Massage Profession Reply to the California Chiropractic Association on SB 412 Wording for Scope of Practice for Range of Motion

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Whatever advantages other aspects of a bill for state regulation might convey, it would be a breach of trust for the organizations of a profession, in negotiating the language of such a bill, to agree to wording excluding practices in common use within the profession and having serious negative impact on the practitioners and schools they represent. A wording proposed for SB 412, defining the scope of practice for massage, places ABMP [1], and CAMBS [2] in exactly such a predicament. This document is a response to the California Chiropractic Association on this issue with the review and concurrence of the aforementioned massage organizations.

The proposed wording in question is that which would exclude from the scope of massage practice "*movement of a joint beyond the active range of motion for that joint*". As will be shown, in deference to the trust placed in us by the massage practitioners in California, ABMP and CAMBS have little recourse but to adamantly oppose such wording. At the same time, we believe that it would be advantageous, for both the massage and chiropractic professions, to find jointly agreeable wording safe-guarding the public interest yet respecting existing practices. This is particularly true as the practices in question lack objective documentation of undue or recurring harm. We also believe that by avoiding a direct legislative conflict, the chiropractic profession would more likely have an effective role in providing input to the proposed private massage certifying organization — a role in creating, improving, and circulating guidelines and norms of training for the safe and effective provision of the more advanced massage subpractices.

There are essentially five elements to be considered in this reply: the implications of the wording itself, that the proposed wording is in conflict with commonly accepted massage training and practice, that initial and continuing massage training contains reasonable precautionary content, that there is a lack of objective evidence of patterns of recurring harm from current practices, and that there is sufficient indication and precedent that less restrictive stipulations are sufficient. These will be considered in turn.

Implications off Exclusion of Movement of a Joint beyond the Active Range

The term *active range of motion* is customarily taken to mean the range of motion that can be obtained via the voluntary contraction of a client's own muscles. The limit of this motion is normally called the *physiological barrier*. Where the normal active range of motion in a given direction has become limited (i.e. stops short of the normal physiological barrier), the term *pathological barrier* is used. The *passive range of motion* is defined to be the range over which another person can move the joint with the client simply allowing such movement. The limits of the passive range of motion are called the *elastic barriers*. The elastic barrier is the point at which there is resistance to further movement in a given direction. Beyond the elastic barrier is the

[1] Associated Bodywork & Massage Professionals

[2] California Alliance of Massage & Bodywork Schools

paraphysiological space. The paraphysiological space terminates with the *anatomical barrier*. Movement beyond the anatomical barrier results in severe damage to the joint structure.

To our knowledge, the above definitions are consistent with standard usage in discussion of range of motion, barriers to motion, and end-feel at the motion restriction (e.g. springy, hard …), including termination of motion due to pain (empty end-feel). The definitions are consistent with the discussions in Greenman[3], Hammer[4], Mills[5], Liebenson[6], Lowe[7], and Lowe[8].

The disagreement in wording between the California Chiropractic Association and the massage profession arises from the passive range of motion being greater than or equal to the active range of motion. Numerous massage techniques often and customarily extend to the full passive range of motion. The first point follows from the simple observation that the passive range of motion is limited only by the resistance to further movement from the inability of an opposing muscle to lengthen or by the capsule and ligaments of the joint itself. The active range of motion has the further limitation of the adequacy of the working muscle to power movement in contracting further. For a muscle crossing two joints, such as the rectus femoris of the quadriceps (crossing hip and knee), muscular contraction is often inadequate to both fully extend the knee and simultaneously fully flex the hip, a situation noted by Kendall and McCreary as *active insufficiency*.[9] The active range of motion, in a practical sense, will even depend on whether a motion is vertical against gravity, vertical with gravity, or horizontal and thus neutral to gravity. We thus have the ambiguity that the active range of motion against gravity may be exceeded by the passive stretch obtained simply by changing position and letting gravity power the motion. Active range of movement also depends on the learned muscle use patterns (conditioned reflexes) for a given muscle, in a given position, to be moved in a specified direction. This learning of movement was pointed out by Sweigard in a work first published in the 1970's.[10]

> "In early life good or poor neuromuscular habits may be established through imitation; later on, they may be established not only through imitation but also in response to all life situations or the teaching of movement patterns in many activities. In all these processes it

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[3] Greenman, Philip, 1989: **Principles of Manual Medicine**, 1st ed., Williams & Wilkins, ISBN 0-683-03556-8, 31-38.

[4] Hammer, Warren, DC, 1992: **An Exercise in Diagnosis**, Dynamic Chiropractic, 10 (01), <http://www.chiroweb.com/archives/10/01/29.html>

[5] Mills, Timothy L., DC, 1993: **Graphic Description of Forces Used in Chiropractic Manipulation under Anesthesia (MUA)**, Dynamic Chiropractic, 11 (3), <http://www.chiroweb.com/archives/11/03/28.html>.

[6] Liebenson, Craig, DC, **Pain, Activity Limitation, and Dysfunction: How Rehabilitation Can Help**, Dynamic Chiropractic, 14 (02), <http://www.chiroweb.com/archives/14/02/09.html>.

[7] Lowe, Whitney, 2001: **Manual Resistive Tests**, Massage Today, 1 (03), <http://www.massagetoday.com/archives/2001/03/08.html>.

[8] Lowe, Whitney, 2001: **What is the "End Feel"**? Massage Today, 1 (11), <http://www.massagetoday.com/archives/2001/11/08.html>.

[9] Kendall, FP, and EK McCreary, 1983: *Muscles — Testing and Function*, 3rd ed., Williams & Wilkins, ISBN 0-683-04575-X, 5.

[10] Sweigard, Lulu E., 1974: **Human Movement Potential**, Harper & Row. Reprinted in 1988 by University Press, Inc., 165.

is the quality of the input that controls the quality of the output—in this case, the conditioned reflex."

Following the healing of an injury, patterns of movement compensation created to avoid pain plus loss of sensory information of joint position (loss of proprioception) can also reduce active range of motion.[11] Thus active range of motion depends considerably on neuromuscular factors independent of the capacity of the joint to allow movement. The various dependencies of the active range are not particularly detrimental to range of motion testing, since other factors are carefully controlled and a comparison is often made to the contralateral side. Such control is not the case when an attempt is made to use active range as a determinant of scope of practice.

The ambiguity of the active range of motion is inherently a poor basis for creating an exclusion from a scope of practice. Moreover, such usage violates both common usage within the massage profession and the lay concept of a stretch. It is an attempt to foster upon the massage profession a lame horse with an ill-made saddle.

In contrast, the lay meaning and usage of a stretch within the practice of massage is to take motion to the point of resistance —the passive limit to motion or equivalently, the elastic barrier. The focus within massage is not, as in chiropractic, to use an impulse mobilization to cavitate the joint. Instead it is to smoothly and slowly apply a resistance to create a stretch of surrounding or opposing muscles and fascia, in effect a form of passive yoga. In clinical massage, such a stretch is also used to help differentiate an injury in an opposing muscle-tendon unit from a sprain of the joint itself. A stretch may subsequently be used in trigger point work to elongate and normalize the muscle tissue after applying direct pressure to the tissue lesion.

Range of Motion Practices within the Massage Profession

While by no means exhaustive, the quotations from several massage textbooks are clearly indicative of the wide use of techniques passively moving joints to the elastic motion barrier and the detection of a palpable end-feel.

Tappan and Benjamin clearly indicate the historical and current role of joint mobilization and stretching within Western massage practice. [12]

"Classic Western massage traditionally includes joint movements as well as soft tissue manipulation. Pehr Ling's original system of medical gymnastics, developed in Sweden in the early 1800s, included passive movements of the soft tissues and joints. … Joint movements are traditionally categorized as active and passive. [13] Joint mobilizations are passive movements performed within the normal range of joint movement. They can easily be integrated into a massage routine. They cause movement of the soft tissues

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[11] Laskowski, ER, K Newcomer-Aney, J. Smith, 1997: *Refining Rehabilitation With Proprioception Training: Expediting Return to Play*, The Physician and Sportsmedicine, 25(10), <http://www.physsportsmed.com/issues/1997/10oct/laskow.htm>

[12] Tappan, Frances M., and Patricia J. Benjamin, 1998: *Tappan's Handbook of Healing Massage Techniques*, 3rd ed., Appleton and Lange, ISBN 0-8385-3676-x, 107-108.

[13] McMillan, M., 1925: *Massage and Therapeutic Exercise*, 2nd ed. Philadelphia, W.B. Saunders.

around and within joints, freeing up the motion of the joints involved. Massage techniques may be applied to muscles when the associated joint is being mobilized. "

"Stretching is a type of passive joint movement that is performed to the limit of the range of motion. It is used to increase flexibility at the joint, as it elongates the muscles and connective tissues that cross the joint. Stretching may also be used for muscle relaxation. Practitioners [of massage] use joint movements for a variety of reasons including to stretch surrounding tissues, increase joint range of motion, stimulate production of synovial fluid, increase kinesthetic awareness, stimulate muscle relaxation, and build muscle strength. … Joint movements, both active and passive have been used for decades to help improve posture and body alignment. Stretching can improve the function of an area such as the shoulder or hip by increasing the flexibility around a joint."

Such use of joint movement, taken to the passive limit of end-feel is also confirmed by Sandy Fritz in her text of massage techniques. [14]

"When a normal joint is taken to its limit, there is usually still a bit more movement possible, a sort of springiness in the joint. This is called a *soft end-feel*. When there is abnormal restriction, the limit does not have this spring, but like a jammed door or drawer, the joint is fixed at the barrier, and any attempt to take it further is uncomfortable and distinctly 'binding' or jamming, rather than springy. This is called a hard end-feel. When doing passive joint movement, feel for the soft- or hard end-feel of the joint range of motion. This will become an important evaluation tool. Joint movement becomes part of the application of muscle energy techniques and stretching methods. Because of this, the massage therapist should concentrate on the ability to efficiently and effectively use joint movement."

Taking a muscle to the elastic barrier is common and essential to numerous specialized massage techniques. In discussing, muscle energy technique (MET), a method of releasing muscle hypertonicity based on a relaxation response following isometric contraction, Mel Cash is explicit about the correct positioning at the end-range of passive motion. [15]

"The therapist passively stretches the tight muscle, by moving the associated joint, until a position is reached that causes the first sign of a mild stretch, but there must be no actual pain. This position is commonly called the *barrier*, and it should be fixed by the therapist so that no movement can occur."

Whitney Lowe, an instructor of orthopedic massage, notes the importance of stretching techniques to the orthopedic massage practitioner. [16]

"Entire textbooks are devoted to the various methods of stretching. Consequently, a thorough discussion of stretching methods is beyond the scope of this text. However, it is important to mention several stretching methods, as they are an integral part of the treatment arsenal for any practitioner of orthopedic massage."

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[14] Fritz, Sandy, 1995: *Mosby's Fundamentals of Therapeutic Massage*, 1st ed., Mosby Lifeline Publishing, ISBN 0-8151-3251-4, 264-265.

[15] Cash, Mel, .1996: *Sport & Remedial Massage Therapy*, Ebury Press, London, ISBN 0-091-80956-8, 209.

[16] Lowe, Whitney, 2003: *Orthopedic Massage: Theory and Technique*, Mosby, ISBN 0-7234-3226-0,, 47.

Lowe also describes a particular technique in which passive stretching is a key part of the effectiveness of treatment.[17]

> "The target muscle will be put in a shortened position. The practitioner applies static compression to a particular area of the muscle tissue while it is in that shortened position. While the pressure in continually applied, the practitioner will elongate the tissues underneath the pressure by passively moving the limb. This technique may also be referred to as pin and stretch."

It cannot be concluded from the description above that stretching of one muscle will stay within the active range of motion of its antagonists.

Thai Massage instructor Richard Gold has noted that passive stretching to the end-feel/elastic limit of a joint is by definition an essential and intrinsic element of Thai Massage. Again, instruction includes an appropriate cautionary note protective of the client. [18]

> "A critical component of Thai massage is stretching of the limbs, torso and neck. The stretching procedures are made by creating a force/counter-force in various locations of the body. As an example, the practitioner pulls at the ankle while simultaneously pressing with the foot into the client's medial thigh. The stretches create elongation and expansion, and open up the joint spaces. The practitioner seeks to give the client an expanded sense of his or her body. With the utilization of the stretches, the goal of working very slowly is especially vital. The practitioner must sense the holding patterns in the client's body and never forcibly stretch the client beyond what is comfortable."

Art Riggs, in his definitive work on deep tissue massage, observes the importance of a stretch to this body of work.[19]

> "In most cases, put muscles into a stretched position to effect a release. The vast majority of problems we encounter are a result of short, contracted muscles. Therapists are often hesitant to move limbs or reposition the client for fear of disturbing the state of relaxation. However, if a tight muscle is placed in an easy stretch near its end range, when the muscle relaxes, it will lengthen. For all practical purposes this educates the muscle stretch receptors to reestablish a new definition of what its resting length is. Many of the positions shown in this book are designed to place muscles into stretched positions while you are working [directly on the tissue]."

James Clay comments in his clinical massage text on the importance of passively stretching a muscle as part of 'trigger point' treatment.[20]

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[17] Ibid, 42.

[18] Gold, Richard, and Ted Kaptchuk (forward), 1998: *Thai Massage – A Traditional Medical Practice*, Churchill Livingstone, ISBN 0-443-05935-7, 29.

[19] Riggs, Art, 2002: *Deep Tissue Massage – A Visual Guide to Techniques*, North Atlantic Books, Berkeley, CA ISBN 1-556-43387-5, 17.

[20] Clay, James, 2003: *Basic Clinical Massage Therapy: Integrating Anatomy and Treatment*, Lippincott, Williams, & Wilkins, ISBN 0-683-30653-7, 22-23.

"Although trigger points may be treated directly with any of the above [direct] techniques, resolution of them requires passive stretching of the muscle as soon after treatment as possible."

While the above quotes paint a definitive picture of the use of passive stretching in published massage texts, I have also asked several of the authors to comment directly on the proposed limitation of scope of practice to the "active range of motion".

"Although in my present textbook (Basic Clinical Massage Therapy: Integrating Anatomy and Treatment[21]) I make some reference to passive stretching, in my textbook in progress (Advanced Clinical Massage Therapy) stretching, both active and passive, is central in emphasis, particularly with regard to trigger point treatment. It is clear, based on the work of Janet G. Travell and particularly the ongoing work of David G. Simons, that trigger points limit range of motion and cannot be effectively treated without passive stretch beyond that range. To deny us the possibility of stretching beyond extant range of motion would effectively deny us the ability to work effectively, and thus deny our clients the benefits of this work." — James H. Clay

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"There are many physiological benefits to massage therapy, but the most significant one is the ability of massage to reduce muscular hypertonicity (tightness). Reducing muscular hypertonicity is a key aspect of general stress reduction and improvement of biomechanical function--the fundamental aspects of massage therapy used as a complementary health care practice. Various techniques are specifically aimed at reducing hypertonicity and they are all enhanced by the inclusion of stretching methods performed within the limits of normal passive range of motion. Denying massage practitioners the application of passive stretching would cause serious detriment to the effective practice of massage and is not a prudent course to enhance public safety. It seems the concerns being expressed about passive stretching are more related to other methods of passive movement that fall outside the normal scope of massage practice. It would be far more realistic to include wording in the definition of massage that appropriately excludes passive techniques such as high-velocity manipulation that are clearly outside the scope of practice of massage." — Whitney Lowe, Director OMERI (Orthopedic Massage Education & Research Institute, <http://www.omeri.com>)

"The use of joint movement is an aspect of therapeutic massage application. Based on my research as I developed and continue to update the textbook line **Mosby's Fundamentals of Therapeutic Massage and Mosby's Essential Science for Therapeutic Massage**, it is clear to me that active and passive joint movement is an integral aspect of massage application. The methods are used for assessment, as method application and for positioning the body to apply various muscle energy and stretching methods. Movement of a joint can be considered as physiologic or within the normal range of motion, pathologic or limited by soft tissue bind or by internal joint dysfunction and anatomic

[21] Clay, Op. Cit.

which is determined and limited by the design of the joint itself. Therapeutic massage application is used to address the soft tissue binding which limits joint range of motion in the normal range. An aspect of the application is to identify the binding soft tissue and stretch that tissue just beyond the soft tissue limits. While it is not within the typical scope of practice to directly manipulate the joint structures within the joint capsule, it is certain acceptable and necessary to stretch the soft tissue surrounding the joint. The limits of 'movement of a joint beyond the active range of motion of a joint' would prevent the massage application from being effective." — Sandy Fritz[22]

"I've done physical therapy rehabilitation work for 20 years either in a PT clinic or on referral. The primary symptoms of either chronic misuse or of surgical intervention are the dysfunction of the joint at end range—not in the neutral position. If the end range of motion is not restored, the joint continues to lose mobility. One of the keys of post surgical work for knees, shoulders, and most other injuries is the movement of joints to stretch traumatized muscles and tendons and adhesions to restore flexibility to both the soft tissue and the joint. This work can only be done at the end range of motion to expand movement or else it is like trying to stretch a rubber band that is limp."

" I have worked on numerous clients suffering from MS, Muscular Dystrophy, strokes, and, most recently, a paraplegic. All of these people have loved the range of motion stretching for the relief of muscle tension and the prevention of the joint freezing. The paraplegic man, even though he has no sensation below T4 suffers from intense leg cramps that actually can throw him out of bed at night. His 'range of active motion' below his upper chest is ZERO, so a massage therapist would not be able to move him at all if the scope of practice were limited to active range. He is almost dependent upon his regular massage therapist to stretch these muscles to help with the cramping so he can sleep at night. Would our friends the chiropractors (or the legislators) want anyone they know or themselves to be prevented from having treatment that they are dependent upon? " — Art Riggs <http://www.deeptissuemassagemanual.com/>

"Massage and bodywork have a long and varied history around the world. A narrow view of massage that is based on massage in America is a faulty approach and highly ethnocentric. Even what we consider to be Swedish massage actually has it's origins in China. In Traditional Thai massage, stretching is a core component. This is a system of bodywork developed approximately 2500 years ago. Muscles are stretched just beyond what their normal relaxed length would be. The muscle spindle organs respond to this by signaling the brain that the muscle is relaxed. Inhibitory nerve impulses to the antagonistic muscles stop and they can regain their normal tone. This is a key component of Thai massage. This approach helps restore balance within and between functional groups of muscles to ease pain, increase flexibility and improve posture. Without these

[22] Sandy Fritz's works include *Mosby's Basic Science for Soft Tissue and Movement Therapies*, Mosby (1999); *Mosby's Essential Sciences for Therapeutic Massage: Anatomy, Physiology, Biomechanics and Pathology*, 2nd ed., Mosby (2003), Mosby; *Mosby's Fundamentals Of Therapeutic Massage*, 3rd ed. And CD, Mosby (2004); *Sports & Exercise Massage: Comprehensive Care for Athletes, Fitness, & Rehabilitation*, book and DVD, Mosby (2005); and *Mosby's Massage Therapy Review*, Mosby (2005).

techniques, Thai Massage would lose it's dramatic therapeutic effect." — Richard Gold <http://www.traditionalthaimassage.com/>

Cautionary and Scope of Practice Training Commensurate with Technique Training

Massage training should not and does not encourage mobilization beyond the commonly accepted scope of massage. As an individual practitioner advances into new, more sophisticated techniques during their career, cautionary training correspondingly advances. The quotes from several texts in this section are typical cautionary statements addressing this point. They indicate a clear concern for the welfare of the client, the need for judicial practice within training, and the teaching of contraindications appropriate to the level of training.

Tappan and Benjamin, in their introductory text, provide a cautionary note on scope of practice. [23]

> "*Joint manipulations or adjustments* (sometimes called *chiropractic adjustments*) are not within the scope of this text. By joint manipulations and adjustments, we mean techniques that take a joint beyond its normal range of motion and that are specific attempts to realign a misaligned joint, usually using a thrusting movement. They should be performed only by those trained to do so within their legal scope of practice."

In the more advanced application of muscle energy technique (MET), a form of post-isometric relaxation at the elastic barrier, Chaitow and Delany caution against applying force to joint restrictions; an example of more advanced and specific cautionary learning being included within more advanced teaching of techniques:[24]

> "When MET is used in relation to joint restriction, no stretching should be introduced after an isometric contraction, only a motion to the new barrier. This is also true of MET treatment of acute soft tissue dysfunction. Therefore, for acute muscular problems and all joint restrictions: identify the barrier, introduce MET, move to the new barrier after release of the contraction. Any sense that force is needed to move a joint, or that tissues are 'binding' as movement is performed, should inform the hands of the practitioner that the barrier has been passed or reached. **Only in chronic soft tissue conditions is stretching beyond the restriction barrier introduced, never in joint restrictions."**

Massage training is neither silent nor cavalier on concerns for reasonable and prudent action based on the history and observable condition of a client. While not extensive, the cautions are salient and to the point, as is appropriate for a profession that should only assess whether a question of advisability of practice without referral is evident and not the extent or specifics of such questionability. [25]

> "Caution is advised in cases of abnormality of the bony structure, hypermobility, recent injury, and diseases of the joints such as bursitis and arthritis. A past trauma may have

[23] Tappan and Benjamin, Op. Cit., 108.

[24] Chaitow, Leon, and Judith Walker Delany, 2000: *Clinical Application of Neuromuscular Techniques, Vol. I – the Upper Body*, Churchill Livingstone, ISBN 0-443-06270-6,180.

[25] Tappan and Benjamin, Op. Cit., 108.

caused some unusual conditions around a joint, including shortening or loss of muscle tissue, scarring in connective tissues, and abnormal joint structure. Sometimes 'hardware', such a metal pins and plates is present from past injuries. Joint replacements are becoming more common, and movement around artificial joints may be restricted. Hip replacements are important to know about, especially in the elderly. Take the time to learn about the condition from the recipient, from available medical records, or from the recipient's physician to ensure a safe application of joint movements. Remember that massage and joint movements are contraindicated when inflammation is present."

"Palpation skills are very important for learning about how joints move. Practitioners can learn much about the condition of the joint and surrounding tissues from the kinesthetic feel of the movement. Sensing things like 'drag' and 'end-feel' offer clues to restrictions to normal range of motion, areas of tightness, patterns of holding, and **the limits of stretches**."

Further cautions and contraindications for assessing the appropriateness of moving an injured ankle are given by Whitney Lowe. [26]

"Before working on an ankle sprain with massage, it is important to verify that a more serious complication is not present. If the sprain was severe, there is a greater likelihood that a fracture or ligament avulsion may exist. These conditions should be ruled out before beginning massage treatment. If there is tenderness over the posterior distal portion of the medial or later malleolus, and the patient is unable to bear weight, they should be properly evaluated for a fracture or avulsion injury."

"Pain that the patient experiences will generally be your guide. Treatment approaches, whether they are specific massage applications or movement of the injured area, should be done within the patient's pain tolerance. As the condition improves, friction massage can become more vigorous and greater range of motion can be attempted."

Clay also cautions on the care required while doing passive stretching.[27]

"The therapist stretches the muscle by moving its attachments away from each other. This technique requires an intimate knowledge of the anatomy of the joints involved and their range of motion. Approach stretching with care. Familiarize yourself with the range of motion of each joint, and move into the stretch slowly. It is very easy to place a client in an uncomfortable position."

Lack of Objective Evidence of Harm

It should first be noted that the sunrise application of the massage profession to the Joint Committee on Boards, Commissions, and Consumer Protection was not founded on the protection of the public from likelihood of direct physical harm from incompetent practice. There are good reasons, as is seen below, to believe that the likelihood of such harm is minimal. Instead, justification for state intervention in the practice of massage was based on providing greater protection of the public from harms of mal-intent by unscrupulous practitioners and on

[26] Lowe, *Orthopedic Massage*, 68-69.

[27] Clay, Loc. Cit.

correction of a variable and inequitable professional business environment created under local licensing of massage. The latter aspect falls under the correction of an existing *market flaw* under the theory of occupational regulation advanced by the Center for Public Interest Law.[28] The market flaw of local licensing, granted to local agencies by the state in government code section 51030-51034, has largely hamstrung the massage profession from self-definition and creation of practice norms under its own auspices. The rationale of SB 412 is not the initiation of regulation, but the normalization of regulation commensurate with current California norms of training and practice. Such norms have been extensively documented in a recent report by Grant and Forman.[29]

Two recent peer-reviewed papers (Grant[30] and Ernst[31]) have reviewed over forty years of indexed medical literature for injuries caused by massage. Ernst concluded that, "Massage is not entirely risk free. However, serious adverse events are probably true rarities." As the author of the other review, the author of this reply concurs with Ernst's summary. A paper by Studdert et al.[32] reported insurance data from 1993 through 1996 indicating only 0.79 paid claims per 1000 insured for the practice of massage. The average indemnity for paid claims was approximately $6000. Of claims made, physical injuries beyond minor represented only about six percent.

The British Columbia Health Professions Council, in a unified review of health care scope of practice determined that the massage profession within British Columbia warranted only a title act despite a more restrictive request by the College of Massage Therapists.[33]

> "In the Council's view, the College's request for these proposed new reserved acts is an attempt to reserve the entire scope of massage practice. If the College's rationale were adopted and if the proposed reserved acts were added to the Reserved Acts List and granted to massage therapists, the practice of unregulated massage practitioners would be inhibited. Every act of massage could be subject to investigation and evaluation of the intent of the massage practitioner. To accede to the College's request would result in an unwarranted infringement of the public's right to choose a massage practitioner. **The Council has seen no evidence that massage therapy carries with it such a sufficient risk of harm to warrant making any portion of its practice a reserved act**."

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[28] Fellmeth, Robert C., 1985: **A Theory of Regulation — A Platform for State Regulatory Reform**, California Regulatory Law Reporter, 5 (2), 3, <http://www.cpil.org/download/A_Theory_of_Regulation.pdf>

[29] Grant, KE, and J Forman, 2004: , *Status and Trends in California Massage Education*, <http://www.ramblemuse.com/articles/massage_training_trends.pdf>

[30] Grant KE, 2003: *Massage safety: injuries reported in Medline relating to the practice of therapeutic massage – 1965–2003*. Journal of Bodywork and Movement Therapies, 7(4), 207-212, doi: 10.1016/S1360-8592(03)00043-3.

[31] Ernst E, 2003: *The safety of massage therapy*. Rheumatology, 42 (9), 1101–1106, <http://rheumatology.oxfordjournals.org/cgi/content/abstract/42/9/1101>.

[32] Studdert DM, Eisenberg DM, Miller FH, Curto DA, Kaptchuk TJ, Brennan TA, 1998: *Medical malpractice implications of alternative medicine*. The Journal of the American Medical Association, 280, 1610-1615, <http://jama.ama-assn.org/cgi/content/abstract/280/18/1610>.

[33] British Columbia Health Professions Council, 2001: *Post-Hearing Update of Preliminary Report: Massage Therapists*, <http://www.healthservices.gov.bc.ca/leg/hpc/review/part-i/update-massage.html>

A 1997 bill for massage regulation was evaluated by the Georgia Occupational Regulation Review Council as to need based on likelihood of physical harm.[34]

> "The potential for harm to the public appears to be remote and would not be alleviated by licensing. The Council's review of available information indicates that the number of complaints concerning massage practitioners is very small and, of those complaints cited, many allege sexual misconduct which under Georgia law is a criminal act. Moreover, there is little evidence that unqualified massage therapists have inflicted physical harm on clients."

In 2003, the West Virginia Legislative Auditor's review of massage licensing contained a similar conclusion of lack of likelihood physical harm.[35]

> "Two years ago the Legislative Auditor reviewed the Massage Therapy Licensure Board and concluded that the Board was not needed for public protection. The Legislative auditor arrives at the same conclusion in this current evaluation. There is no compelling evidence to support continued licensure of this profession because there is low risk of physical harm if the profession were unregulated. Essentially, the existence of this Board provides no added safety or competency to the practice of massage therapy."

At this point, it should be clear why the sunrise application by the massage profession in California to the Joint Committee was not based on the issue of physical harm but on other issues of public benefit. Neither the direct documentation nor the conclusions of the quoted reviewing agencies support the likelihood of harm. Nor are there sufficient statistics on recurring patterns of harm to allow evidence-based changes in training or practice protocols. SB 412 is, in large part, recognition by the legislature that there is a rational basis for and public interest in regulating the commercial provision of touch practices and that such regulation deserves to be done in a uniform and equitable manner. Despite the above analyses from Georgia and West Virginia, Georgia has recently enacted state regulation of massage and West Virginia has continued with their existing regulation. There is a strong if implicit recognition in these examples of state regulation that public benefits other than prevention of direct harm are perceived to exist.

Stemming from the public benefit basis for regulation, the definition of massage encompasses more than a single hierarchy of knowledge, skills, and abilities and leads to multiple types of practice — as much personal service as health care; as much neuromuscular education as treatment. Because regulation covers multiple practices, advanced applications are best addressed by ongoing career training. Apart from currently being at the individual discretion of referring medical practitioners and facility managers, this is not structurally different from the medical profession's use of specialty boards to assess competence in defined specialties and

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[34] Georgia Occupational Regulation Review Council, 1997: *Review of Senate Bill 300 which Proposes to Regulate Massage Therapists*, <http://www.ramblemuse.com/articles/ga_opb_masgrev.html>

[35] West Virginia Legislative Auditor's Office, 2003: *Regulatory Board Evaluation — Massage Therapy Licensing Board*, <http://www.ramblemuse.com/articles/sunset_wv_massage_full.pdf >.

subspecialties.[36] The ultimate consideration is that practice on specific client populations and with specific treatment goals is done within training. This need was noted by Grant in a recent informal article on the populations served and treatment goals implied in the medical literature from 1997 to present discussing the use of massage in healthcare.[37] **The uniform regulation of massage proposed under SB 412 does not extend massage beyond the norms of practice the profession has achieved already via our own efforts. What SB 412 does do, is recognize that an existing profession of service and care deserves to operate under equitable oversight and a fair business model.**

Precedence for less restrictive wording

The Canadian provinces of Ontario and British Columbia both have lists of restricted or controlled acts uniformly defined for all health professions. This approach provides clarity that the restrictions found within these lists encompass their evaluation of the likelihood of harm from practice. Both the Ontario Controlled Acts List[38] and the British Columbia Reserved Acts List[39] have clearly defined criteria relative to concepts of joint manipulation and range of motion.

In Ontario, the restriction is on, "Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust".

In British Columbia, the restriction is on, "movement of the joints of the spine beyond the limits the body can voluntarily achieve but within the anatomical range of motion using a high velocity, low amplitude thrust".

Both the Ontario and British Columbia lists of reserved/controlled acts are explicit that the reservation is on manipulation of the spine and that the technique involves an impulse or thrust. No other motion restrictions are deemed as requiring control. Since these are uniform lists, it is also unlikely that additional restrictions would be found elsewhere.

From 1989 to 1999, the Pew Health Professions Commission undertook a major analysis of health care delivery in the United States and the evolution they believed to be necessary for effective provision of care in the 21st century. The Ontario model of a single set of thirteen reserved acts was highlighted as the fourth of five case studies for creating more efficient health care delivery.[40] In introducing the case studies, the Pew commission noted, "The following case studies exhibit the institutions and governmental bodies which have undertaken strategies that the Commission believes will be necessary across the entire health care system."

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[36] American Board of Medical Specialties, 2002: Which Medical Specialist for You? <http://www.abms.org/Downloads/Which%20Med%20Spec.pdf>

[37] Grant, KE, 2005: *Searching for Medical Massage*, Massage Today, October 2005, 05 (10), <http://www.massagetoday.com/archives/2005/10/06.html>.

[38] Ontario Health Professions Regulatory Advisory Council, *Controlled Acts List*, Cited 24 September 2005, <http://www.hprac.org/english/pageDisplay.asp?webDocID=542>.

[39] British Columbia Health Professions Council, *Reserved Acts List*, Cited 24 September 2005, <http://www.healthservices.gov.bc.ca/leg/hpc/review/reserved-list.html>

[40] Pew Health Professions Commission, 1995: *Critical Challenges, Revitalizing the Health Professions for the 21st Century*, 59-66, <http://www.futurehealth.ucsf.edu/pdf_files/challenges.pdf>

> "A unique feature of the RHPA[41] is its specification of hazardous acts. The RHPA recognizes that only a relatively small number of acts or procedures performed in health care place the consumer at serious risk, and it is regulation of the performance of these acts — and not the regulation of the professions themselves —that constitutes the legitimate use of the government's regulatory power. … Presumably, any number of occupational groups or individuals might be competent to provide these treatments, and neither consumer choice nor market forces should be restricted beyond the state's interest in assuring that these treatments are performed by competent individuals. The RHPA's 24 companion acts delineate the scope of practice of the regulated professions, including which, if any, of the controlled acts may be performed by members of each profession (massage therapists, for example, may not perform any of the hazardous acts)."

Interestingly, a precedent for a limited and specific set of reserved acts along the Ontario and British Columbia models has already occurred in California with the passage of SB 577 (2001-2002).[42] Apart from the issues of increased oversight and exemption from local regulation discussed above, SB 577 defined an adequate scope of practice for massage therapy. The wording is vaguer than that in the Ontario and British Columbia lists, but the intent is the same. For acts that don't break the skin, the unlicensed practitioner is in violation of the act if he or she

> "Willfully diagnoses and treats a physical or mental condition of any person under circumstances or conditions that cause or create a risk of great bodily harm, serious physical or mental illness, or death."

High velocity impulses would be interpreted to create such a condition, but there seems little medical consensus that a low velocity stretch would be so interpreted. **Restricting the scope of a certified practitioner beyond that granted to an uncertified/unlicensed health practitioner by SB 577 is both problematic as to regulation and serves no public benefit.**

Conclusion

Unlike the high-velocity/low-amplitude (i.e. HVLA, mobilization with impulse[43]) techniques used in the practice of chiropractic, the various practices of massage confine themselves to slow, yoga-like stretches. The techniques used are either evaluative techniques or, in effect, passive yoga, as in Thai massage. As discussed above, the massage training literature takes full note of this difference in scope. Unlike an impulse technique, the slower stretching provides ample opportunity for the incremental assessment of restriction and the input of feedback from the involved client. The documentation of harm from massage practices, from a compendium of sources and assessments, is indicative of only minimal likelihood and not of sufficient number or recurrence to objectively motivate the need for remedial changes in training or protocols.

Outcome-based guidelines for the inclusion of massage within the U.S. system of healthcare delivery are virtually non-existent. Such inclusion has had to rely on individual evaluation by referring medical practitioners and healthcare facility managers as to the suitability of a massage practitioner's knowledge, skills, and abilities. Grant and Forman, in a recent report,

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[41] Regulated Health Professions Act of 1991.

[42] SB 577, 2001-2002, Burton, J, Health: *Complementary and Alternative Health Care Practitioners*, <http://www.leginfo.ca.gov/>.

[43] Greenman, Op. Cit., 94.

have noted both the current status and trends of massage education within California and the need for development of outcome-based guidelines.[44] Specific criteria for the development of such guidelines are recommended in that report.

The profession of massage therapy respectfully disagrees with the California Chiropractic Association that an exclusion of "movement of a joint beyond the active range of motion of the joint" from the scope of practice of massage is warranted or has an objective basis for protection of the public. We contend that there is an extensive basis both in published texts and in the direct opinion of the authors that use of the full passive range of motion is a safe and intrinsic part of massage training and practice. We believe that the appropriate scope of practice language should follow the explicit simplicity of the Ontario model in excluding "*Moving the joints of the spine beyond the individual's usual physiological range of motion using a fast, low amplitude thrust*".

We in the massage profession would hope that, in weighing this response, the Chiropractic Association as well as the California Legislature and Governor would consider the benefits to the public of the uniform oversight and business model provided by the proposed private certification under state review compared to the current vagaries of local ordinances and zoning. The enactment of SB 412 would allow considerable volunteer time and thought, currently taken up in dealing with local ordinances, to be shifted back to the more professionally productive arena of the development of guidelines and practice norms. The existence of the private certifying organization as the state delegate for massage regulation would allow California to participate in these ventures within the larger framework of the new national Federation of State Massage Therapy Boards (FSMTB) [45]. We would also hope that the Chiropractic Board would recognize the benefit to the public of working with the proposed private organization in these efforts and to document future instances of harm, should they occur, and to develop remedial training and practice protocols. We feel that our position in these matters is consistent with the greatest public benefit from massage as well as with current education, technique usage, and business practices for massage within California.[46]

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[44] Grant and Forman, Op. Cit.

[45] Korn, Cliff: 2005: *New Organization Formed to Benefit Massage Therapy*, Massage Today, July 2005, 5 (7), <http://www.massagetoday.com/archives/2005/07/01.html>

[46] Grant and Forman, Op. Cit.