been employed within the province's health care system. If other jurisdictions had adopted a

similar legislative approach to regulating their health professions and if massage therapists in those jurisdictions were more integrated into their health care systems, the College would then expect to find jurisdictions that would have granted reserved acts to their massage therapists.

5. SUPERVISED ACTS

The following definitions are based on the Council's discussion of these terms starting on page 11 of its *Working Paper*:

- "Delegation" occurs when the delegating professional who has been granted a reserved act determines that another person who has not been granted that reserved act is nonetheless competent to perform a task or service that falls within the reserved act with the direct or continuous presence of the delegating professional;
- "Supervision" means that the delegation professional must usually provide direct or continuous oversight or control over the other person while they are performing a task or service that falls within the reserved act.

On pages 12 to 13 of that paper, the Council:

recommends that a provision be enacted which deals with general principles regarding delegation of reserved acts. The provision would apply generally, not to individual cases. It should require the following:

- The assigning health professional's governing body must provide assent to the proposed reserved act being performed by someone else;
- The reserved act to be assigned as well as the level of supervision must be clearly defined and circumscribed by the assigning health professional's governing body;
- Where the person to whom the act will be assigned is a regulated health professional, his or her governing body must approve the assignment;
- The instruction to perform the act must be made in writing either by way of a general written protocol or through a case-specific instruction;
- The assigning health professional must be satisfied that the individual who will be performing the act has the necessary skills and training to perform the act safely;
- The assigning health professional must ensure that the person who will be performing the act accepts the assignment.

The Council comments that delegation of reserved acts would not have to proceed on a case-by-case basis; approval by the governing body is to apply generally and would be satisfied if there was a general delegation protocol in place for any given reserved act granted to the profession. The delegation of a profession's reserved acts are likely to vary from profession to profession, and may include only subsets or variations on the reserved acts granted to the profession. Those delegated reserved acts may be performed under a myriad of circumstances and conditions.

Finally, and perhaps most importantly, the Council:

Öemphasizes that the issue of supervised or delegated acts arises only with respect to reserved acts. Thus, the general provision regarding supervision will not apply in respect to acts which are not reserved.

From this, the College has concluded that if another profession has been granted the same or similar reserved acts as a massage therapists, there is no need for delegation or supervision by massage therapists to members of that profession, so long as they are providing services that fall within the shared reserved act. It also follows that, if massage therapists are not granted any reserved acts, there is no need for delegation protocols or the supervision of others by massage therapists.

If, however, massage therapists are granted reserved acts as proposed in this revised submission, the College would consider the need for and the feasibility of implementing a delegation protocol along the lines proposed by the Council in its *Working Paper*.

6. PROHIBITED ACTS

Under the current *MT Regulation*, massage therapists are prohibited from providing certain services. Prescribing or administering a drug or anaesthetic, or treating a recent fracture of a bone are prohibited acts specifically set out under section 6. Providing medical electrical therapy is prohibited under the closing words of the section 1 definition of massage therapy.

Given the Council's new approach to defining reserved acts for health professionals, there is no longer a need for any prohibitions to be placed on the practice of massage therapists. For example, massage therapist could only prescribe or administer a drug or anaesthetic, or treat a recent fracture of a bone if they were granted these reserved acts. However, massage therapists are not seeking these reserved acts therefore it is legislatively redundant to maintain this prohibition.

It is the College's understanding that the prohibition in section 1 of the *MT Regulation* that makes it illegal for massage therapists to provide any form of medical electrical therapy continues a similar prohibition that existed when massage and physical therapists were regulated together under the Physiotherapists Act. That prohibition helped to distinguish physical therapists from massage therapists.

If only hazardous forms of medical electricity are to be regulated under the Council's proposed reserved acts, it follows that any health practitioner would be allowed to provide patients with treatments that involve non-hazardous forms of medical electricity, so long as such treatments are therapeutically indicated and the practitioner has the skills, knowledge and ability to provide those non-hazardous treatments. Some massage therapists have been trained to provide certain non-hazardous forms of medical electricity, such as cold lasers, ultra violet, infra red and micro-current therapies. The College will continue to monitor the use of non-hazardous forms of medical electricity by therapists to ensure that they have sufficient education and experience to use them safely. However, as with administering a drug, the medical electrical therapy prohibition is also legislatively redundant and should, therefore, be removed. The College is not proposing that massage therapists be granted the reserved act of applying hazardous forms of electrical energy.

7. EXCLUSIVE OCCUPATIONAL TITLES FOR MASSAGE THERAPY

Perhaps more than any other health care professionals, massage therapists have had to cope with unregistered practitioners using massage therapy techniques, often while also using similar sounding titles to describe themselves.

It is important that the use of the reserved titles granted to the profession be strictly controlled, because that is the best way to help the public identify members of a profession among the array of both regulated and unregulated health practitioners. Currently, section 3 of the *MT Regulation* sets out four occupational titles that have been granted to members of the College:

No person other than a registrant may use the title "massage therapist," "registered massage therapist," "massage practitioner" or "registered massage practitioner."

The Council made the following observation about occupational titles in its recent report on the review of the scope of practice of physicians and surgeons:

Reserved titles are titles reserved exclusively to a health profession. Reserved titles afford consumers a means to identify the different types of health care providers, to distinguish the qualified from the unqualified, and to differentiate those practitioners who are registered from those who are not. Titles must adequately serve the public in describing the practitioner and the services being provided and must distinguish the practitioner from others performing services outside the jurisdiction of the college.

Members of the College have been known to the public by these four titles, mostly as either "massage therapists" or "registered massage therapists", and commonly with the abbreviation "RMT". Massage therapists have worked hard to educate the public that a registered massage therapist meets the high educational, practice and ethical standards set by the College.

For these reasons, the College proposes that the current four titles continue to be the exclusive occupational titles granted to the profession.

In addition, the College proposes a new title for members of the profession: "registered myofascial therapists", which would also be abbreviated as "RMT".

It is useful to consider the origin of the word "myofascial".

- "myo-" word element (Gr.), "muscle" (*Dorland's Pocket Medical Dictionary - 22nd Edition*);

"myo-" (from the Greek *mys*, muscle) "Combining form [pertaining] to muscle." (*Taber's Cyclopedic Medical Dictionary - 16th Edition*).

- "Fascia" (L.) a sheet or band of fibrous tissue such as lies deep to the skin or invests muscles. " (*Dorland's Pocket Medical Dictionary - 22nd Edition*);

"Fascia" (L, a band). A fibrous membrane covering, supporting, and separating muscles. It also unites the skin with underlying tissue. Fascia may be superficial, a nearly subcutaneous covering permitting free movement of the skin, or it may be

deep, enveloping and binding muscles. ." (*Taber's Cyclopedic Medical Dictionary - 16th Edition*).

The College believes that "myofascial" is a reasonable and useful alternative word to describe the therapists who are licensed to practice this form of therapy in BC.

When members of the public and the medical community see the title, Registered Massage Therapist, they often respond according to their past experience with "massage". Their experience may or may not have been acquired from a personal experience of therapy provided by a Registered Massage Therapist. The services of an Registered Massage Therapist are medical or health care services, in the same way that the services provided by a Physical Therapist are medical services. On the other hand, there is evidence of public confusion regarding the services provided by Registered Massage Therapists and the non-therapeutic massage services provided by persons who include the word "massage" in their titles or advertising. The new title Registered Myofascial Therapist would further help to differentiate members of the College from those who include the word "massage" to describe themselves or their services, but who are not providing a medical or therapeutic service, and are not covered by public and private health care insurance plans.

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