Journal of the
Australian Traditional Medicine Society

Volume 22 | Number 2 | Winter 2016

Practice Management 101 – *Building a Client Base*

Boundaries in *Therapeutic Practice*

Table *Mechanics*

For manual therapy

The Childhood Obesity *Epidemic*

Evidence for the effectiveness of clinical nutrition therapy *in diabetes mellitus type 2*

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Journal of the
Australian Traditional Medicine Society

Volume 22 | Number 2

Contents

WINTER 2016

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Associate member
Student membership (free)

MEMBERSHIP AND GENERAL ENQUIRIES

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President's *Report*

Betty Tannous | ATMS President

It amazes me how quickly the Journal comes around and I have to report to you on the workings of the Board and ATMS. I'm happy to report that your Board has made substantial progress. Sometimes victories are small and tedious, like reviewing and updating our operations protocols, and sometimes they are large and will have a lasting effect, like our partnership with 1st Available or our launch of Natural Medicine Week. I would like to say I'm confident we're heading in the right direction and I wish to thank each Director for their efforts over the past few months.

As for my role of leading the Board of Directors, this is an easy task given the professionalism and dedication of every director. With contributions by all, we have made considerable headway in meeting the tasks in our Strategic Plan. We have an enormous responsibility to take the Society forward and to leave our footprints in the sands of time. Our teamwork has enabled the Board to set a new course for the Society and to move forward on new projects, initiatives and partnerships.

Communication

Once again I can report that our communications outreach is expanding, with more than 13,600 Facebook likes, almost 600 followers on LinkedIn and in excess of 3,000 on Twitter.

As I write this, we are preparing for the first Natural Medicine Week, which is a very exciting initiative that the Board, Management and staff of ATMS have been planning for some time; 2016 sees the reality of this dream.

Many of our members are benefiting from this increased exposure and content. Sharing the content from the ATMS Facebook page has been very popular and our members can reuse this content for their own social media, blogs or newsletters. Another excellent resource is the Friends of ATMS. You can ask your clients to join the Friends of ATMS from the ATMS website. Again the content from this e-newsletter can be shared or used in your own communication strategy. Our Friends of ATMS has grown to more than 800 subscribers. This can only aid in the promotion of natural medicine to the public.

Natural Medicine Week

As I write this, we are preparing for the first Natural Medicine Week, which is a very exciting initiative that the Board, Management and staff of ATMS have been planning for some time; 2016 sees the reality of this dream. The project was spearheaded by our Treasurer and Director Christine Pope, with the help of the Marketing Committee and the CEO, Charles Wurf. The aim is to raise awareness and understanding of the important role natural medicine practitioners play in the health and wellbeing of Australians. A range of special events and offers were planned for the week of 20th to 27th of May. A special microsite was created, **www.naturalmedicineweek.com.au**, which will be used every year for this event. Information on this site included a short history of ATMS, a link for the Government and Media with information about the natural medicine industry, a page advertising the special events and offers for the week, and a blog. If you did not plan an event this year look out for next year's event and make sure you participate.

PRESIDENT'S REPORT

ATMS and Nature & Health Awards

I am delighted to report that for the second year ATMS has partnered with Nature & Health to provide these awards, recognising achievement in the natural medicine profession. The annual ATMS and Nature & Health Awards recognise the practices, professionals and rising star students who contribute to the growth and prosperity of Australia's diverse and pioneering natural medicine industry. There are three categories: Practitioner of the Year, Clinic of the Year and Student of the Year, and nominations close on the 25th July. For more details click on the link on the ATMS website.

Membership

Our Society remains strong, with membership numbers growing as the year progresses. I would like to welcome new members to ATMS and remind everyone about renewing their membership. Staying current with your membership ensures that you keep up to date on all the news in the industry as well as retaining your Health Fund rebates for your clients.

Research

The last Journal saw the launch of the Research grants; this initiative again is part of the Strategic Plan to generate more research into natural medicine. Data and statistics support arguments for or against an issue. With more research data, we can promote our profession. There are projects that are in progress and we'll report on those results in the next issue of the journal. ATMS will continue to put a high priority on research funding and this will become an annual event, with the possibility of increasing the budget allocated for research.

Advocacy and partnerships

ATMS directors continue to represent our members on government and official committees, including the Industry Skills Council, the Therapeutics Goods Administration and the Chinese Medicine Board. Complementary Medicine Australia held a function at Parliament House in March and generously invited the CEO and myself. We met a number of MPs, including Fiona Nash, Sussan Ley, John Alexander and Richard Di Natale. The discussion centred on reforming the regulation of the complementary medicines industry. It was a great day to meet industry heavyweights with many companies present that employ our members – naturopaths, nutritionists, TCM practitioners and others.

With the federal election announced, this is your opportunity to ask your local member about their position on natural/ complementary medicine and lobby for your profession.

Some fast facts on the products side of the industry, sourced from **www.cmaustralia.org.au**, which is important for our practitioners: $4.2bn in revenue, 59 TGA licenced manufacturing sites in Australia, and 6,000 direct high value jobs. With the federal election announced, this is your opportunity to ask your local member about their position on natural/ complementary medicine and lobby for your profession. It's all about numbers in politics, and we have people power. If you think about how many people visit natural medicine practitioners from the perspective that they are all members of the voting public you can see that you have leverage you can exercise with your local member. Of course the CEO and Board will continue to advocate for our members by conveying their concerns about health policy, especially in regard to Health Fund rebates and subsidies, and the efficacy of natural medicine.

The ATMS Board has brokered a special deal for our members with 1st Available, an online booking system. You will have received the Wise-n-Well with a link to the video advertisement and the benefits of using this product. We are very excited to be able to get this deal for our members to assist you in building your practice.

Administration

Behind the scenes there is a lot that must be done to serve the Society, and the more experience I gain as a Director and President the more this becomes apparent. Innovation is critical and when we can do things like upgrade our software and utilise the expert knowledge of the staff this can only improve our service to you.

I want to thank all of the ATMS staff, led by our CEO Charles Wurf. I have appreciated their resilience through all the transition and reorganization that have taken place, always keeping a positive outlook and high energy - especially in their response to our member queries.

In closing, I would like all ATMS members to know there are many other irons in the fire and ideas on the table that we will continue to pursue and communicate to you. I welcome any suggestions and constructive feedback that would make our Society even stronger.

Betty Tannous
President

CEO's *Report*

Charles Wurf | ATMS CEO

Supporting members in practice

Natural Medicine Week - what a wonderful initiative ATMS has facilitated on behalf of all practitioners! The operational aspects of the ATMS Strategic Plan are designed to sustain and support Accredited members in their practice of natural medicine. Natural Medicine Week is a week-long celebration of events and education aimed to raise awareness of the important role natural medicine practitioners play in the health and wellbeing of Australians. The inaugural Natural Medicine Week, 20 – 27 May 2016, established the platform for future planning by ATMS, and Natural Medicine Week will continue as a key part of our actions to sustain and support practitioners.

Thank you to those members who willingly organised and ran events during Natural Medicine Week 2016, and we look forward to 2017!

The four essential requirements to maintain ATMS accredited membership

In working to sustain and support practitioners, it is essential that ATMS is able to rely on the ongoing professional standards of accredited members. We do this with a systematic engagement on behalf of natural medicine in setting and maintaining education and professional standards, in fostering and encouraging research and collaboration and in facilitating open and transparent processes to resolve and learn from consumer feedback and complaints.

When it comes to each individual accredited member, there are four essential requirements to maintain accredited membership:

- Completion of 20 Continuing Professional Education (CPE) points per year
- Current professional indemnity insurance of at least $1M
- Current senior first aid certificate
- Payment of membership fees for the current financial year

These four essential requirements provide the bulk of the ATMS operational workload, and are the reason for the major part of our day-to-day communications with members.

To maintain professional standing with ATMS accredited membership careful attention is required to meet these four essential requirements. To support members, ATMS has detailed procedures to assist each member with these requirements, and we do communicate with all accredited members in advance of key dates.

Our procedures and communications are designed to support accredited members to maintain their membership – doing so is essential for both professional standing as well as for any recognition with Health Funds.

Maintaining Health Fund recognition

In general, the key requirement for an accredited member to be recognised with any Health Fund is to have current professional standing in the modality for which the Health Fund offers a rebate or benefit to the Health Fund policy holder. Each Health Fund has its own requirements and benefit levels – the ATMS website offers detailed and updated information on the different aspects of Health Fund requirements. Please contact ATMS at any time to confirm your current status and to check any eligibility issues.

Gaining Health Fund recognition creates a valuable commercial relationship. It enables a practitioner to offer access to rebates and benefits for Health Fund policy holders who have that entitlement and who use the services of the recognised practitioner. In all of my discussions with members, the discussion inevitably turns to Health Funds, and the tightening and greater monitoring of requirements for recognition status.

TO MAINTAIN RECOGNITION WITH HEALTH FUNDS IT IS ESSENTIAL TO MAINTAIN ALL ATMS REQUIREMENTS FOR ACCREDITED MEMBERSHIP.

In this age of modern communications and data analysis Health Funds maintain their own records and closely audit the legal requirements of practitioners to be and remain recognised. The surest way

to maintain ATMS professional standing and Health Fund recognition is to ensure close attention to each of the four essential requirements, as follows.

Continuing Professional Education

Each accredited member accepts the professional obligation to regularly update clinical skills and professional knowledge. The ATMS Continuing Education (CPE) Policy requires an Accredited member to accumulate 20 CPE points per annum, with each year being from 1 July to 30 June.

Current Professional Indemnity Insurance

Each accredited member must maintain a current professional indemnity insurance policy. To maintain a current policy, an accredited member must ensure that there is no break or gap in cover, and that policy coverage is continuous for all periods.

Current First Aid Certificate

Each accredited member must maintain a current Provide First Aid certificate. To maintain a current certificate, an accredited member must ensure that there is no break or gap in cover, and that the Provide First Aid (or equivalent) certificate is continuous for all periods.

Payment of Membership Fees

The membership year for ATMS is 1 July to 30 June. Membership renewals are prepared and distributed to members in May, requesting payment for the coming financial year. Membership Fees are adjusted in accordance with ATMS Board policy, to increase membership fees by the inflation rate as at March each year, rounded up to the nearest $5.

For the period 1 July 2016 to 30 June 2017, membership fees for accredited members will increase from $220 to $225 (both figures inclusive of GST).

This outline of the work we do is to reinforce the requirements for an accredited member to maintain ATMS professional standing. When professional standing is maintained there is a surer path to maintaining any relevant Health Fund recognition.

Charles Wurf
CEO

Table *Mechanics:*

Part 1.

Joe Muscolino | DC

Photography by Yanik Chauvin

Manual therapy can be hard work. It is physically stressful to the body. This is especially true if deep pressure techniques are being employed and/or if the therapist is small and the client is large. And when stretching the client, this size differential is even more challenging than when doing soft tissue manipulation (massage). For this reason, a lot of attention is paid to proper body mechanics, as well it should be. But perhaps there is not enough attention paid to table mechanics. After all, the best body mechanics in the world are compromised if the mechanics of the table do not allow for efficient use of our body when generating force to work on the client. Following are some key points about what to look for in a manual therapy (massage) table and how to employ efficient body mechanics to take advantage of the table mechanics. Employing optimal body and table mechanics cannot eliminate all physical stress to the therapist's body, but it can minimize it. This article is presented in three parts: Part 1 deals with table height, Part 2 with table width and Part 3 with table length. Parts 2 and 3 will be published in the September and December issues of *JATMS*.

Table height

The single most important criterion about table mechanics is the height of the table. There are two ways to create and transfer force into the client's body: They are taking advantage of gravity by using body weight, and by contracting musculature. Muscular contraction requires effort and can be exhausting, whereas gravity is free and does not create fatigue. For this reason, it makes sense that we should take advantage of gravity whenever and as much as we can. The problem is that gravity only works in one direction; that is downward. So we must be above the client to employ our body weight. This requires the table to be low. The lower it is, the more of our body we can position above the client.

Simply lean in

There is a very simple demonstration that shows the effectiveness of having the table low to utilize gravity. We place a weight scale on a table that is positioned at three different heights. In each instance, we simply lean into the scale without exerting any muscular effort; our force will be measured by the scale. The greatest force is created when the table is lowest (Figure 1).

Relationship between contacts and table height

Of course, taking advantage of gravity is only effective if we are working on the surface of the client's body that is oriented upward; for example on the paraspinal musculature of the client's back when the client is in prone position. The ideal height of the table varies depending on the size of

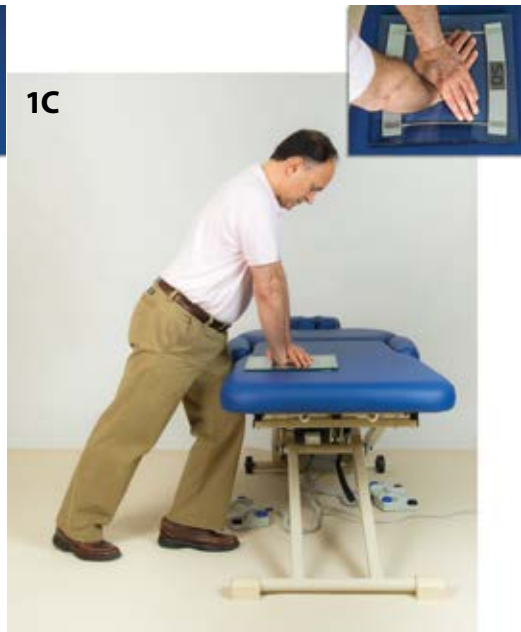


Figure 1. A weight scale placed on a table at differing heights shows the force created at each height when the therapist simply leans on the scale. **A,** Just below therapist's knee. **B,** Just above therapist's knee. **C,** Height at therapist's mid thigh.

the client, whether the client is prone, supine, or side-lying, and which contact we are using. Ideally, we want to be able to have the joints of our upper extremities stacked (in extension), allow our shoulder girdles to be relaxed downward, and have a stable stance with our feet on the floor. Using finger pads, thumb pads, knuckles, or palms require the lowest table height. Elbow and forearm contacts allow for the table to be relatively higher. A general guideline when using thumb/fingers/palm is to have the top of the table at or just below the level of our knee. For elbow/forearm contacts, it can be mid thigh (Figure 2).

Figure 2. A, Table height needs to be the lowest when using finger pads, thumb pads, knuckles, or palms. **B,** The table can be higher when using elbow or forearm contacts.

The need for a low table

The problem is that many tables to do not go low enough. Their design has not advanced from the era of massage being only a gentle soothing modality that required only light pressure. But with the increasing popularity and recognized effectiveness of deep tissue/deep pressure work, therapists who choose to do clinical orthopedic work on higher tables often end up overexerting by 'muscling' the massage, and consequently become injured. The obvious solution is to buy a table that can be adjusted to be low (preferably an electric-lift table; see later section: Electric lift tables).

Compensating for a high table

Unfortunately, there are times when a therapist does not have access to a low table. When, for whatever reason, this is the case, there are a few ways to adjust the mechanics to compensate and protect the health of the therapist's body. Following are three compensations.

Platform

A platform can be bought and kept under the table. When more height is needed, it can be taken out to stand on. It is important that this platform is wide enough and long enough to allow for a comfortable and stable stance of the therapist. A step aerobic platform usually works very well (Figure 3A). They can be found at most sporting goods stores or online. And depending on the additional height needed, they can usually be stacked.

Remove the extension legs

Another mechanical compensation that might help is to remove entirely the 'extension legs' of the table (always ask the manufacturer about the safety of the table before removing extension legs). Often, the extension legs, even when placed at the lowest possible setting, cause the table to be higher than if they were simply removed. For these tables, removing the extension legs can drop the table by an inch or more. The problem is that the legs that remain usually do not have any sort of grip on the bottom, so if the table is being used on a wood or tile floor, it may slide when working on the client. One solution is to place small pieces of material that offers grip under the legs to prevent sliding (Figure 3B). If the extension legs are removed, it is also a good idea to cover the screws that jut out by re-placing the knobs. Another possible idea is to drill new holes in the extension legs (if they are wooden legs) that allow them to be on the table without raising its height.

Figure 3. Possible mechanical compensations when having to work on a table whose height cannot be sufficiently lowered. **A,** Using a platform. **B,** Removing entirely the "extension" legs (note: pads placed under the main legs to offer grip and prevent the table from sliding).

Use elbow and forearm contacts

If neither of these two ideas work, then the last alternative is to work primarily with elbow and forearm contacts.

Figure 4. Working on a low table with elbow/forearm contacts requires bending. **A,** Stooped bend. **B,** Inclined bend. **C,** Bending from the lower extremities.

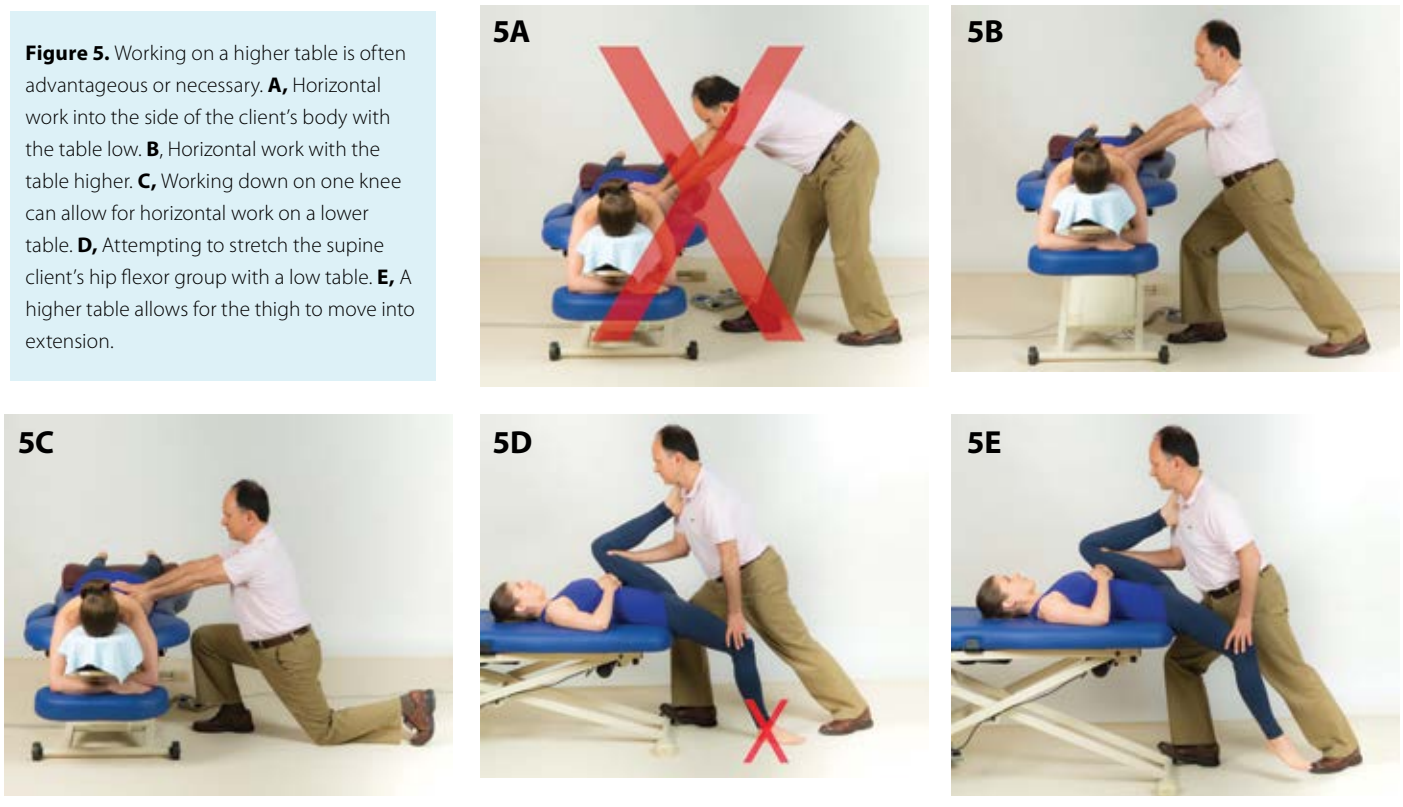
When the table should be high

As important as it is to have a table that can adjust to be low, it is not always advantageous to work with the table low. For example, as mentioned, using elbow and forearm contacts is best performed when the table is higher. If these contacts are employed with a lower table, the therapist must bend. Unfortunately, many therapists bend at the spine, creating a stooped and imbalanced posture that is unhealthy for the spinal joints because they are in an unstable open-packed position, and unhealthy for the paraspinal (erector spinae and transversospinalis) extensor musculature because it must contract to prevent the trunk from falling into flexion (Figure 4A). Other therapists bend by anteriorly tilting the pelvis at the hip joints. This is better in than the spine is straight, therefore the spinal facet joints are in a more stable closed-packed position, but the spine is inclined diagonally forward and still imbalanced, continuing to place stress on the paraspinal musculature (Figure 4B). The best solution is to bend at the ankle, knee, and hip joints so that the spine can be both straight and vertical, with the centre of weight of the trunk better balanced over the pelvis (Figure 4C). The downside to bending from the lower extremity joints is that if the therapist's knee joint is unhealthy this position may be painful.

There are many other instances of manual therapy in which a higher table is desired or necessary. For example, when light work is being done, utilization of body weight is not an important factor. In these cases, a higher table is likely desirable. Working into the myofascial tissue on the side of the client's body is also facilitated by having a higher table.

When working into the side of the client, the force production must be horizontal in direction. This necessitates force production not from core body weight but rather by pushing off from the lower extremities (Figure 5ABC). Many stretching maneuvers actually require the table to be higher and cannot be done if the table is low. For example, stretching the hip flexor group with the client supine requires excursion of their thigh into extension. With a low table, the client's heel hits the floor, blocking the stretch (Figure 5DE).

Figure 5. Working on a higher table is often advantageous or necessary. **A,** Horizontal work into the side of the client's body with the table low. **B**, Horizontal work with the table higher. **C,** Working down on one knee can allow for horizontal work on a lower table. **D,** Attempting to stretch the supine client's hip flexor group with a low table. **E,** A higher table allows for the thigh to move into extension.



Electric lift tables

As discussed, there are times when the optimal table height is low and there are other times when the optimal height is higher. For this reason, it is imperative that the table height be adjustable. Nowadays, it is rare to find a table that is not adjustable; almost every table allows for the height to be changed. However, as advantageous as this seems, many therapists never utilize this feature. They simply decide on a height that they believe to be best for them (often too high because it was chosen early on in school when the massage they were practising involved only light pressure) and leave it there. The reason is that changing table height on most tables is a somewhat onerous procedure of adjusting the height of each of the four legs, one at a time (there are a few table models that do allow for height adjustment of two legs together at the same time at each end of the table, but these tables are relatively rare). Even though changing the height of the legs does not seem to be the most time-consuming or difficult of chores, it is sufficiently annoying to discourage most therapists from bothering, especially if the client is already on the table! As a result, the therapist keeps the same table height whether their client is big or small, whether the client's position is prone, supine, or side-lying, whether the area being worked is the neck, low back, or an extremity, or whether they are massaging, stretching, or performing joint mobilization. Most of the time, the table is too high and the therapist loses the assistance of body weight. Instead, the therapist must rely primarily or solely on muscular effort, often concluding that they are not strong enough to do deep pressure, and often injuring themselves. The problem is not their strength. It is compromised body mechanics caused by an excessively high table.

Investment in quality

There is only one solution to this problem, and it is one that unfortunately most therapists do not even consider. That is to buy and use an electric lift table. An electric lift table is not a luxury;

6A

6B

6C

Figure 6. Electric lift tables. **A** and **B,** Excellent electric lift tables that optimize most every parameter that a massage/manual therapy table should have. **A,** Model PT400M by Oakworks. **B,** Model 300 (with stool) by Comfort Craft. **C,** The ProLuxe Convertible table (with portable table), an electric lift base that allows a portable table to be placed on top, by Oakworks.

it is an investment in the quality and success of the therapist's practice. An electric lift table's mechanics will not only improve the therapist's body mechanics, increasing the likelihood of a long and injury-free practice, it will also increase the efficacy and success of the therapist's work. And this increase in the success of the practice will more than compensate for the cost of the table.

When one considers the finances of becoming a massage therapist (or any type of manual therapist for that matter) there are really only two major financial investments: the cost of the initial education and the cost of the table (a third possible cost would be the lease and furnishings if the therapist chooses to work for himself/herself). These are both upfront costs that in the short run seem challenging, but in the medium and long run are the smart decisions. Your education will last you your entire career. And a quality electric lift table will last for decades, if not for the length of your career. If you have your own practice and are in control of the table you use, an electric lift table is essential. If you work for an employer or rent or share space with another therapist, then it is imperative to convince your employer or colleague that an electric lift table is essential.

Electric lift table or electric lift base?

Once the decision has been made to invest in an electric lift table, there are a few choices to make. Its height range should be sufficiently large so that it can go low enough and high enough. It should also fit the rest of the parameters discussed in this article (width, shape, length, etc.). Two excellent electric lift tables are shown in Figures 6A and 6B. There is one other major choice. Although I believe it is best to entirely replace your present portable table and choose the optimal electric lift table that considers each and every variable, a compromise can be made. It is possible to buy an electric lift base that allows a portable table to be placed on top of it (Figure 6C). Electric lift bases usually cost far less than a full electric lift table. But you will be constrained by all the rest of the parameters of your present portable table. If this decision is made, I recommend it be made as a short-term solution. In the long run, the clear and lasting choice for your practice is to buy the optimal electric lift table.

Dr Joe Muscolino is a soft-tissue oriented chiropractor in private practice in Stamford, Connecticut in the United States. He has been an instructor in the world of manual and movement therapy for over 30 years. He runs a CPE Certification in Clinical Orthopaedic Manual Therapy (COMT) in the US, Australia, and around the world. He will be teaching COMT courses in Sydney this July (July 15-18). He also is the author of numerous textbooks and DVDs on manual therapy. For more information, visit his website: ***www.learnmuscles.com.***

Evidence for the effectiveness *of clinical nutrition therapy in diabetes mellitus type 2*

Management in primary care

Manuela Malaguti-Boyle | PhD candidate, MHSc, ND

Clinical nutrition therapy

The term clinical nutrition therapy was first introduced in 1994 by the American Dietetic Association to define the implementation of specific nutrition services to treat diabetes mellitus type 2. It was established that the therapy would involve two phases: a precise assessment of the patient's nutritional status and an individualised treatment, which includes nutrition therapy, counselling, and the use of specialised nutrition supplements.[1]

Clinical nutrition therapy for diabetes mellitus incorporates a process that, when implemented correctly, includes several important steps: assessment of the patient's nutrition and diabetes self-management knowledge and skills; identification and negotiation of individually designed nutrition goals; application of flexible nutrition plans, involving a careful combination of a meal-planning approach and educational materials to the patient's needs; and evaluation and review of outcomes with ongoing monitoring. These four steps have been shown to be necessary in order to assist patients in acquiring and maintaining the knowledge, skills, attitudes, behaviours, and commitment to successfully meet the challenges of daily diabetes self-management.[2]

Diabetes mellitus

Diabetes mellitus is a chronic disorder characterised by high blood glucose level and either insufficient or ineffective insulin. It can be defined as a syndrome of carbohydrate intolerance following altered beta cell function. The maintenance of normal blood glucose ordinarily depends on two processes.[3] When the liver receives signals that its blood glucose level is too low, food can rapidly replenish it; in the absence of food, glucagon signals the liver to break down glycogen stores. When blood glucose is too high, insulin signals the cells to take in glucose for energy. Eating balanced meals helps the body to maintain a medium between the extremes, allowing for glucose to enter the blood gradually. Dietary protein, in particular, elicits the secretion of glucagon, whose effects oppose those of insulin, helping to maintain blood glucose within the normal range. In diabetes mellitus the cells fail to respond to insulin and chronically elevated blood glucose alters glucose metabolism in virtually every cell of the body. For example, in most cases the structure of the blood vessels and nerves may be damaged, leading to loss of circulation and nerve function. Infections are likely to occur due to poor circulation coupled with glucose-rich blood and urine. Atherosclerosis tends to develop early, progress rapidly and be more severe in people with diabetes. As a chronic disease, diabetes mellitus is preceded by a long period of milder disturbances in glucose metabolism. Even in early phases of impaired glucose metabolism, these disturbances carry an increased risk not only for the development of diabetes mellitus, but also for cardiovascular morbidity and mortality.[4] Disorders of the small blood vessels are also common and may lead to loss of kidney function and retinal degeneration with accompanying loss of vision. Numerous studies have shown that obesity (central obesity in particular), physical inactivity,[5] high-fat diet, and diet rich in saturated fatty acids increase the risk of

diabetes mellitus type 2.[6] Furthermore, based mainly on epidemiological studies, low intakes of dietary fibre, low-glycaemic carbohydrates, and whole grain cereals have been shown to increase the risk of developing this chronic and degenerative disease.[7]

Evidence for nutritional therapy in diabetes mellitus

In 1997 the United States Congress instructed the Institute of Medicine (IOM) to conduct a study aiming at evaluating the cost-effectiveness and significance of clinical nutrition therapy for diabetes mellitus type 2. In 1999 the IOM released a detailed report based on evidence from randomised controlled trials, observational studies and meta-analyses. The report concluded that there was overwhelming evidence that metabolic outcomes were improved in nutrition intervention studies, making clinical nutrition therapy a cost effective and valid therapeutic method to manage diabetes mellitus type 2.[8] The report recommended that individualised treatment plans are provided by a registered dietitian and include nutrition, exercise, blood glucose monitoring, HbA1c testing, medications and ongoing evaluation. A brief summary of the evidence is included in Table 1.

Prevention studies

In 2010, the Diabetes Prevention Program (DPP), the first large scale prevention study of people at high risk for developing diabetes, showed that lifestyle intervention to lose weight and increase physical activity reduced the development of type 2 diabetes by 58% during a 3-year period.[18] The reduction was even greater for older people with a significant 71% reduction recorded among adults aged 60 years or older. Furthermore, the study has shown that treatment with the drug Metformin reduced the risk by 31% overall and was most effective in younger (aged 25–44 years) and in heavier (body mass index ≥ 35) adults. Prevention or delay of type 2 diabetes with either lifestyle or Metformin intervention was effective in all racial and ethnic groups studied. Interestingly, this large scale study confirmed that lifestyle interventions were more cost-effective than a long-term medication plan.[19] The Centre for Disease Control and Prevention in the United States has recently confirmed that it is not just extra weight, but primarily inactivity, to be blamed for hundreds of thousands of premature deaths. The report suggested that at least ten million overweight people could minimise the risk of developing diabetes by making relatively simple lifestyle changes and introducing exercise into their daily life.[20]

A study published in the New England Journal of Medicine was conducted on 84,041 non-diabetic female nurses who were observed from 1980 to 1996. During the 16 years follow-up 3300 new cases of diabetes mellitus type 2 were documented. Obesity was the single most important predictor of diabetes, but a lack of exercise, poor diet and cigarette smoking also contributed to the risk. The researchers concluded that the vast majority of cases of diabetes mellitus type 2 could be prevented by adopting a healthier lifestyle.[21] Furthermore, researchers at the Tulane National Centre for Cardiovascular Health confirmed that individuals with

TABLE 1: BRIEF SUMMARY OF EVIDENCE FOR NUTRITION THERAPY IN DIABETES MELLITUS

TYPE OF INTERVENTION	STUDY LENGTH	NUMBER OF SUBJECTS	OUTCOME
RCT - UKPDS Group, 1990 (9)	3 months	3,042 newly diagnosed patients with type 2 diabetes	In 2,595 patients who received intensive nutrition therapy (447 were primary diet failures), HbA1c decreased 1.9% (8.9 to 7%) during the 3 months before study randomisation
RCT - Franz et al., 1995 (10)	6 months	179 persons with type 2 diabetes; 62 in comparison group; duration of diabetes: 4 years	HbA1c at 6 months decreased 0.9% (8.3% to 7.4%) with nutrition practice guidelines care; HbA1c decreased 0.7% (8.3% to 7.6%) with basic nutrition care; HbA1c was unchanged in the comparison group with no nutrition intervention (8.2% to 8.4%)
RCT - Sadur et al., 1999 (11)	6 months	185 adult patients with diabetes	97 patients received multidisciplinary (MD) care and 88 patients received usual primary care. HbA1c decreased 1.3% in the MD care group compared with 0.2% in the usual care group; intervention group had an MD team with a registered dietitian (RD) who provided nutritional therapy
Observational Studies -Johnson and Valera, 1995 (12)	6 months	19 patients with type 2 diabetes	At 6 months, blood glucose levels decreased 50% in 76% of patients receiving nutrition therapy from an RD. Mean total weight reduction was approximately 2.27 kg
Observational Studies - Johnson and Thomas, 2001 (13)	12 months	162 adult patients	Nutrition therapy intervention decreased HbA1c levels 20%, bringing mean levels <8% compared with subjects without nutrition therapy intervention who had a 2% decrease in HbA1c levels
Observational studies - Christensen et al., 2000 (14)	3 months	102 patients (15 type 1 and 85 type 2 diabetic patients with duration of diabetes >6 months	HbA1c levels decreased 1.6% (9.3 to 7.7%) after referral to an RD
Meta-analysis of trials - Brown, 1996, 1990 (15)		89 studies	Educational intervention and weight loss outcomes; nutrition therapy had statistically significant positive impact on weight loss and metabolic control
Meta-analysis of trials - Padgett et al., 1988 (16)		7,451 patients	Educational and psychosocial interventions in management of diabetes (including nutrition therapy, exercise, and relaxation); nutrition education showed strongest effect
Meta-analysis of trials - Norris et al., 2001 (17)		72 studies	Positive effects of self-management training on knowledge, frequency and accuracy of self-monitoring of blood glucose, self-reported dietary habits, and glycaemic control were demonstrated in studies with short follow-up (<6 months)

consistently elevated insulin levels had a 36-fold increase in the prevalence of obesity.[22]

In 1997 and 2003 the Expert Committee on Diagnosis and Classification of Diabetes Mellitus recognised an intermediate group of individuals whose glucose levels, despite not meeting the criteria for diabetes, were nevertheless higher than those considered normal. These subjects were defined as having impaired fasting glucose (IFG) [fasting plasma glucose (FPG) levels 100 mg/dl (5.6 mmol/l) to 125 mg/dl (6.9 mmol/l)], or impaired glucose tolerance (IGT) [2-h values in the oral glucose tolerance test (OGTT) of 140 mg/dl (7.8 mmol/l) to 199 mg/dl (11.0 mmol/l)].[23, 24] The individuals with IFG and/or IGT were classified as showing symptoms of pre-diabetes, with a relatively high risk for the future development of diabetes. Global prevalence of diabetes is shown in Table 2.

Despite limitations in methodology and heterogeneous population characteristics, settings, interventions, outcomes, and lengths of follow-up, a number of generalisations can be made from these and similar studies:

1. Prevention of diabetes is a major challenge that faces nearly every nation and is now being recognised by the international community. In December 2006, against the background of an escalating diabetes epidemic, the United Nations General Assembly voted unanimously to pass Resolution 61/225 declaring diabetes an international public health issue.

2. Diabetes is a chronic progressive disease often co-existing with hypertension, hyperlipidimia, atherosclerosis, major depression, sleep disorder, obesity and painful neuropathy.

3. The benefits of nutritional intervention and lifestyle modifications for the prevention and management of diabetes mellitus type 2 in primary care are receiving increasing attention by the research community.

Managing diabetes mellitus in primary care

Over the past 20 years the responsibility for the care of people with diabetes mellitus type 2 has shifted away from hospitals to primary care.[26, 27] During this period randomised trials have demonstrated that if regular review of patients is guaranteed, the standard of primary care in the short term can be as good as or better than hospital outpatient care.[28] Several guidelines and diabetes management programs have been developed nationally and locally to improve diabetes care in the community.[29,30] Research indicates that primary care practitioners have a unique opportunity to evaluate, predict and prevent many of the devastating long-term complications associated with diabetes. Simply identifying patients at high risk for developing diabetes on the basis of their family history, ethnicity, and history of gestational diabetes or body fat distribution should warrant the introduction of nutrition and lifestyle modifications that could delay or prevent the onset of diabetes.[31]

In December 1999 the IOM, on behalf of the National Academy of Science, was given a specific mandate by the Congress of the United States to release an advisory report on the validity of nutrition therapy in primary settings based on a series of forums, cross-disciplinary thinking and round tables. The report concluded that nutrition therapy can improve clinical outcomes while possibly decreasing the cost to Medicare of managing diabetes. IOM recommended to Congress that individualised nutrition therapy, provided by a registered dietitian with a physician referral, is part of the multidisciplinary approach to diabetes care, which includes nutrition, exercise, blood glucose monitoring, and medications.[32]

The IOM recommendation is consistent with the 2002 American Diabetes Association Position Statement Evidence-Based Nutrition Principles and Recommendations for the Treatment and Prevention of Diabetes and Related Complications which has indicated that, given the complexity of nutrition issues, it is crucial that a registered dietitian, knowledgeable and skilled in implementing nutrition therapy into diabetes management and education, is the designated team member providing medical nutrition therapy.[33]

Patient compliance and diabetes education

The evidence from randomised controlled trials, observational studies, and meta-analyses has shown that nutrition intervention improves metabolic outcomes, such as blood glucose and HbA1c levels, in individuals with diabetes. This evidence also suggests that nutrition therapy is

Table 2: Estimated numbers of people with diabetes by region for 2000 and 2030 and summary of population changes[25]

	2000	2030
Geographical location	Number of people currently diagnosed with diabetes mellitus (millions)	Estimated number of people diagnosed with diabetes mellitus (millions)
Established market economies	44.268	68.156
Former socialist economies	11.665	13. 960
India	31.705	79.441
China	20.757	42.321
Other Asia and Islands	22.328	58.109
Sub-Saharan Africa	7.146	18.645
Latin America and the Caribbean	13.307	32.959
Middle Eastern Crescent	20.051	52.794
World	171.228	366.212

beneficial at initial diagnosis as well as at any time during the disease process, and that ongoing evaluation and intervention are essential for positive outcomes.[34] However, empirical data suggest that compliance with recommendations in primary care are still inadequate[35, 36] and that a large proportion of patients with diabetes remain at high risk.[37, 38] Critically reviewing the literature makes it clear that diabetes management has evolved from the educational interventions of the 1970s and 1980s into the collaborative, patient-centred model of the 1990s. Historically, although generic informative interventions in medical settings demonstrated some positive effects on glycaemic control and blood pressure, they had only a mild effect on weight change, confirming that factors other than knowledge were needed to achieve long-term health changes.[39] More recently, the implementation of an integrative treatment protocol focused on improving the patient's attitude and motivation has been shown to be one of the most significant factors in the achievement of metabolic control.[40] Research has shown that combining patient education with the intervention of a dietitian for follow-up leads to significant improvements in patient outcome and facilitates the process of diabetic care.

In my review of the literature, it has emerged that nutrition therapy in primary care focuses on knowledge, lifestyle and skills, achieving optimum results for the prevention and long-term management of diabetes mellitus type 2. However, I have found mixed results for the relative merits of group and individual therapy. Lifestyle interventions were generally more effective in group settings, with positive outcomes noted for weight loss[41-45] and glycaemic control,[46, 47] although two studies of lifestyle interventions in individual settings showed positive effects on weight.[48, 49] Both individual[50-52] and group[53, 54] lifestyle interventions had positive effects on diet and self-care behaviours. Notably, skills teaching was effective in both group[55, 56] and individual settings.[57]

Brown's study[58, 59] has demonstrated support for diabetes education in primary care and its positive effect on knowledge, dietary compliance, skill performance, metabolic control, psychological outcomes, and weight loss. Brown and colleagues[60, 61] completed a meta-analysis of 89 studies of educational interventions and outcomes specific to weight loss in diabetes care. An important highlight of the results from these findings is that nutrition therapy alone had the largest statistically significant impact on weight loss and

metabolic control. The combination strategy of nutrition and behavioural therapy with exercise had a small effect on body weight, but a very significant impact on HbA1c. These findings lend support to the effectiveness of diabetes patient education in improving patient outcomes.

Another interesting study was conducted by Padgett et al.[62] In a paper published in 1988 the researchers reviewed the effectiveness of diabetes education and found diet instruction and approaches based on social learning theory to be the most effective interventions in the improvement of physical outcomes. This qualitative review concluded that behaviour change strategies were much more effective than didactic methods and that patient education was most effective when combined with adjustment of health-care provider medication and reinforcement of educational messages.[63] In another paper Anderson et al. suggested that effective diabetes management programs should be non-complex, individualised to a person's lifestyle, reinforced over time, and respect an individual's habits, routines and incorporate social support.[64] In a broader sense, this concept highlights that for a treatment program to be effective in chronic disease it should include a continuum of self-management training and support services as well as active and sustained follow-up. Furthermore, Wagner et al.[65] stated that chronic illness programs additionally require psychoeducational programming, emphasizing the importance of responding to patients' individual needs, readiness to change, and self-sufficiency. This paper has reinforced the concept that the most beneficial components of educational interventions in chronic diseases are individualisation, relevance, feedback, reinforcement, and facilitation.

An intensive nutrition intervention has been shown to result in better outcomes than isolated treatments. In 1995, Franz et al.[67] completed a randomised controlled trial on 179 individuals with diabetes mellitus type 2, comparing the usual nutrition care consisting of only one visit with a more intensive nutrition intervention, which included at least three visits with a dietitian. The results concluded that with more intensive nutrition intervention, changes in lifestyle can lead to significant improvements in glucose control. In the control group, the fasting plasma glucose level decreased by 50–100 mg/dl and the HbA1c dropped by 1–2%. The average duration of diabetes for all subjects was 4 years and the decrease in HbA1c was 0.9% (from 8.3 to 7.4%). In the subgroup of subjects with a duration of diabetes <1 year, the decrease in HbA1c was 1.9% (from 8.8 to 6.9%). In 1998, a prospective randomised trial conducted by Kulkarni et al.[68] examined the effect of using nutrition practice guidelines in patients with diabetes mellitus type 2, compared with the use of standard nutrition intervention in a control group. The patients who received intervention that included nutrition practice guidelines achieved a greater reduction in HbA1c (1.0 vs. 0.33%) than that of patients who received standard nutrition intervention. Furthermore, the paper has shown that dietitians who incorporated the nutrition practice guidelines were more likely to conduct a detailed nutrition assessment of their patients and their glycaemic control goals.

The inclusion of a dietitian in diabetic care has been strongly linked to positive outcomes. In 2002, using a cross-over design, Glasgow et al.[69] studied 162 type 2 diabetic patients over the age of 60 years using a multidisciplinary team that included a dietitian. The study has shown a significant reduction in caloric intake and percentage of calories from fat in the intervention group compared with the control group. When control patients crossed over to the intervention group, their HbA1c levels decreased from 7.4 to 6.4% while the intervention group had an unexpected rebound effect, with their HbA1c results returning to pre-study levels.

Self-care management improves if diabetic care is assigned to a multidisciplinary team. In 2009 Sadur et al.[70] published the results of a randomised controlled trial with 185 patients participating in a health maintenance organisation. A total of 97 patients received care from a multidisciplinary team (dietitian, nurse, psychologist, and pharmacist) in cluster-visit settings (10–18 patients per month for 6 months) and 88 patients received usual care provided by primary care physicians. HbA1c was shown to have decreased by 1.3% in the intervention group compared with 0.2% in the control subjects.

The role of the dietitian in diabetes care was further investigated in the 2002 Diabetes Control and Complications Trial (DCCT) study. Delahanty and Halford[71] reported the results of a cross-sectional survey intended to examine the role of nutrition behaviours in achieving improved glycemic control in 623 intensively treated patients with diabetes mellitus type 2. Both the control and intervention groups received dietary advice by an appointed dietitian: while the control group received nutrition counselling every six months, the intervention group received it every month. The four nutrition behaviours associated with clinically significant reductions in HbA1c (0.9%) were shown to be:

1. adherence to prescribed meal and snack plan
2. adjustment of insulin dose in response to meal size
3. prompt treatment of hyperglycemia
4. avoidance of overtreatment of hypoglycemia

At the conclusion of the study, the DCCT Trial Research Group[72] published an expert opinion statement recognizing the importance of the dietitian as a team member in educating patients on nutrition and adherence to achieve HbA1c goals and co-managing patients. The DCCT conducted a further study demonstrating that diabetes mellitus type 2 can be prevented and delayed.[73] The findings are based on a randomised control trial involving more than 3,200 adults who were >25 years of age and who were at increased risk of developing diabetes mellitus type 2 type because of impaired glucose tolerance, overweight and having a family history of metabolic syndrome. The study involved a control group and two intervention groups. One intervention group received an intensive lifestyle modification that included a healthy diet and moderate physical activity consisting of 30 min/day for 5 days/week. The second intervention group received standard care and Metformin. The major study findings indicate that subjects in the intensive lifestyle modification group reduced their risk of developing diabetes mellitus type 2 by 58% compared with the medication intervention group, who reduced their risk by 31%. Even more dramatic was the finding that individuals over 60 years of age in the intensive lifestyle modification group decrease their incidence of developing type 2 diabetes by 71%.

The efficacy of nutrition therapy was further examined by Johnson and Thomas[74] who published the results of a 12 month retrospective chart audit with 162 adult patients with diabetes mellitus type 2. Of these patients, 81 received nutrition therapy intervention with at least two visits from a dietitian. The remaining subjects served as a non-intervention group and were chosen by random selection from a registry of diabetic patients who had never seen a dietitian. In the patients who received nutrition therapy intervention, HbA1c levels decreased by 20% (−2.14 units), bringing mean levels to <8%. In comparison, subjects without nutrition therapy intervention had a 2% decrease in HbA1c levels (−0.2 units), with mean levels remaining >8%. There were noted positive effects of nutrition therapy on knowledge, frequency, and accuracy of self-monitoring of blood glucose, self-reported dietary habits, and glycaemic control in studies with short-term follow-up of <6 months. Interestingly, educational interventions that involved patient collaboration were thought to be more effective than didactic interventions in improving glycaemic control, weight, and lipid profiles.

One recent study[75] showed that type 2 diabetes can be prevented by lifestyle interventions in subjects who are at high risk for diabetes. In the Finland Diabetes Prevention Study, published in 2011, 522 overweight subjects with impaired glucose tolerance were randomly assigned to an intervention or control group. The intervention group received a total of seven sessions of individualised nutrition therapy over 12 months to reduce weight and to increase physical activity. At the conclusion of the 12 month trial there were recorded weight losses of 4.2 and 0.8 kg for the intervention and control groups respectively.

The incidence of diabetes mellitus type 2 after four years was 11% in the intervention group and 23% in the control group. The risk of diabetes was reduced by 58% in the intervention group.

The beneficial economic outcome of nutrition therapy in primary care has been shown in a study of 12,308 patients with diabetes mellitus type 2. Sheils et al.[76] measured the potential savings derived from implementing nutrition therapy in primary care and estimated the net cost to Medicare. Differences in health care utilisation levels of individuals with diabetes, cardiovascular disease, and renal disease were estimated for hospital discharges and outpatient visits for those who did and did not receive nutrition therapy. Nutrition therapy was associated with a reduction in utilisation of hospital services of 9.5% for patients with diabetes. The authors concluded that after an initial period of implementation, coverage for nutrition therapy in primary care can result in a net reduction in health service utilisation and costs. These findings also suggest that individualised nutrition interventions can be delivered by dietitians with a reasonable investment of resources, and that cost-effectiveness is enhanced when dietitians are engaged in active decision-making regarding intervention based on patient needs.

The role of the dietitian requires more than tailoring a meal plan; rather, it involves integrating nutrition with the medical and behavioural care of the individual. This role can be expanded further by maintaining a close communication with other health care professionals, and serving as a case manager with diabetes patients.[77] Effective diabetes care requires patients and health care professionals to collaborate in the development of management plans that integrate the clinical expertise of health care professionals with the health concerns of the patient.[78]

The existing structure of diabetes care management in primary care has nutrition therapy along with physical activity at the initial stage of care. Individuals with diabetes type 2 who cannot achieve optimal control with nutrition therapy and whose disease may be progressing due to β-cell failure should be prescribed blood glucose-lowering medication, along with additional encouragement to achieve goals of nutrition therapy and physical activity.[79] However, the question remains as to whether this model of primary care management could become more effective and improve compliance. A large body of literature points to the need for a paradigm shift in the treatment care model. With over 1450 citations on Medline addressing the issue of lack of adherence to diabetes mellitus type 2 management plans,[80] patient non-compliance has predictively been shown to result in consistent negative health outcomes. Although the issue has been addressed frequently, the assumptions embedded in the traditional approach of the acute care paradigm have seldom been called into question.[81-83] Recent research has been shown that in many instances treating diabetes mellitus type 2 within the acute care paradigm could have a negative outcome because, in their efforts to control the patient's diabetes, many health care professionals are perceived by patients as trying to control their lives[84] and encroaching on the patient's personal autonomy.[85] It is recognised that in primary care health care professionals are time-poor and under increasing pressure to become more efficient[86]. In primary care, doctors, nurses, and dietitians are being asked to see more patients in less time, practice evidence-based medicine and evaluate measurable health outcomes. A paradigm shift towards fostering responsibility for the diabetic patient to take an active part in self-management could significantly improve health outcomes. In his essay, The Structure of Scientific Revolution, T.S. Kuhn advocates the importance of elucidating empowerment as a paradigm and of an overall philosophy or overall approach to chronic disease.[87] Over time, an increasing number of health care professionals, especially diabetes educators, have become interested in the person-centred philosophy approach and the data supporting its evidence.

Conclusion

Meta-analysis studies looking at diabetes mellitus type 2 management and education in primary care have shown that nutrition intervention has the largest statistically significant effect on metabolic control and weight loss[88, 89] as well as being effective in improving knowledge, skills, psychosocial adjustment and metabolic control.[88, 89] Overall, the evidence in many types of studies involving nutrition therapy in the management of diabetes supports nutrition intervention. Further research is encouraged on how to improve diabetes mellitus type 2 management in primary care based on patient-centred, relationship-oriented and collaborative care.

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Practice Management 101 – *Building a Client Base*

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Introduction

One of the most frustrating things about being in practice is building and growing your client base. You graduate with your diploma or degree and you are brimming with knowledge and a desire to help people - but you open your clinic doors and there is no one in the waiting room. Many new practitioners struggle in the first few years and have part-time work in other fields to fund their new careers. In this article we will look at the three major areas you can develop to build and maintain a client base so that you can fully immerse yourself in your new career.

The major areas covered in this article are developing your marketing persona, helping people find your business and building networks in your community.

Find your marketing persona

Many practitioners start with a limited marketing budget and don't really consider the value of 'investing' in their business. In fact in my first year of clinic I spent large sums on further study in relevant fields of Homoeopathy and Nutrition and nothing on learning about marketing my business. No surprise then that at the end of the first year in clinic I had just covered the rent.

The other reality of running a practice is that you have many different roles. One day it's IT support, the next day you are emptying the bins and washing the cups. While many areas can be delegated, if you really struggle it is essential that you get comfortable marketing your business. Realistically, unless you manage to find a job with a clinic that does all the marketing for you, which is unlikely, you will need to invest significant effort in marketing yourself in your first years in practice.

How do you find your marketing persona? Think honestly about what you do well and what you dislike doing. Did you find it difficult to get up and present at college/university? Do you enjoy catching up with people for a cup of tea but find large groups intimidating? What was the driver for getting into natural medicine to start with? Can you use that as a base for explaining why natural medicine can help people? Tailor your marketing strategy to your preferences and passions to ensure it is authentic and comfortable for you to maintain. The reality is you will always need to market your practice so it's best to find strategies that work for you.

Getting discovered

The very first thing you need to do once you graduate is set up a website.

This is non-negotiable. Just think about how you find a business when you need one? Chances are the first thing you do is search on Google to find a business in your local area. If you do not have a website you won't appear in the simplest search your clients are doing - but other practitioners will.

A recent Sensis report on social media use highlighted that 79% of Australians use the internet and 49% of those users access social media every day. Users were accessing the following forms of social media:[1]

Facebook	93%
LinkedIn	28%
Instagram	26%
Google+	23%
Pinterest	17%
Twitter	17%

Your website needs to answer five simple questions. Who are you? Where are you? Why should I see you? When are you available? Why should I see you in preference to another practitioner? In essence it is a flyer for your business and needs to answer all these questions to make it easy for a client to see that you do meet their needs and further, that they need to make an appointment with you.

Adding functionality to your website to make it easier to make a booking is also a good idea, particularly if you don't have reception. There are a number of online booking packages available and ATMS have a very affordable option with 1st Available at a significant discount for ATMS members. The premium version provide a widget for your website or facebook page to allow clients to access your online bookings.

In addition to your website you should also consider appropriate social media, with at least two forms that work well with your practice. This could include Linkedin, Facebook, Twitter, Instagram, Google+ or Pinterest. You need to look at where your target market is operating and plan to be in this space. For most practitioners that means at a minimum a Facebook Business Page for your clinic. Social Media News reported that there are currently 14 million users of Facebook in Australia in December 2015 whereas LinkedIn has 3.8 million users and Twitter 2.7 million.[2]

Different types of social media work better for different types of practices. For example, Instagram and Pinterest work well for more visual practices, whether it's sharing recipes or photos of meals, or inspirational pictures. Simple Green Smoothies is a great Instagram account to follow for anyone interested in nutrition. Lots of amazing smoothie recipes and beautiful pictures to get people to fall in love with kale and spinach.

LinkedIn is a good area for people who want clients who can afford their services as this is an area where executives tend to be listed. Ideally, material posted in this arena would be pitched for this market: short and relevant. LinkedIn would suit practitioners who are working in and around the CBD of a major city.

Twitter is a good space if you can easily compose pithy messages, and in many arenas this is often a space where you can find key influencers and start to engage in discussion. You can build a twitter following quite quickly provided you 'follow back' if people follow your account, but ensure that you don't include people who are offering to sell you followers or other undesirable products.

IN ADDITION TO YOUR WEBSITE YOU SHOULD ALSO CONSIDER APPROPRIATE SOCIAL MEDIA, WITH AT LEAST TWO FORMS THAT WORK WELL WITH YOUR PRACTICE ... SOCIAL MEDIA NEWS REPORTED THAT THERE ARE CURRENTLY 14 MILLION USERS OF FACEBOOK IN AUSTRALIA IN DECEMBER 2015 WHEREAS LINKEDIN HAS 3.8 MILLION USERS AND TWITTER 2.7 MILLION.

Regardless of the form of social media you choose make sure that you post content that is relevant and engaging and be prepared for a slow build in your numbers. A mix of your own content and curated content works well. Curated content could be articles or blogs from other industry participants as well as material you have written yourself for magazines or newspapers. Just ensure you inject your own personality into your posting, as ultimately this is the practitioner clients will engage with.

You can actually start to build a presence before graduation and have a platform you can build on. Alternatively, as a minimum, start following industry leaders to see what will work well in that area for your own social media after graduation.

Building networks in your community

Many years ago at a Metagenics VLA seminar an inspirational New Zealand naturopath spoke about building a successful practice in a town with a population of less than 5,000 people. Working with sporting clubs and offering bioimpedance analysis gave her an opportunity to talk about what she did and how she could help. Within three years she outgrew her home-based clinic and moved to a larger clinic on the main road.

Building a successful practice means developing networks. This could be through existing ones such as sporting clubs or other interests, or through an appropriate business networking group. There are many different options and it may depend on your location. However what you do need are groups where you can build personal relationships, not just hand out business cards. Look at groups such as Rotary, BNI or She Business (females only). The advantage of a networking group is that you can develop a group of advocates for your business, people who really understand what you do and how you can help, who can help you promote and build your business.

Ideally join at least one regular group and look for a 'stretch' event monthly, which gives you a chance to meet other business owners in the area. This could include business training or other community events.

Networking within your own industry is also critical. Meeting all the local practitioners when you first set up practice not only provides you with a referral network but over time assists in building a group of practitioners who may refer back to you. In my own practice at least 30% of referrals come

from other practitioners. You should always track where clients are referred from and acknowledge the referral with a short note or card.

Offering to speak or providing regular workshops is also a good way to build your client base. Frequently it gives potential clients an easy way to meet you and assess whether you could work together without committing to an initial appointment. Many of my clients came from my original Homoeopathic First Aid Workshops. Other popular topics have included;

- Detox your life
- Stress Management
- Hormonal Health with Natural Medicine

It can also be good to give joint talks with another practitioner, which enables both of you to effectively cross-promote to each other's client base.

Attending seminars in your area of expertise is also a good way to meet other practitioners from different locations, as well as to upskill. It enables you to build referral networks as well. While some practitioners can operate using Skype and similar technology, for many people a local practitioner is a much more practical option.

Conclusion

Building a client base requires planning and consistency. Developing a marketing plan at the start of each year and following it consistently will enable you to develop a loyal client base. After you finish this article sit down and, assuming you already have a website, set up your preferred form of social media, book yourself in to a regular networking event and organise a cup of tea with a couple of local practitioners. Schedule the networking events monthly and post on social media regularly.

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Further Research *in Homoeopathy*

Robert Medhurst | BNat ND DHom

A recent report from the Australian National Health and Medical Research Council said that "... there are no health conditions for which there is reliable evidence that homoeopathy is effective." This doesn't reflect the reality of the situation. There is a significant amount of evidence that supports the effectiveness of homoeopathy. What follows are summaries of some of the more recent or recently unearthed research in homoeopathy that add to the growing body of material in this area.

Human Research

1. Goldstein MS, Glik D, Use of and satisfaction with homoeopathy in a patient population. *Altern Ther Health Med,* 1998, 4, 2, 60-5. Carried out in nine homoeopathic clinics in the Los Angeles area, this study was done to determine the success or otherwise of constitutional homoeopathic practice as assessed by the people who'd undergone this therapy. The study also looked at the characteristics of the people involved in the study. Information was provided by 77 clients. At four months after treatment 71% of clients reported improvement in their health status. This is contrasted with the fact that 80% of all clients enrolled in this survey had had previous orthodox medical treatment for their condition which they had found unsuccessful. The most common presenting complaints involved the respiratory, gastrointestinal and female reproductive systems and most clients were highly educated but had little knowledge of homoeopathy prior to their treatment with it.

2. Haidvogl M, Riley DS, Heger M. Homoeopathic and conventional treatment for acute respiratory and ear complaints: a comparative study on outcome in the primary care setting. *BMC Complement Altern Med.* 2007, 7:7 doi:10.1186/1472-6882-7-7. The aim of the authors of this study was to compare the effectiveness of homoeopathic treatment for acute respiratory and ear complaints with orthodox medical treatment for the same conditions. 1577 clients from 57 clinics from Austria, Germany, the Netherlands, Russia, Spain, Ukraine, the United Kingdom and the USA were enrolled in the study. They were asked to rate their response to either therapy at 14 days after beginning treatment: 86.9% of those given homoeopathic medicines declared that they had had either a complete recovery or major improvement in their symptoms; 86% of those given orthodox medical treatment reported the same thing. Subgroup analysis found that 88.5% of children given homoeopathics reported a complete recovery or major improvement in symptoms whereas 84.5% of those given orthodox medical treatment reported similar success. In addition, the onset of improvement within the first seven days after treatment

was significantly faster in those with homoeopathic treatment, both in children and adults.

3. Itamura R. Effect of homoeopathic treatment of 60 Japanese patients with chronic skin disease. *Complement Ther Med*. 2007, 15, 2, 115-20. Sixty people were enrolled in this uncontrolled trial which was carried out in Obitsu Sankei Hospital in Kawagoe and designed to determine the effect of individualised homoeopathic medicines on several common skin disorders. These disorders included atopic dermatitis, eczema, acne, urticaria, psoriasis and alopecia universalis. Treatment occurred over a period of three months to two years and seven months and subjects were permitted to use conventional dermatological treatments while taking part in the trial. Using the trial participants' own assessment, improvement or otherwise was assessed using a nine-point scale similar to the Glasgow Homoeopathic Hospital Outcome Scale. On this basis, six people reported a complete recovery, 23 reported a 75% improvement, 24 found a 50% improvement and 7 had a 25% improvement). In all, 88.3% of patients reported over 50% improvement.

4. Klopp R, Niemer W, Weiser M. Microcirculatory effects of a homoeopathic preparation in patients with mild vertigo: an intravital microscopic study. *Microvasc Res*, 2005, 69, 1-2,10-6. The aim of this non-randomised open study was to test the effectiveness of a homoeopathic combination product on variables related to microcirculation in 16 people suffering from vestibular vertigo, compared to a control group of 16 untreated people also suffering from vestibular vertigo. Measurements were carried out in two areas (defined by selecting 60 blood-cell perfused nodal points of arterioles, venules, and capillaries with a mean diameter > or = 40 microns): the cuticulum/subcuticulum of the inside left lower arm and an area five mm behind the left earlobe. After 12 weeks of treatment, those people receiving the homoeopathic preparation exhibited an increased number of nodal points, increased flow rates of erythrocytes in both arterioles and venules, increased vasomotion, and a slight reduction in hematocrit vs. baseline. None of these changes were observed in the control group. Measurements were also made of partial oxygen pressure and the numbers of cell wall-adhering leucocytes, both of which were significantly increased in the test group compared to the control group. All of these parameters were associated with a reduction in the severity of the vertigo symptoms, both on patient as well as practitioner assessment...

Animal Research

1. Dos Santos AL, et al. In vivo study of the anti-inflammatory effect of Rhus toxicodendron. *Homoeopathy,* 2007, 96, 2, 95-101. This study was essentially designed to do two things: to determine which homoeopathic potency of Rhus tox provides the most effective anti-inflammatory action, and to reconfirm the results of previous studies aimed at demonstrating any anti-inflammatory effect of Rhus tox on paw oedema in rats. Of 6C, 12C, 30C and 200C potencies of this remedy, 6C was found to provide the highest level of activity, and, using an in-vivo inflammation model, researchers confirmed the anti-inflammatory activity of the remedy by interfering with inflammatory processes involving histamine, prostaglandins and other inflammatory mediators, when compared with controls.

2. Epstein OI, Pavlov IF, Shtark MB. Improvement of Memory by Means of Ultra-Low Doses of Antibodies to S-100B Antigen. *Evidence Based Complementary and Alternative Medicine,* 2006, 3, 4, 541-545. Antigen S-100B of nervous tissue affects the mechanisms of nervous system plasticity and memory. In this trial, 28 rats were given either a placebo, or Antigen S-100B, at a 6C potency to determine the effect of either on three learning behavioural models: inhibitory avoidance, choosing of bowls with sucrose, and feeding behaviour cessation after auditory signal. For all three tasks, parameters of reproduction of the learned skills improved after per oral administration of potentiated antibodies to S-100B antigen immediately after learning when compared to placebo.

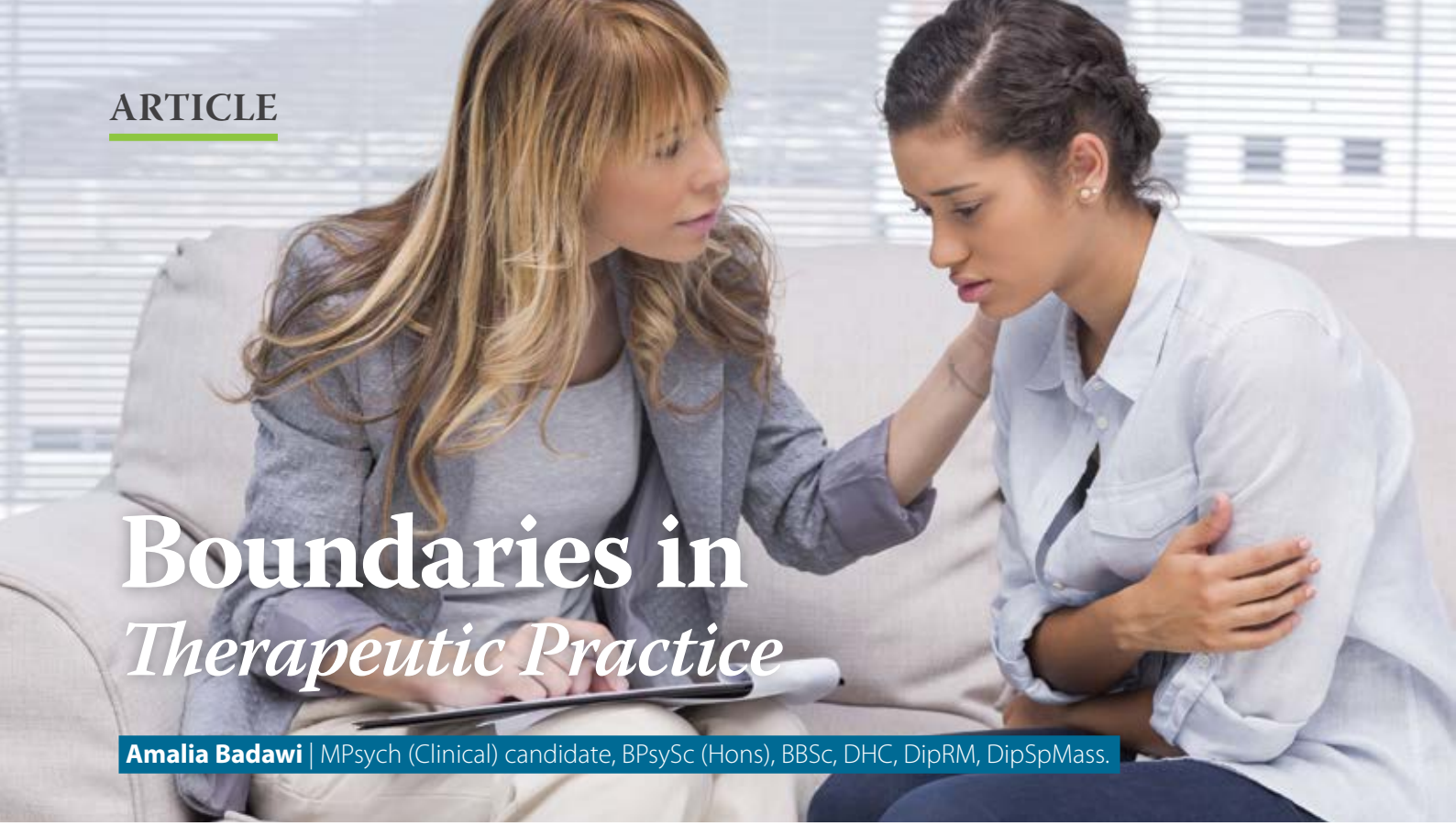
3. Sukul A, Sukul NM. Effect of Rhus tox and Causticum on rat adjuvant arthritis. Int J High Dilution Res, 2013, 12, 44, 135-136. *Proceedings of the XXVII GIRI Symposium;* 2013 Sep, 03-04; Bern (Switzerland) 135. Indian researchers set out to confirm the effects of homoeopathically prepared Causticum 30C and Rhus tox 30C on rats suffering from musculoskeletal inflammation. Rats were given the homoeopathic medication or controls for 18 days and assessed before and after treatment for inflammatory swelling, locomotor capacity and open field activity. An analysis was made of the collected observational data and it showed that when compared to controls, the rats given the homoeopathically prepared materials had significant improvement in all of the three parameters measured.

4. da Silva DM, et al. Oral, topical, and inhalation of Calcarea carbonica derivative complex (M8) to treat inflammatory mammary carcinoma in dogs. Int J High Dilution Res, 2012, 11, 40, 166-167. *Proceedings of the XXVI GIRI Symposium;* 2012, Sep, 20-22; Florence (Italy). This reports on an investigation carried out at the Federal University of Paraná in Brazil using a combination of homoeopathically prepared materials (M8) with dogs suffering from inflammatory mammary carcinoma (IMC). Three dogs diagnosed with this condition and with an average age of 10 years were treated with M8 orally, topically or via inhalation or with oral pyroxican. Thoracic radiographs showed pulmonary metastasis in all dogs. After seven days of treatment all of the dogs showed clinical improvement, specifically a reduction of mammary gland inflammation, decreased pain sensitivity, and owner-reported quality of life. One dog had eight months of complete remission, and the other two died one and two months after initial treatment. However none of the dogs had progressive pulmonary disease, showed by radiographic examination, which would have been a normal consequence to the IMCs.

In-Vitro Research

1. Walchli C, Baumgartner S, Bastide MJ. Effect of low doses and high homoeopathic potencies in normal and cancerous human lymphocytes: an in vitro isopathic study. *Altern Complement Med,* 2006, 12, 5, 421-7. The aim of this study was to determine the effect of pretreatment with either low doses, or homoeopathic potencies, of cadmium chloride on the ability of normal lymphocyte or cancerous lymphocyte cultures to withstand exposure to toxic doses of cadmium. Normal lymphocytes exposed to toxic levels of cadmium which were pretreated with either low dose of cadmium or potentised cadmium showed a significant increase in viability. This effect was the same in the cancerous lymphocytes except that these cells showed no increase in viability after pre-treatment with potentised cadmium.

2. Arora S, et al. Anti-proliferative effects of homoeopathic medicines on human kidney, colon and breast cancer cells. *Homoeopathy,* 2013, 102, 4, 274-82. This study set out to investigate the potential cytotoxicity of homoeopathic mother tinctures and 30C, 200C, 1M and 10M homoeopathic potencies of Sarsaparilla, Ruta graveolens and Phytolacca decandra, against cell lines deriving from tumors of particular organs. Sarsaparilla was tested against ACHN cells from human renal adenocarcinoma as well as non-malignant Madin-Darby canine kidney (MDCK) cells. Ruta was tested against COLO-205 cells from human colorectal carcinoma, and Phytolacca was tested against MCF-7 cells from human breast carcinoma. Cytotoxicity was measured using the 3-(4, 5-dimethylthiazolyl-2)-2, 5-diphenyltetrazolium bromide (MTT) method, anti-proliferative activity by trypan blue exclusion assay, apoptosis determined by dual staining the cells with ethidium bromide (EB) and acridine orange (AO) dyes. On analysis it was found that all of the remedies tested (particularly the mother tinctures), produced cytotoxicity and a decrease in cell proliferation. Signs of apoptosis were evident, including cell shrinkage, chromatin condensation and DNA fragmentation. The MDCK cells were unaffected by any of the Sarsaparilla potencies.



Boundaries in *Therapeutic Practice*

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Boundaries define and constrain the limits of the therapeutic relationship and serve to uphold professional standards in order to protect client, general public, and practitioner welfare.[1] By increasing awareness of the complex nature of boundaries, this article aims to assist therapists to readily clarify, establish, and maintain ethically appropriate relationships with clients. Complementary and alternative medicine (CAM) practitioners attend to clients in a holistic manner, which may make it more difficult to discern the appropriate boundaries required in practice. This is of particular relevance to body workers who not only have high levels of physical contact with clients, but also tend to be privy to the client's emotional and psychological issues.

Boundary discussions often revolve around sexual and intimate relations with clients, which are clear violations of professional codes of conduct.[2] However, subtle boundaries require greater exploration as they can be more difficult to delineate.

Concerns regarding boundaries generally arise due to a lack of understanding in regard to boundary continuums and dimensions, dual relationships, therapist self-disclosure,[3] and mechanisms of boundary establishment. Boundaries have evolved, and continue to evolve, based on societal norms and values.[4] There is debate about the type of boundaries that should be clear and rigid, and those requiring flexibility.[5] Perhaps the simplest example of the need for clear and rigid boundaries is the matter of maintaining non-sexual engagement with clients. However, inflexible boundaries may negatively affect the therapeutic alliance by failing to attend to the client as a unique individual, thereby presenting the practitioner as insensitive and inauthentic.[6]

Boundary Continuums and Dimensions

Boundaries can be conceptualised on a continuum ranging from rigid to entangled at the polarities, with balanced boundaries sitting around the midpoint of this range.[6] Adhering rigidly to boundaries may constitute a form of boundary violation.[7] For example, practitioners are expected to respect client autonomy and their right to informed decision-making.[2] Therefore, should the therapist seek to impose an inflexible course of treatment or adopt an authoritarian approach, this rigidity may readily constitute a boundary violation. Entanglement with a client may also lead to boundary breaches or violations. Forms of entanglement include the therapist investing more time or emotional energy in a particular client than in others, or the therapist seeking to meet their own social, physical or emotional needs through the client-therapist exchange, to the client's detriment. Therapists with a balanced approach to boundaries carefully consider client welfare and bring a sense of genuineness to treatment, while also taking care to incorporate boundary judgments from a professional and reflective position.[6]

Figure 1: Vignette for Reflection[1]

You have a client who is extremely distressed but the session has already gone over time and your next client is in the waiting room. You decide to give your private number to the client and tell them that they can contact you between now and the next appointment if things get really bad. Next time you are away on holiday, your colleague who is covering for you is not willing to do the same. What impact do you think this might have on:

- *The client?*
- *Your colleague?*
- *Your relationship with your colleague?*
- *Your workplace generally?*

(Adapted from Parkes & Jules, 2008)

Figure 2: Am I Placing My Client's Needs First?[13]

The following questions can be of assistance in determining whether or not an anticipated boundary crossing is appropriate.

- *Am I motivated by what the client needs rather than by own needs?*
- *Is the boundary crossing consistent with the client's treatment plan?*
- *Have the client's history, culture, values, and presenting issues been considered?*
- *Has the rationale for the boundary crossing been documented on client's record?*
- *Has the boundary crossing been discussed with the client in advance to prevent misunderstandings?*
- *Have I considered any power differentials to ensure that the client's trust is safeguarded?*
- *Do I need to consult with colleagues to help guide my decision?*

Boundary crossings and violations are generally viewed in a linear manner, ranging from less harming acts such as extending the time during a particularly emotionally-charged session or receiving a small gift, to breaches such as dual relationships and therapist self-disclosure, through to violations such as sexual contact with the client.[8] Crossing a boundary may be of potential benefit to the client, yet still be a deviation from standard practice.[7] For example, going over time or giving the client a lift home may seem relatively harmless. Yet these behaviours may reinforce unhealthy feelings or patterns such as the client feeling special for having received extra time or the client booking the final session of the day in an attempt to have more time with the therapist. Boundary violations are never acceptable. They include consensual and non-consensual sexual contact, physical/mental or financial abuse, harassment or bullying, and any criminal acts. Violations are always harmful to the client and are generally easier to define and identify than boundary crossings.[8]

Boundaries also have structural and interpersonal dimensions. Structural boundary elements include length and location of appointments, cost of service and type of treatment. Interpersonal aspects of boundaries involve degree and type of physical contact, limits of the client-practitioner relationship, and agreements about conditions such as gift giving. At all times, the onus is on the practitioner to uphold the appropriate boundaries.[8] Although the establishment of boundaries may be perceived as a divisive factor between client and therapist, appropriate boundaries can actually facilitate appropriate connection and protection for both client and practitioner.[7-8]

Figure 3: Therapeutic Decision-Making[7]

The following questions can be used to reflect on professional practice behaviours.

- *If I had to tape my client sessions, would my behaviour be different?*
- *Are there things I would do now that I would hesitate to do if my colleagues were to view these tapes?*
- *Would I want my work with this client to be published?*
- *Would I welcome my peers' input in regard to my work?*
- *If I am not comfortable with the above, why not?*

(Adapted from Corey et al., 2011)

Boundary Crossings

A common boundary breach presenting in the CAM field is that of a dual relationship. A dual relationship refers to the existence of more than a single point of connection between client and therapist.[9] For example, clients may be family friends, the workplace manager, or the practitioner's yoga teacher. Dual relationships tend to be particularly common in regional and rural areas where encountering the client is likely due to limited availability of facilities such as shopping centres or medical centres.[10-11] Belonging to a minority population such as being a member of a certain ethnic or religious background, or maintaining a particular lifestyle may also make it difficult to avoid dual relationships.[12] With consideration of appropriate boundary protocols, prior knowledge may foster the client's trust and confidence in the therapist.[9]

Boundary crossings and dual relationships differ in that crossings can serve the client's welfare. For example, extending a distressed client's appointment or scheduling a home appointment due to illness may constitute a boundary crossing, but does not necessarily indicate a dual relationship.[9] Fundamental to the decision-making process for the practitioner is whether their actions will harm, disrespect or coerce the client into an action that does not support the client's welfare, and whether the crossing is congruent with the therapeutic treatment plan agreed to. Boundary crossings and dual relationships do not violate the ATMS Code of Conduct,[2] but caution must be taken to ensure that principles such as not harming the client, respecting client autonomy, and professional care are upheld.

Client-therapist relationships tend to have an inherent power imbalance, with the therapist holding more power and influence than the client, who enters the relationship believing the therapist to have superior knowledge and skills that can be of benefit.[13] Therapists unable to recognise this differential may inadvertently breach client boundaries or undermine ethical practice by engaging with the client beyond their skill set or guiding the client based on personal, rather than professional, experience. In this context, self-disclosure is an important boundary to consider. Self-disclosure may involve the practitioner telling the client that they too have experienced a similar problem, follow a specific religious path, or have a certain sexual orientation. Benefits of self-disclosure include modeling, presenting a different viewpoint, being authentic, enhancing the therapeutic relationship and evening out power discrepancies.[9] However, self-disclosure should not be self-serving for the therapist. Instead, the welfare of the client should always be placed first and provision of treatment should be within the practitioner's expertise.[2]

Influencing Factors

Holding balanced and clear boundaries requires that the therapist understand the factors influencing their own personal boundaries.[6] Both clients' and therapists' boundary limits will be influenced by personal factors such as gender, family values, cultural/religious beliefs, and generation.[7] For example, a therapist who was raised to respect their elders may find it difficult to be directive when treating an older client or to impose their standard requirement of timely payment in the case of an older patient. As each individual's norms will seem entirely acceptable and natural to themselves, practitioners will need to ensure that any of their own norms likely to affect their practice are clarified and adjusted in order to uphold ethical and professional practice.

The notion that there is a power differential between practitioner and client may seem surprising to practitioners who lack clarity or struggle to assert their boundaries, particularly in the CAM field, where the client may be perceived as holding greater power than they would in a medical or psychotherapeutic setting. Indeed, Lazarus[14] challenged the persisting myth of therapists holding the power and clients being vulnerable by drawing attention to the power positions that may present for both parties. According to Lazarus, a client may feel overly dependent or reliant on the therapist for support. On the other hand, the client may also deem themselves more powerful than the therapist because they are paying for the service or because of their status in the community or workplace. In such situations, the therapist may find it challenging to assert and maintain appropriate boundaries.

Although establishing a therapeutic frame involves the clinician's setting and maintaining boundaries,[11] client collaboration should also be enlisted in this process. Clients and practitioners may assume shared knowledge of treatment norms, without clarifying individual understandings or expectations.[4] Client input can be obtained by practitioners a) asking the client about their understanding of what treatment involves, b) explaining treatment protocols to the client, and c) obtaining written informed consent to proceed with treatment. Section 6 of the ATMS Code of Conduct[2] requires practitioners to inform clients of the proposed treatment plan. The process of obtaining informed consent is therefore an opportunity to ensure that the client is adequately informed about treatment inclusions and exclusions, and to establish mutually agreeable boundaries.

In summary, the topic of boundaries often brings to mind unethical behaviour that harms or exploits the client. However, boundaries comprise complexities that necessitate distinction between boundary violations, breaches and beneficial crossings.[9] Crossing a boundary in order to attend to the client's wellbeing may

strengthen therapeutic alliance, which is predictive of treatment outcome.[15] However, the decision to do so must be preceded by contemplation of the client's needs and stipulations of the ATMS Code of Conduct.[2] Practitioners are encouraged to discuss potential boundary concerns with colleagues and senior practitioners, and to increase knowledge of the ethical decision-making process. Reflection on vignettes and questions, such as those in Figures 1, 2 and 3, may be beneficial in increasing knowledge and reflective skills. By understanding the components, application and issues surrounding boundaries, CAM practitioners are better placed to deliver ethical and professional standards of therapeutic practice.

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The Childhood Obesity *Epidemic*

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Introduction

Obesity is about much more than just being fat. It is a global epidemic with serious health, social and economic consequences.[1,2] Before they reach the age of five, 40 million of the world's children will have become obese.[3] Today it is widely documented that 25% of Australia's children are obese or overweight.[4-6] Obesity has also become Australia's single biggest threat to public health.[6]

Body weight is commonly classified using Body Mass Index (BMI).[7] One standard for obesity is a BMI greater than or equal to 30. Obesity is also defined as an excessive fat accumulation that presents a risk to health.[7] When we consider that this presentation is often the result of an excessive caloric intake with a deficit in energy expenditure, it is startling to consider that a health and social epidemic which is essentially preventable is actually on the rise.

With a focus on childhood obesity between the ages of nought and 18, this paper explores the causes, results and management strategies associated with its presentation. It will also discuss the role of the health professional in relation to obesity and attempt to shed light on the difficulties associated with monitoring, caring for and preventing obesity.

Prevalence Of Obesity

One quarter of Australia's children are currently obese, up 4% from 1996.[4,7] Ranging from 3% and 4% in the developed nations of Japan and Korea to over 30% in the USA, obesity is now also prevalent in developing nations, which account for 10 million of the 40 million obese children worldwide. Although this pattern of increase is generally accepted and expected to continue,[4] there are a number of studies which question the legitimacy of these statistics. Although the BMI is the current unified measure to determine obesity, inconsistent BMI percentile bands, the use of waist-to-height ratios and absence of age, gender and growth classifications are creating unreliable data.[8] Further to this, there are likely to be errors from self-reported data collection when individuals weigh and measure themselves.[9,10] Current statistical data may also be flawed because of lack of participation of those overweight individuals who are unprepared to participate because of social stigma.[10,11]

Rather than an exponential growth of obesity, some authors argue that obesity trends will not follow the expected trajectory.[9-11] There are suggestions that it is media hype reinforced by public health spokespeople which continues to drive a misrepresentation of the obesity epidemic.[10,12] Holland et al.[12], in their analysis of newspaper coverage of the weight trends in Australia, concluded that the image of Australian obesity has been framed by political, media and public agendas rather than reality.

Causes Of Obesity

The fundamental cause of obesity is an energy imbalance between calories consumed and calories expended.[7,13] Globally, the increase in energy-dense foods high in fat and sugar but low in nutritional value, and a decrease in physical activity due to sedentary activity, modes of transport and increased urbanisation all contribute to this imbalance. [7,13] Childhood obesity appears to be associated with low socio-economic status, maternal nutritional status, single parent status, and low education levels.[2,4,14,16,17] Childhood obesity has also increased with the use of media games and hand-held devices,[7,18] mass media marketing of junk food products,[14,19] and lack of stay-at-home parenting.[4,14]

Obesity has also been linked to age, ethnicity and gender. According to the World Health Organisation (WHO),[13] since 1976 Caucasians have had the lowest obesity rates for all childhood age brackets. In comparison Aboriginal and Torres Strait Islander Australians are 1.9 times as likely as non-indigenous Australians to be obese.[20]
Cinelli & O'Dea [15] concluded that in Australia male and female indigenous adolescents desired and pursued weight gain as a reflection of health and success, reinforced and encouraged by parental advice.

Strong associations have been established between obesity in adolescent girls and underserviced healthy lifestyle promotion for this age bracket.[14,16,17] Byrne et al [14] also refer to a higher obesity rate in single parent girl children aged four to nine due to lack of exercise. Bacha et al [21] suggest that single mothers perceive their neighbourhoods as unsafe for their daughters and limit their outdoor activities. In addition, obesity has deep social, environmental, economic and cultural roots, each one of which needs to be taken into account when looking for ways to address the obesity epidemic.

Health And Social Costs

The health consequences of obesity are clearly documented. Obesity leads to diabetes, cardiovascular disease, cancer, and joint, musculoskeletal and arthritic conditions.[10,14] Obesity breeds anxiety, depression, poor self-image and social stigma, and reduces happiness and life expectancy.[22] Childhood obesity produces breathing difficulties, apnoea, hypertension and insulin resistance, fatty liver, high blood fats, low self-esteem, and behavioural problems.[7] Since there is a 50% – 80% chance of obesity in a child with obese parents,[4,14] and childhood obesity leads to adult obesity and an earlier onset of these disorders,[14,16,22] it is imperative to begin early to address the childhood obesity health risk.

It is obvious that obesity does not merely have health consequences for the individual, but has vast economic and social ramifications world- and nation-wide. According to a number of studies obesity costs Australia around $58 billion a year and produces 7200 deaths.[3]
In a study by Aitken et al [24] it was concluded that in Australia alone over 200 lives and $51.5 million a year could have been saved if childhood obesity had been curbed in the years 2004/5. Obesity also produces indirect costs via carers, welfare payments and lost productivity and taxation.[24,25] It has been estimated that indirect costs for obesity in Australia are 3.3 times greater than its direct costs.[26]

Management

Today there is much debate over who is responsible for obesity and therefore how to manage the problem. In 2004 the WHO adopted a global strategy on obesity in order to decrease unhealthy diets and increase physical activity, particularly in childhood.[13] Australia has adopted a similar focus. Since the 1980s government intervention has included the funding of social marketing campaigns, new sport and recreation facilities and healthy eating and physical activity programs in schools. The 2008 Its your Move project was a three-year obesity intervention study in secondary schools in Australia with positive adolescent prevention outcomes.[27] Unfortunately childhood obesity figures have not reflected significant change.[19]

If childhood obesity is to be curbed that there needs to be a rethink about who and what is targeted. This may require changes to the law.[19,28] Despite current government initiatives for healthy eating, the food industry is left to self-regulate and continues practices designed to maximise consumption of its products, including junk food marketing to children.[19] Australia's continuing lax legislation in this area, based on claims of loss of autonomy from some sections of the community and from the Primary Food industry, may be to blame.[19,28]

Obesity management also requires age, culture and individual identity consideration. Healthy eating and exercise regimes can cause conflict and confusion for adolescents under the influence of families who are promoting differing ideals, especially within indigenous communities.[15] Blame imposed by personal and societal stigmas limits participation in healthy practices by obese children requiring parental consent, and by obese adults, which inhibits both research and development projects.[22,29]

If we are to manage obesity effectively we must recognise and tackle our social and cultural structures as well as the underlying physiological nature of obesity. If policies are to be effective they must spring from accurate and relevant research. According to Nathan et al [28] policy action associated with obesity in Australia and New Zealand has always proceeded without this integral input.

The Role Of The Health Professional

Management and prevention of childhood obesity requires management and treatment of the adult obesity that surrounds it.[4,28,29] This is mainly achieved through education and behavioural changes associated with diet and activity.[17,30]

THE FUNDAMENTAL CAUSE OF OBESITY IS AN ENERGY IMBALANCE BETWEEN CALORIES CONSUMED AND CALORIES EXPENDED. GLOBALLY, THE INCREASE IN ENERGY DENSE FOODS HIGH IN FAT AND SUGAR BUT LOW IN NUTRITIONAL VALUE, AND A DECREASE IN PHYSICAL ACTIVITY DUE TO SEDENTARY ACTIVITY, MODES OF TRANSPORT AND INCREASED URBANISATION ALL CONTRIBUTE TO THIS IMBALANCE.

According to Lowery & Taylor [30] no single profession can solve this growing problem by itself. Obesity care and prevention requires a multidisciplinary team including general practitioners (GP), dietitians, exercise physiologists,[30] and natural medicine practitioners. This in turn indicates the need for greater inter-professional interaction, adequate referral guidelines and recognition of certification in obesity management.[30]

Further education of health professionals may be required to provide access, useful and efficacious support to obese patients. In their qualitative study of obese people in Australia, Thomas et al [22] concluded that many obese individuals refer to humiliating and derogatory experiences when associating with the health industry. Obese individuals also reported high levels of dissatisfaction with their GPs due to limited consultation time and an exaggerated focus on antidepressant prescription.[22]

Such interventions as gastric banding and employment of personal trainers and exercise therapists raise the issue of affordability for many obese individuals. [22,29]

There needs to be a heightened cultural and gender tailoring in individual consultations across all health professions.[15,22,29] A simple change in language can also help clients feel respected and wish to participate and comply.[22]

Osteopathy is one such health profession which has enormous potential to aid in reducing obesity. [31,32] Obesity is frequently associated with musculoskeletal disorders, including joint and lower back pain.[31] The osteopathic approach to obesity aims to improve function in all areas in order to best support overall structure. [31,33] For many overweight individuals the simple passive movements offered by osteopathic physicians can lead to functional increases in activities of daily living.[31]

With its holistic approach osteopathy also has potential to increase the natural processes of blood, lymph, neural, and organ function [31,33] and thus positively effect many of the non-communicable diseases associated with obesity.[31] Osteopaths use diet, exercise and behaviour modification to treat obese patients. [32] This multidimensional approach increases their potential for functional improvements.

Osteopathic treatment is tailored to treat individual patients, not the condition [31,33] and provides a consultation time suitable for personally engaging, screening and documenting a complete history.

There may be less focus on the obesity presentation and more focus on the individual behind it. This may help to reduce the experience of guilt and social burden which often restricts obese individuals from seeking professional intervention. However, it is important that osteopaths continue to learn about managing obese patients, as many osteopaths have been found to lack understanding of how to assess obesity, and their training found to be deficient in regard to its treatment.[32]

Conclusions

It is widely accepted that one quarter of Australian children are obese, creating a problem of such proportions that it is deemed Australia's number one public health issue. However, the true incidence of obesity and the nature of its causes and associations need to be fully understood for truly effective preventative and management programs to be developed. Obesity at any age appears to be a result of social, environmental, economic, cultural and lifestyle factors, with children and low socioeconomic status individuals and families at the greatest risk for its development. It appears that obese adults are likely to produce obese children who will develop high levels of non-communicable disease at very early ages. This places enormous pressure on the national health budget. If we are to curb the increasing prevalence of childhood obesity through policies that have real impact, we must provide health education with relevance for individuals, their families and community groups. Without a social environment which enables these changes to occur, obesity in all age groups will continue.

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Work Health and Safety:

Managing Workplace Incidents and Injuries

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In the last issue of this Journal we started our series on Work Health and Safety in the Workplace with a review of emergency plans and providing first aid. In this article we'll review how to manage workplace incidents and injuries, including who to notify and when.

Two of the main duties of a person conducting a business or undertaking (PCBU) are to notify the regulator of serious injuries in the workplace and to keep records of any workplace incident in a register of injuries.

Reporting workplace accidents and incidents

When an accident or incident occurs in the workplace it must be recorded. Some accidents and incidents also need to be reported to the regulator. From 1 September 2015 there was a change in the regulatory and insurance functions in this area. SafeWork NSW (**www.safework.nsw.gov.au**) is the regulator for work health and safety issues. Previously this was WorkCover NSW. The State Insurance Regulatory Authority (SIRA) (**www.sira.nsw.gov.au**) is responsible for the regulation and administration of workers compensation and is run through WorkCover, as it was before.

What injuries must be notified to WorkCover?

If a PCBU becomes aware of any notifiable incident that has arisen in the workplace they must ensure that WorkCover is notified immediately by the fastest possible means, for example by phone or email (section 38 of WHSA). A 'notifiable incident' means a work-related death or serious injury or illness, or a dangerous incident, and is outlined in section 35 of the WHSA. It can relate to a worker, a contractor or a visitor to the workplace.

Section 36 of the WHSA defines a serious injury or illness and gives examples, such as amputations, serious head or eye injuries, serious burns and lacerations. It also includes injuries that require immediate hospital treatment and medical treatment given within 48 hours after exposure to a substance. A serious illness also means any infection to which carrying out the work has made a significant contribution. This includes any infection that can be reliably attributed to the work and which involves micro-organisms, such as providing treatment or care to a person and contact with human blood or body substances.

Section 37 covers the meaning of a dangerous incident (sometimes called 'near misses') which exposes a worker, or any other person, to a serious risk to their health or safety from an immediate or imminent exposure to a spillage, explosions, electric shocks, collapse of a structure or falls. Dangerous incidents usually have to be notified as well, even though no-one may have been injured.

Generally, a good rule of thumb in deciding whether or not to notify the regulator is if an injury is one which incapacitates the worker for work for a specified time. It is not necessary to notify the authorities of minor injuries, such as scratches or small cuts. If you are unsure it is always best to contact WorkCover for guidance.

Who should notify WorkCover?

Generally a PCBU is the person who should notify WorkCover. Procedures should be put in place in every workplace so that all work and safety incidents are bought to the PCBU's attention as quickly as possible. If you are in a building with many PCBUs or officers then they must all ensure that the incident has been notified to the regulator. They don't all need to report it but they must be sure that it has been.

When should you notify WorkCover?

For any notifiable incident a PCBU must notify WorkCover immediately after they become aware of the incident. This means as quickly as the particular circumstances allow. A PCBU is said to become aware of a notifiable incident when any of their workers in a supervisory role becomes aware of the incident. This is why it is very important to have clear guidelines about incident reporting.

How should you notify WorkCover?

The notice must be given by the fastest possible means, either by telephone, email or in writing. If it is by phone, a PCBU is usually asked to give written notice of the incident within 48 hours after its occurrence.

What should you include in your report to WorkCover?

The table pictured here is from the SafeWork Australia Incident Notification Fact Sheet. It is a very useful summary of what you should include in reports to WorkCover when notifying them of incidents.

What happened? (an overview)	• Provide an overview of what happened. • Nominate the type of notifiable incident — was it death, serious injury or illness, or 'dangerous incident' (as defined above)?
When did it happen?	Date and time.
Where did it happen?	Incident address. Details that describe the specific location of the notifiable incident — for example, section of the warehouse or the particular piece of equipment that the incident involved — to assist instructions about site disturbance.
What happened: detailed description	Detailed description of the notifiable incident.
Who did it happen to?	• Injured person's name, salutation, date of birth, address and contact number. • Injured person's occupation. • Relationship of the injured person to the entity notifying.
How and where are they being treated (if applicable)?	• Description of serious injury or illness — ie, nature of injury • Initial treatment of serious injury or illness. • Where the patient has been taken for treatment.
Who is the PCBU (there may be more than one)?	• Legal and trading name. • Business address (if different from incident address), ABN/ACN and contact details including phone number and email.
What has/is being done?	Action taken or intended to be taken to prevent recurrence (if any).
Who is notifying?	• Notifier's name, salutation, contact phone number and position at workplace. • Name, phone number and position of person to contact for further information (if different from above).

What records must you keep?

The person who notifies the regulator, usually the PCBU, must keep a record of each notifiable incident for at least five years from the date of notification.

The other record you must keep is a Register of Injuries to record workplace injuries or illnesses sustained by workers regardless of whether there has been a claim.

The register of injuries must include the:

- name of the injured worker
- worker's address
- worker's age at the time of injury
- worker's occupation at the time of injury
- industry in which the worker was engaged at the time of injury
- time and date of injury
- nature of the injury
- cause of the injury.

The register of injuries may be kept in writing or electronically and must be accessible to all workers so that they can register accidents and incidents. A record of each notifiable incident must also be kept. For a sample Register of Injuries please see WorkCover at http://**www.workcover.nsw.gov.au/workers-compensation-claims/report-an-incident-or-injury/register-of-injuries.**

Duty to keep records

Keeping records of your WHS activities will help you to monitor the health and safety performance of your business as well as meet your legal requirements. See section on Notifying Workplace Accidents, above.

You will need to keep the following records:

- incidents and injuries, including near misses;
- hazardous chemicals and asbestos register (if they are present at your workplace);
- plant registration documents; and
- tests, maintenance, inspection and other records for specific types of plant.

It may also be useful to keep records of:

- hazard identification, risk assessment and control processes;
- maintenance of all plant and equipment; and training.

So in summary if there is a serious injury or illness, a death or a dangerous incident, these are the things you must do:

- Provide first aid and make sure your worker gets the right care.
- Then notify WorkCover immediately by phone 13 10 50 or email.
- Record it in your register of injuries.
- Notify your worker's compensation insurer of any injury or illness within 48 hours.
- Help your worker to return to work.
- Make sure your organisation creates and implements a policies or procedures for the reporting of incidents.

Acupuncture and TCM

Kim MK, Bang CY, Yun GJ, Kim H-Y, Jang YP, Choung SY.

Anti-wrinkle effects of Seungma-Galgeun-Tang as evidenced by the inhibition of matrix metalloproteinase-I production and the promotion of type-1 procollagen synthesis. BMC Complementary and Alternative Medicine 2016. DOI: 10.1186/s12906-016-1095-z

Background: Seungma-Galgeun-Tang (SMGGT), a traditional herbal medicinal formula, has been used to treat various skin problems such as inflammation and rashes in Korean traditional medicine. In order to clarify the scientific evidence for the biological efficacy of SMGGT on the prevention of skin aging and in particular wrinkle formation, molecular anti-wrinkle parameters were evaluated in cultured human dermal fibroblasts.

Methods: Standard SMGGT was prepared from KFDA-certified herbal medicines and the chemical fingerprint of SMGGT was verified by HPLC-ESI-MS to insure the quality of SMGGT. To evaluate the inhibitory effects of SMGGT on the synthesis of matrix metalloproteinase-1 (MMP-1) and type-1 procollagen, the content of MMP-1 and type-1 procollagen synthesizing enzymes in cultured human dermal fibroblasts were measured using an ELISA kit and Western Blot, respectively.

Results: The treatment of SMGGT water extract significantly inhibited the production of MMP-1 and promoted type-1 procollagen synthesis concentration dependently.

Conclusions: These results suggest that SMGGT has the potential to prevent wrinkle formation by down-regulating MMP-1 and up-regulating type-1 procollagen in human dermal fibroblasts.

Ярошевський ОА.

Nonspecific symptoms of pain syndromes of cervicobrachial localization and their dynamics under the influence of non - pharmacological treatment. Wiad Lek. 2016;69(1):10-3.

Introduction: The relevance of this study is caused by the wide spread of musculoskeletal pain, particularly among young people of working age and lack of effectiveness of drug treatment.

Aim: To study the capability of non-pharmacological treatment in patients with myofascial pain syndrome of cervicobrachial localization considering the influence to nonspecific symptoms of myofascial pain syndrome (autonomic dysfunctions and emotional disorders).

Material and methods: We studied 115 patients aged from 18 to 44 years with myofascial pain syndrome of cervicobrachial localization. We used neurological, vertebral- neurological, neuropsychological examination. The severity of pain was assessed by the Visual analog scale for pain (VAS pain). Patients were divided into two groups. The first group of patients (59 individuals) received the complex of manual therapy. The second group of patients (56 individuals) received the complex of manual therapy combined with acupuncture.

Results: Non-pharmacological treatment was effective in patients with myofascial pain syndrome of cervicobrachial localization. Application of manual therapy methods in the treatment of myofascial pain syndrome of cervicobrachial localization leading to the reduction of severity of pain, emotional disorders and autonomic dysfunctions. The combination of manual therapy with acupuncture increases the effectiveness of treatment of myofascial pain syndrome of cervicobrachial localization by reducing the emotional disorders and autonomic dysfunctions.

Conclusion: Patients with myofascial pain syndrome of cervicobrachial localization need the complex of manual therapy combined with acupuncture. The manual therapy corrects abnormal biomechanical pattern while acupuncture corrects autonomic dysfunctions and emotional disorders

Aromatherapy

Press-Sandler O, Freud T, Volkov I, Peleg R, Press Y1.

Aromatherapy for the Treatment of Patients with Behavioral and Psychological Symptoms of Dementia: A Descriptive Analysis of RCTs. J Altern Complement Med. 2016 May 9. [Epub ahead of print]

Background: Behavioral and psychological symptoms of dementia (BPSD) are a common problem among patients with dementia. This problem is usually treated by drugs, but they have limited efficacy and often cause adverse effects. Aromatherapy is a nonpharmacologic treatment that is simple to use and devoid of significant adverse effects.

Objectives: To review the literature on the effectiveness of aromatherapy treatment in patients with BPSD.

Design: A descriptive analysis of randomized clinical trials (RCTs) published in the English-language literature and cited in PubMed.

Results: Eleven articles on RCTs were found, of which 1 had fewer than 10 participants, 2 were mistakenly presented as RCTs, and another did not report treatment for BPSD. In all, 7 articles with 417 participants total (range, 15-114) were reviewed. The mean age in all studies was greater than 69 years (range, 69-85 years), and the percentage of women was 55% (range, 50%-57%). The intervention period ranged from 10 days to 12 weeks. Two studies used Melissa oil and 5 others used lavender oil. The studies described different methods of administration for the oils, including spraying and rubbing over various body organs. The duration of treatment differed among the studies. In 3 studies the investigators concluded that the treatment was not effective and in 3

that it was effective; in 1 study no clear conclusion could be drawn.

Conclusions: The difference between positive and negative studies was not explained by differences in the study population, the type of oil, or the duration of treatment. The significant difference apparently stems from the method of administration. When the oil was applied close to the olfactory system the outcome was positive. A study should be designed to assess the effect of the site of application of aromatherapy.

Karaman T, Karaman S, Dogru S, Tapar H, Sahin A, Suren M, Arici S, Kaya Z.

Evaluating the efficacy of lavender aromatherapy on peripheral venous cannulation pain and anxiety: A prospective, randomized study. Complement Ther Clin Pract. 2016 May;23:64-8. doi: 10.1016/j.ctcp.2016.03.008. Epub 2016 Mar 25

Objective: This study was designed to evaluate the effectiveness of lavender aromatherapy on pain, anxiety, and level of satisfaction associated with the peripheral venous cannulation (PVC) in patients undergoing surgery.

Method: One hundred and six patients undergoing surgery were randomized to receive aromatherapy with lavender essential oil (the lavender group) or a placebo (the control group) during PVC. The patients' pain, anxiety, and satisfaction scores were measured.

Results: There was no statistically significantly difference between the groups in terms of demographic data. After cannulation, the pain and anxiety scores (anxiety 2) of the patients in the lavender group were significantly lower than the control group (for $p = 0.01$ for pain scores; $p < 0.001$ for anxiety 2 scores). In addition, patient satisfaction was significantly higher in the lavender group than in the control group ($p = 0.003$).

Conclusion: Lavender aromatherapy had beneficial effects on PVC pain, anxiety, and satisfaction level of patients undergoing surgery.

Herbal Medicine

Niknam R, Mousavi S, Safarpour A, Mahmoudi L, Mahmoudi P.

Self-medication of irritable bowel syndrome and dyspepsia: How appropriate is it? J Res Pharm Pract. 2016 Apr-Jun;5(2):121-5. doi: 10.4103/2279-042X.179576.

Objective: Self-medication is common among patients with gastrointestinal (GI) symptoms. This study was performed to evaluate self-medication among patients who fulfilled irritable bowel syndrome (IBS) and dyspepsia diagnostic criteria and to investigate the appropriateness of self-medication with chemical and herbal drugs.

Methods: A prospective, descriptive cross-sectional study was conducted in outpatient's GI clinics at Shiraz from November 2011 to May 2012. A GI specialist visited the patients and recruited those who had IBS (base on Rome III adapted criteria) or functional dyspepsia. We surveyed self-medication among these patients, using a questionnaire containing specific questions about self-medication.

Findings: One thousand four hundred and forty-seven patients visited by the GI specialist during the study period. Seven hundred and forty-seven patients had the inclusion criteria, 337 of them fulfilled criteria for IBS, with IBS-mixed (52%) being the most prevalent subtype, and 410 patients had dyspepsia. Overall, 78.8% of the total participants had recently sought medical attention for their GI complaint. Twenty-eight percent of patients selected inappropriate medication for their GI complaints. The H2-blockers class were most common medicines reportedly used. We did not find any significant relationship between age, gender, level of education, marital status, and self-medication frequency.

Conclusion: Patients who fulfilled criteria for IBS had a high tendency to self-treat their GI symptoms, use of acid-suppressive agents was common among patients. Around one-third of patients self-treated GI symptoms inappropriately. Consequently, the concept of self-medication among patients has to be revised. We recommend conduction of educational programs to improve self-medications selection and attitude among patients to reduce the burden on other health care resources.

Homoeopathy

Grimaldi-Bensouda L, Abenhaim L, Massol J, Guillemot D, Avouac B, Duru G, Lert F, Magnier AM, Rossignol M, Rouillon F, Begaud B.

Homeopathic medical practice for anxiety and depression in primary care: the EPI3 cohort study. BMC Complement Altern Med. 2016 May 4;16(1):125. doi: 10.1186/s12906-016-1104-2.

Background: The purpose of the study was to compare utilization of conventional psychotropic drugs among patients seeking care for anxiety and depression disorders (ADDs) from general practitioners (GPs) who strictly prescribe conventional medicines (GP-CM), regularly prescribe homeopathy in a mixed practice (GP-Mx), or are certified homeopathic GPs (GP-Ho).

Methods: This was one of three epidemiological cohort studies (EPI3) on general practice in France, which included GPs and their patients consulting for ADDs (scoring 9 or more in the Hospital Anxiety and Depression Scale, HADS). Information on all medication utilization was obtained by a standardised telephone interview at inclusion, 1, 3 and 12 months.

Results: Of 1562 eligible patients consulting for ADDs, 710 (45.5 %) agreed to participate. Adjusted multivariate analyses showed that GP-Ho and GP-Mx patients were less likely to use psychotropic drugs over 12 months, with Odds ratio (OR)=0.29; 95 % confidence interval (CI): 0.19 to 0.44, and OR=0.62; 95 % CI: 0.41 to 0.94 respectively, compared to GP-CM patients. The rate of clinical improvement (HADS <9) was marginally superior for the GP-Ho group as

compared to the GP-CM group (OR = 1.70; 95 % CI: 1.00 to 2.87), but not for the GP-Mx group (OR = 1.49; 95 % CI: 0.89 to 2.50).

Conclusions: Patients with ADD, who chose to consult GPs prescribing homeopathy reported less use of psychotropic drugs, and were marginally more likely to experience clinical improvement, than patients managed with conventional care. Results may reflect differences in physicians' management and patients' preferences as well as statistical regression to the mean.

Massage

Airosa F, Arman M, Sundberg T, Ohlen G, Falkenberg T.

Caring touch as a bodily anchor for patients after sustaining a motor vehicle accident with minor or no physical injuries - a mixed methods study. BMC Complementary and Alternative Medicine. DOI: 10.1186/s12906-016-1084-2

Background: Patients who sustain a motor vehicle accident may experience long-term distress, even if they are uninjured or only slightly injured. There is a risk of neglecting patients with minor or no physical injuries, which might impact future health problems. The aim of this study was to explore patients' subjective experiences and perspectives on pain and other factors of importance after an early nursing intervention consisting of "caring touch" (tactile massage and healing touch) for patients subjected to a motor vehicle accident with minor or no physical injuries.

Methods: A mixed method approach was used. The qualitative outcomes were themes derived from individual interviews. The quantitative outcomes were measured by visual analogue scale for pain (VAS, 0-100), sense of coherence (SOC), post-traumatic stress (IES-R) and health status (EQ-5D index and EQ-5D self-rated health). Forty-one patients of in total 124 eligible patients accepted the invitation to participate in the study. Twenty-seven patients completed follow-up after 6 months whereby they had received up to eight treatments with either tactile massage or healing touch.

Results: Patients reported that caring touch may assist in trauma recovery by functioning as a physical "anchor" on the patient's way of suffering, facilitating the transition of patients from feeling as though their body is "turned off" to becoming "awake". By caring touch the patients enjoyed a compassionate care and experience moments of pain alleviation. The VAS pain ratings significantly decreased both immediately after the caring touch treatment sessions and over the follow-up period. The median scores for VAS ($p < 0.001$) and IES-R (p 0.002) had decreased 6 months after the accident whereas the EQ-5D index had increased ($p < 0.001$). There were no statistically significant differences of the SOC or EQ-5D self-rated health scores over time.

Conclusions: In the care of patients suffering from a MVA with minor or no physical injuries, a caring touch intervention is associated with patients' report of decreased pain and improved wellbeing up to 6 months after the accident.

Tejero-Fernandez V, Membrilla-Mesa M, Galiano-Castillo N, Arroyo-Morales M.

Immunological effects of massage after exercise: A systematic review. Physical Therapy in Sport 2015 May;16(2):187-92.

Objective: The objective of this review was to determine whether immune parameters can be modulated by massage after intense physical activity.

Methods: A search was conducted in Pub Med Medline, PEDro, and Cochrane databases, using the key words: "massage", "myofascial release", "acupressure", "recovery", and "warm up" combined with "exercise", "exercise-induced muscle damage", "sport", "immunology", and lymphocytes" independently. Only controlled studies published between 1970 and 2012 were selected, with no restrictions regarding publication language. The CONSORT Declaration was applied to assess the quality of the selected studies.

Results: The initial search identified 739 publications in the databases, of which only 5 met the review inclusion criteria. A positive relationship between immunological recovery and post-exercise massage was reported by some of these studies but not by others.

Conclusion: There is preliminary evidence that massage may modulate immune parameters when applied after exercise, but more research is needed to confirm this possibility.

Nutrition

Knowlden AP, Hackman CL, Sharma M.

Systematic Review of Dietary Interventions Targeting Sleep Behavior. The Journal of Alternative and Complementary Medicine 2016, 22(5): 349-362. doi:10.1089/acm.2015.0238

Objectives: Nearly 9 million Americans use prescription sleep aids to induce or maintain sleep; however, the long-term effects of these medications are unknown. Considering the number of individuals reporting insufficient sleep, nonpharmacologic methods for improving sleep are needed.

Design: A systematic review of published studies was conducted to determine the efficacy of nutritional intake as a modality for improving sleep behavior. Inclusion criteria for the review were interventions (both in vivo and in natura), using any quantitative design, employing a dietary intervention as the primary treatment variable, targeting sleep behavior, in nonclinical human populations age 18–50 years.

Results: A total of 21 studies (17 in vivo and 4 in natura) met the inclusion criteria and were included in the systematic review.

Conclusions: The evidence for nutrition as treatment modality for improving

sleep is mixed. Nearly half of the in vivo trials suggested a significant change in a primary sleep variable of interest. However, a majority of these trials relied on small sample sizes of healthy sleepers and manipulated nutrition in an acute fashion. Among the in natura studies, macronutrient composition appeared to have no effect. However, the small number of studies mainly recruited healthy sleepers, and most had limited control of the diet of participants.

Jo S-H, Cho C-Y, Lee J-Y, Ha K-S, Kwon Y-I, Apostolidis E.

In vitro and in vivo reduction of post-prandial blood glucose levels by ethyl alcohol and water Zingiber mioga extracts through the inhibition of carbohydrate hydrolyzing enzymes. BMC Complementary and Alternative Medicine. DOI: 10.1186/s12906-016-1090-4

Background: Type 2 diabetes is a serious problem for developed and developing countries. Prevention of prediabetes progression to type 2 diabetes with the use of natural products appears to be a cost-effective solution. Zingiber mioga has been used as a traditional food in Asia. Recent research has reported the potential health benefits ofZingiber mioga, but the blood glucose reducing effect has not been yet evaluated.

Methods: In this study Zingiber mioga extracts (water and ethanol) were investigated for their anti-hyperglycemic and antioxidant potential using both in vitro and animal models. The in vitro study evaluated the total phenolic content, the oxygen radical absorbance capacity (ORAC) and the inhibitory effect against carbohydrate hydrolyzing enzymes (porcine pancreatic α-amylase and rat intestinal sucrase and maltase) of both Zingiber mioga extracts. Also, the extracts were evaluated for their in vivo post-prandial blood glucose reducing effect using SD rat anddb/db mice models.

Results: Our findings suggest that the ethanol extract of Zingiber mioga (ZME) exhibited the higher sucrase and maltase inhibitory activity (IC50, 3.50 and 3.13 mg/mL) and moderate α-amylase inhibitory activity (IC50, >10 mg/mL). Additionally, ZME exhibited potent peroxyl radical scavenging linked antioxidant activity (0.53/TE 1 μM). The in vivo study using SD rat and db/db mice models also showed that ZME reduces postprandial increases of blood glucose level after an oral administration of sucrose by possibly acting as an intestinal α-glucosidase inhibitor (ZME 0.1 g/kg 55.61 ± 13.24 mg/dL)

Conclusion: The results indicate that Zingiber mioga extracts exhibited significant in vitro α-glucosidase inhibition and antioxidant activity. Additionally, the tested extracts demonstrated in vivo anti-hyperglycemic effects using SD rat and db/db mice models. Our findings provide a strong rationale for the further evaluation of Zingiber mioga for the potential to contribute as a useful dietary strategy to manage postprandial hyperglycemia.

Spirituality and Health

Rickhi B, Kania-Richmond A, Moritz S, Cohen J, Paccagnan P, Dennis C, Liu M, Malhotra S, Steele P, Toews J.

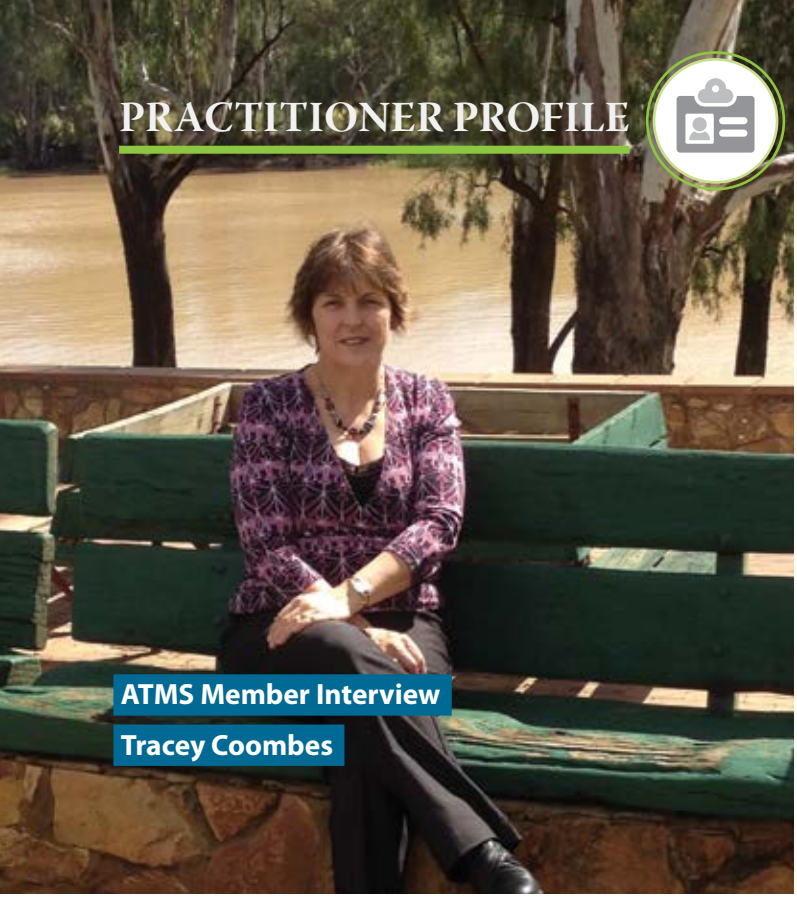
Evaluation of a spirituality informed e-mental health tool as an intervention for major depressive disorder in adolescents and young adults – a randomized controlled pilot trial. BMC Complementary and Alternative Medicine 2016. DOI: 10.1186/s12906-015-0968-x

Background: Depression in adolescents and young adults is a major mental health condition that requires attention. Research suggests that approaches that include spiritual concepts and are delivered through an online platform are a potentially beneficial approach to treating/managing depression in this population. The purpose of this study was to evaluate the effectiveness of an 8-week online spirituality informed e-mental health intervention (the LEAP Project) on depression severity, and secondary outcomes of spiritual well-being and self-concept, in adolescents and young adults with major depressive disorder of mild to moderate severity.

Methods: A parallel group, randomized, waitlist controlled, assessor-blinded clinical pilot trial was conducted in Calgary, Alberta, Canada. The sample of 62 participants with major depressive disorder (DSM-IV-TR) was defined by two age subgroups: adolescents (ages 13 to 18 years; n = 31) and young adults (ages 19 to 24 years; n = 31). Participants in each age subgroup were randomized into the study arm (intervention initiated upon enrolment) or the waitlist control arm (intervention initiated after an 8-week wait period). Comparisons were made between the study and waitlist control arms at week 8 (the point where study arm had completed the intervention and the waitlist control arm had not) and within each arm at four time points over 24-week follow-up period.

Results: At baseline, there was no statistical difference between study and waitlist participants for both age subgroups for all three outcomes of interest. After the intervention, depression severity was significantly reduced; comparison across arms at week 8 and over time within each arm and both age subgroups. Spiritual well-being changes were not significant, with the exception of an improvement over time for the younger participants in the study arm ($p = 0.01$ at week 16 and $p = 0.0305$ at week 24). Self-concept improved significantly for younger participants immediately after the intervention ($p = 0.045$ comparison across arms at week 8; $p = 0.0175$ in the waitlist control arm) and over time in the study arm ($p = 0.0025$ at week 16). In the older participants, change was minimal, with the exception of a significant improvement in one of six factors (vulnerability) in study arm over time ($p = 0.025$ at week 24).

Conclusions: The results of the LEAP Project pilot trial suggest that it is an effective, online intervention for youth ages 13 to 24 with mild to moderate major depressive disorder with various life situations and in a limited way on spiritual well-being and self-concept.



PRACTITIONER PROFILE

ATMS Member Interview

Tracey Coombes

Which modality(ies) do you practice?

I am a Rosemond Muscle Neurology Therapy Practitioner and Remedial Massage Therapist. I also practise Lomi Lomi Heartworks Massage. I am currently upgrading my qualifications to the Diploma of Remedial Massage through the School of Integrated Body Therapy in Charmhaven. I also continue to upskill through the CPE program, books and webinars. The webinars I find extremely beneficial, not just on content but the additional benefits of saving on travel costs and time away from home and work.

How long have you been in practice?

I have been in practice since 2007 after completing my Diploma of Rosemond Muscle Neurology Therapy, with Rosemary and Ray Mullen at the Rosemond Academy in Sawtell, NSW. After completing my training I set up a part-time practice working from home in the Queensland outback town of St George. My practice has remained part-time as I have continued to work a full time position in administration, mainly due to a change in my relationship. My original plan was to take the show on the road and massage my way around Australia.

Major influences on your career?

Rosemary Mullen and the Rosemond Academy would be the biggest influence on my career. In 2005 I was travelling from St George to Coffs Harbour to meet up with my partner at the completion of the Queensland Endeavour car rally. I decided that while I was away I was going to have a massage, for at the time we only had someone who travelled into St George once a month. Whenever possible I was having Bowen and massage therapy. My inner self was searching for something more. I went online and started searching the yellow pages for a massage therapist in Coffs Harbour. I found 62. Now, how do I choose? I kept going over the list and asking the question, "Who do I choose?" Rosemary and the Rosemond Academy were the answer I received, so I phoned up and made a booking. Being the early bird that I am, and not wanting to lose any of my precious massage time by arriving late (I have a penchant for taking the wrong turn), I arrived, along with my daughter Holly, around half an hour early for my appointment. It just happened to be the weekend Rosemary was conducting classes and we were both invited to sit in on the course while we waited. I was so intrigued that I lost track of time and almost missed my appointment. The therapist came out to tell Rosemary that I had failed to show up. Holly, who was then in year 12, stayed in the class while I had my treatment. By the time I came out, Holly was chatting to Rosemary and began babbling like a brook about everything she had learned. She was hooked. We were both very impressed with what the other students and practitioners had to say about the things they were learning and experiencing through the Rosemond MNT. The releases that I experienced myself after only one treatment with Rosemond told me that I had found what it was I was searching for. Holly commenced the course in 2006 and I started in 2007. I had already become interested in natural medicine, essential oils and natural therapies. This seemed like the next logical step. I was dedicated, travelling seven to eight hours just to attend classes. Before this course the only massage I had ever done was on my husband's hand after he damaged the tendons in his fingers in a farm accident. We could not afford to travel back and forth to town for treatment, so I became the home therapist.

The second major influence in my massage career was becoming a single mum in 2010 at age 45. I had to hold onto the security of a permanent income, especially as the area had been in drought for ten years, and there was no money around for so-called pleasures, so a fulltime career as a Rosemond and Remedial Massage Therapist was put on hold.

What do you most like about being a natural medicine practitioner?

The single most rewarding thing about being a natural medicine practitioner is being able to help clients to wellness without drugs. To assist them to use their own natural self-healing systems, to effect change not just on a physical level but on the mental, emotional and spiritual levels as well. To see the changes to people's lives, especially those who have been in the medical system for a long time without seeing results. Working as a natural therapist there is always an exchange of energy and this helps both the client and the practitioner. Every client we work with has something to teach us, helping us as practitioners to grow and develop. There is so much to the human body and natural therapies that there is always something new to learn, something new to add to our tool box.

The hardest part about being a natural therapist is that you can't help everyone.

What advice would you give to a new practitioner starting out?

I think the best piece of advice that I could give a new practitioner is to experience for yourself first hand the modalities that you wish to study. Try them with different practitioners and find yourself a mentor. Determine what it is you wish to gain from a career as a natural therapist and what it is you want to give your clients. Study takes time and money, so find something that can create income and allows flexible hours, such as relaxation massage or Lomi Lomi Heartworks Massage. These two types of massage courses allow you to earn income immediately as well as help to build skills that will benefit you and your future business. Look for skills that you can add to or complement your chosen modality. The more you learn and experience, the better practitioner you will become. "Knowledge is no burden to carry. It will follow you wherever you go." Don't think of other therapists as competition. We are all on the same team, with a

common goal for natural health. Trust in yourself and your abilities and learn who you are and how to sell yourself.

What are your future ambitions?

I would like to stay in natural therapy as long as I can and learn as much as I can. I have my next course already to go as soon as I have completed my Diploma of Remedial Massage. There is so much more out there that I still want to learn and experience, such as Australian Bush medicine and growing the plants that produce them. I have had my interest in hypno-birthing sparked, so another avenue to look into. I am interested in the physical, emotional and spiritual aspects of the body and the balance of all three to create oneness, and how an imbalance invites sickness.

I would like to see Health Care Centres and hospitals everywhere inlude natural therapies and have doctors that promote natural health.

Once a Toastmaster, I would love to get back into public speaking.

Anything else you want to add?

I'm not big on government and its policies. I vote for the day we have a non-corrupt political system that is not driven by greed, where policies are made for the good of the country and its people, and not for the rich and powerful organisations that influence our government and its decisions.

Funds should be used to create a Wellness industry, not to support and maintain a sickness industry. I would like to see natural therapies supported in the same way that the current medical system is. I believe that real food should be more affordable, and GMO foods and foods containing additives and chemicals should have a health tax applied to help the medical system cope with the rising cost of the long-term effects of these foods. I am excited about the new Australia Health Party. I like to think that this party will take a stance against practices such as fracking, that are creating "good wealth" not "good health". I'm not the kind of person to get involved in the political arena, but I wish all those who do every success. I would like to see all the natural therapy societies get behind this party. United we stand, regardless of our modality. We all have a common goal for health and wellbeing for every single person. I'm a natural therapist and I vote.

What are you thoughts on the status and/or role of natural medicine in the broad context of Australian health care?

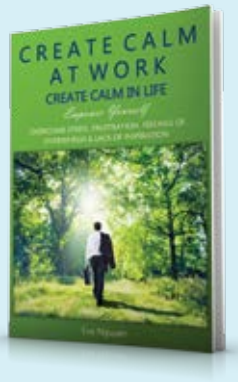
Natural medicine and manual therapies have an ever-increasing presence in mainstream health within the Australian Health Care system. As more people become aware of the benefits of natural health care they are slowly swinging away from the Western medicine system. Many are learning that the Western system is a sickness industry, not a wellness industry. In my words, "I was sick of being sick".

The cost of natural health care is prohibitive to a large number of people, not only the cost of the medicine or treatment but the travel involved to attend. Many are now leaving their medical benefits funds as they no longer meet their needs, opting to pay for their own natural health care.

I believe that there is a place for everyone in the medical system, be it Western or natural and that the goal of everyone should be the complete health and wellbeing of the individual, to treat the cause, not focus on the symptoms. To treat the symptoms is like spraying water on the leaves of a wilting plant, although the roots have been undermined by pests and disease.

Be Happy, Be Healthy – One body, One Life

BOOK REVIEW



Create Calm at Work, Create Calm in Life

Reviewed by Stephen Clarke

Eve Nguyen. Self-publication
ISBN 978-0-9944047-1-8
Price. AUD 47.27
Can be purchased at **www.createmorecalm.com** (soft cover $22) or Amazon (including a Kindle version)

As the title of this well-organised and thoughtful book suggests, it has twin but inseparable focuses: mastery of calm both in the particular world of work and in general living. The author recounts a finding of a 2013 study showing that one in seven Australians reported severe symptoms of depression, seven in ten suffered physical symptoms of stress, and in one in five these symptoms were severe.

Many practitioners in all fields of therapies are therefore likely to have patients in one of these categories, and Eve Nguyen's book should be a valuable resource for such patients (and, let's admit it, perhaps for a few practitioners too). For example, this reviewer was particularly pleased that it clearly sets out five steps for dealing with procrastination, that constant handmaid to stress. Eve explores numerous other domains of stress: in Chapter Three she identifies features of workplaces that induce stress and explains the value of creating boundaries between the self at work and these stressful features (which may well present in the form of colleagues).

There are many other very constructive approaches to both physiological and emotional parameters to creating calm. Eve espouses the values and practices of forgiving and apologising (both to oneself and others), meditation, gratitude and compassion, and cites research that supports such claims (practising gratitude, for example, has been associated with enhanced immune function, sleep and blood pressure.) They serve both staff retention and nurturing friendship. Therapists might counsel patients in the value of experiencing the natural world outside the office (or wherever relationships may have become stress-inducing): studies have shown that a walk in the park is better at restoring inner calm than a coffee break. Even looking at pictures of natural spaces induces calm and improves cognitive performance – an implication for the décor of the clinic?

Eve is a clinical nutritionist, and expertly examines the contribution appropriate nutrition can make to stress reduction. For example, the serotonin manufactured by a low-protein, carbohydrate-dense diet has been shown to reduce hyperactivity, anxiety, insomnia and depression, and Eve is a strong advocate of this dietary approach.

Among other topics examined in this book are the roles of exercise, music and good sleep in creating inner calm. Counsellors and any therapist with patients dealing with stress should find it of considerable value in their practices and perhaps in their own lives.

Health Funds

ATMS is a 'professional organisation' within the meaning of section 10 of the Private Health Insurance Accreditation Rules 2011. This potentially allows ATMS accredited members to be recognised as approved providers by the various private health funds. Approved health fund provider status is, however, subject to each individual health fund's eligibility requirements.

Consequently, membership of ATMS does not automatically guarantee provider status with all health funds. Please also note that several health funds do not recognise courses done substantially by distance education, or qualifications obtained overseas.

Additional requirements for recognition as a provider by health funds include:

- Clinic Address (Full Street Address must be provided – Please note that some health funds may list your clinic address on their public websites)
- Current Senior First Aid
- Current Professional Indemnity Insurance (some health funds require specific minimum cover amounts. Please refer to the individual health fund terms and conditions for further information)
- Compliance with the ATMS Continuing Education Policy along with any additional continuing education requirements stipulated by the health fund
- Current National Registration (where applicable)
- Compliance with the Terms and Conditions of Provider Status with the individual health funds.

ATMS must have current evidence of your first aid and insurance on file at all times.

When you join or rejoin ATMS, or when you upgrade your qualifications, you will need to fill out the ATMS Health Fund Application and Declaration Form available on the ATMS website. Once this is received, along with any other required information for health fund eligibility assessment, details of eligible members are sent to the applicable health funds on their next available listing. The ATMS office will also forward your change of details, including clinic address details to your approved health funds on their next available list. Please note that the health funds can take up to one month to process new providers and change of details as we are only one of many health professions that they deal with.

Lapsed membership, insurance or first aid will result in a member being removed from the health funds list. As health funds change their provider eligibility requirements from time to time, upgrading qualifications may be necessary to be re-instated with some health funds.

TERMS AND CONDITIONS OF PROVIDER STATUS

Many of the Terms and Conditions of Provider Status for the individual health funds are located on the ATMS website. For the Terms and Conditions for the other health funds, it will be necessary to contact the health fund directly.

BEING A PROVIDER IMPLIES ACCEPTANCE OF THE TERMS AND CONDITIONS FOR THE HEALTH FUNDS.

Please note that whilst there is no law or regulation requiring patient clinical notes to be taken in English, many of the major health funds do require patient clinical notes to be taken in English. Failure to do this will be a breach of the Health Funds Terms and Conditions and may result in the practitioner being removed as a provider for that health fund.

For health funds to rebate on the services of Accredited members, it is important that a proper invoice be issued to patients. The information which must be included on an invoice is also listed on the ATMS website. It is ATMS policy that only Accredited members issue their own invoice. An Accredited member must never allow another practitioner, student or staff member to use their provider details, as this constitutes health fund fraud. Misrepresenting the service(s) provided on the invoice also constitutes health fund fraud. Health fund fraud is a criminal offence which may involve a police investigation and expulsion from the ATMS Register of Members.

It is of note that the health funds require practitioners to be in private practice. Some health funds will not recognise claims where accommodation, facilities or services are provided or subsidised by another party such as a public hospital or publicly funded facility. Rebates are only claimable for the face to face consultation (not the medicines or remedies); however this does not extend to mobile work including markets, corporate or hotels. Home visits are eligible for rebates.

ONLINE OR PHONE CONSULTATIONS ARE NOT RECOGNISED FOR HEALTH FUND REBATES.

Please be aware that whilst a health fund may indicate that they provide a rebate for specific modalities, this rebate may only be claimable if the client has the appropriate level of health cover with that fund and has not exceeded any limits on how much they are eligible to claim back over a certain period of time.

Australian Health Management (AHM)

Names of eligible ATMS members will be sent to AHM each month. AHM's eligibility requirements are listed on the ATMS website **www.atms.com.au.** ATMS members can check their eligibility by checking the ATMS website or by contacting the ATMS Office on 1800 456 855. Your ATMS Number will be your provider number, unless you wish to have online claiming. You will then need to contact AHM directly for the new provider number.

Australian Regional Health Group (ARHG)

This group consists of the following health funds:

- ACA Health Benefits Fund Ltd
- Cessnock District Health Benefits Fund
- CUA Health Limited^
- Defence Health
- HBF (Including GMF Health)#
- GMHBA (Including Frank Health Fund)
- Health.com.au
- Health Care Insurance Limited#
- HIF WA
- Latrobe Health Services (Federation Health)
- Mildura District Hospital Fund
- Navy Health Fund
- Onemedifund
- Peoplecare Health Insurance
- Phoenix Health Fund
- Police Health Fund
- Queensland Country Health Fund Ltd#
- Railway and Transport Fund Ltd#
- St Luke's Health#
- Teachers Health#
- Teachers Union Health#
- Transport Health#
- Westfund

Details of eligible members, including member updates are sent to ARHG by ATMS monthly. The details sent to ARHG are your name, address, telephone and accredited discipline(s). These details will appear on the ARHG websites. If you do not wish your details to be sent to ARHG, please advise the ATMS office on 1800 456 855.

The ARHG provider number is based on your ATMS number with additional lettering. To work out your ARHG provider number please follow these steps:

1 Add the letters AT to the front of your ATMS member number

2 If your ATMS number has five digits go to step 3. If it has two, three or four digits, you need to add enough zeros to the front to make it a five digit number (e.g. 123 becomes 00123).

3 Add the letter that corresponds to your accredited modality at the end of the provider number;

A ACUPUNCTURE
C CHINESE HERBAL MEDICINE
H HOMOEOPATHY
N NATUROPATHY
O AROMATHERAPY
W WESTERN HERBAL MEDICINE

If ATMS member 123 is accredited in Western herbal medicine, the ARHG provider number will be AT00123W.

4 If you are accredited in several modalities, you will need a different provider number for each modality (e.g. if ATMS member 123 is accredited for Western Herbal Medicine and Aromatherapy, the ARHG provider numbers are AT00123W and AT00123O.

ARHG - REMEDIAL MASSAGE AND CHINESE MASSAGE

Remedial Massage and Chinese Massage therapists who graduated after March 2002 must hold a Certificate IV or higher from a registered training organisation.

Members who are accredited for Remedial Massage or Chinese Massage, will need to use the following letters.

M MASSAGE THERAPY
R REMEDIAL THERAPY

The letter at the end of your provider number will depend on your qualification, not the modality in which you hold accreditation*. All members who meet the ARHG eligibility requirements, who hold a Diploma of Remedial HLT50302 or HLT50307 or a Diploma of Chinese Remedial Massage HLT50102, HLT50107 or HLT50112 will be able to use both the 'M' and 'R' letters. It is recommended to use the 'R' as often as possible, but as not all health funds under ARHG cover 'Remedial Therapy', it will be necessary to use the 'M' at the end of the provider number for those funds only. All other eligible Remedial Massage Therapists who do not hold the Diploma of Remedial HLT50302 or HLT50307 or a Diploma of Chinese Remedial Massage HLT50102, HLT50107 or HLT50112 are required to use the 'M' at the end of their provider number.

**Members accredited for Remedial Therapies and approved for ARHG for this modality under their previous criteria will continue to be recognised under Remedial Therapy and will be fine to use the 'R' in their provider number. Should members in this situation lapse membership, first aid or insurance etc they will then be required to meet the current ARHG criteria.*

CUA HEALTH– BOWEN THERAPY, KINESIOLOGY AND REFLEXOLOGY

^ For the additional modalities that CUA Health covers that are not listed above including Bowen Therapy, Kinesiology and Reflexology, eligible providers will need to use the following to work out your provider number:

1 Add the letters AT which will be the start of your provider number

2 Then add the letter that corresponds to your accredited modality;

B BOWEN THERAPY
K KINESIOLOGY
R REFLEXOLOGY

3 Then add your ATMS Number. If your ATMS number has five digits your provider number will now be complete. If it has two, three or four digits, you need to add enough zeros to the front to make it a five digit number (e.g. 123 becomes 00123).

If ATMS member 123 is accredited in Kinesiology, the CUA provider number will be ATK00123.

4 If you are accredited in several modalities, you will need a different provider number for each modality (e.g. if ATMS member 123 is accredited for Kinesiology and Reflexology, the CUA provider numbers are ATK00123 and ATR00123.

RESERVE BANK HEALTH SOCIETY –REFLEXOLOGY

^ For the additional modalities that Reserve Bank Health Society covers that are not listed above including Reflexology, eligible providers will need to use the following to work out your provider number:

1 Add the letters AT which will be the start of your provider number
2 Then add the letter that corresponds to your accredited modality;

R REFLEXOLOGY

3 Then add your ATMS Number. If your ATMS number has five digits your provider number will now be complete. If it has two, three or four digits, you need to add enough zeros to the front to make it a five digit number (e.g. 123 becomes 00123).

If ATMS member 123 is accredited in Reflexology, the Reserve Bank Health Society provider number will be ATR00123.

TEACHERS HEALTH– BOWEN THERAPY, KINESIOLOGY, REFLEXOLOGY AND SHIATSU

^ For the additional modalities that Teachers Health covers that are not listed above including Bowen Therapy, Kinesiology, Reflexology and Shiatsu, eligible providers will need to use the following to work out your provider number:

1 Add the letters AT which will be the start of your provider number
2 Then add the letter that corresponds to your accredited modality;

B BOWEN THERAPY
K KINESIOLOGY
R REFLEXOLOGY
S SHIATSU

3 Then add your ATMS Number. If your ATMS number has five digits your provider number will now be complete. If it has two, three or four digits, you need to add enough zeros to the front to make it a five digit number (e.g. 123 becomes 00123).

If ATMS member 123 is accredited in Kinesiology, the Teachers Health provider number will be ATK00123.

4 If you are accredited in several modalities, you will need a different provider number for each modality (e.g. if ATMS member 123 is accredited for Kinesiology and Reflexology, the Teachers Health provider numbers are ATK00123 and ATR00123.

ADDITIONAL NOTE

For all modalities that these funds (HBF, GMF Health, Health Care Insurance Limited, Queensland Country Health Fund Ltd, Railway and Transport Fund Ltd, St Luke's Health, Teachers Union Health, Transport Health) cover that are not listed above including Bowen Therapy, Kinesiology, Nutrition and Reflexology, eligible providers will need to use their ATMS number. Please refer to the Health Fund Table.

Australian Unity

Names and details of eligible ATMS members will be sent to Australian Unity each month. ATMS members will need to contact Australian Unity on 1800 035 360 to register as a provider, after filling out the Australian Unity Application Form located on the ATMS website to activate their provider status. This only needs to happen the first time. The provider eligibility requirements for Australian Unity are located on the ATMS website **www.atms.com.au.** Your ATMS number can be used as your Provider Number, or you can contact Australian Unity for your Australian Unity generated Provider Number. Please note that Australian Unity requires Professional Indemnity Insurance (to at least $2 million) and Public Liability Insurance (to at least $10 million).

BUPA

Names and details of eligible ATMS members will be sent to BUPA on a weekly basis. The provider eligibility requirements for BUPA are located on the ATMS website **www.atms.com.au.** The Provider eligibility requirements include an IELTS test result of an overall Band 6 or higher for TCM qualifications completed in a language other than English. BUPA will generate a Provider Number after receiving the list of eligible practitioners. BUPA advises ATMS of your Provider Number and ATMS will then advise those members directly.

CBHS Health Fund Limited

Names and details of eligible ATMS members will be sent to CBHS each month. The details sent to CBHS are your name, address, telephone and accredited discipline(s). These details will appear on the CBHS website. If you do not want your details to be sent to CBHS, please advise the ATMS office on 1800 456 855. The provider eligibility requirements for CBHS are located on the ATMS website **www.atms.com.au.** Your ATMS number will be your Provider Number.

Doctors Health Fund

Names and details of eligible ATMS members will be sent to Doctors Health Fund each month. Please note that Doctors Health Fund only covers Remedial Massage. The provider eligibility requirements for Doctors Health Fund are located on the ATMS website **www.atms.com.au.** Your ATMS number will be your Provider Number.

Grand United Corporate

To register with Grand United Corporate, please apply directly to Grand United on 1800 249 966.

HCF

Names and details of eligible ATMS members will be sent to HCF on a weekly basis. The provider eligibility requirements for HCF are located on the ATMS website **www.atms.com.au.** HCF do not issue provider numbers nor use your ATMS number as your provider number. They do however require your ATMS membership details, including your ATMS number, to be clearly indicated on all invoices and receipts issued.

Health Partners

Names and details of eligible ATMS members will be sent to Health Partners each month. The provider eligibility

requirements for Health Partners are located on the ATMS website **www.atms.com.au.** Health Partners uses the same Provider number system as ARHG for certain modalities and the ATMS number or other modalities.

The provider number is based on your ATMS number with additional lettering. To work out your Health Partners provider number please follow these steps:

1 Add the letters AT to the front of your ATMS member number
2 If your ATMS number has five digits go to step 3. If it has two, three or four digits, you need to add enough zeros to the front to make it a five digit number (e.g. 123 becomes 00123). If ATMS member 123 is accredited for either Acupuncture, Chinese Herbal Medicine, Homoeopathy, Remedial Massage, Naturopathy, Shiatsu or Western Herbal Medicine, the Health Partners provider number will be AT00123.

For all other modalities that Health Partners cover that are not listed above including Alexander Technique, Bowen Therapy, Kinesiology and Reflexology, eligible providers will need to use their ATMS number.

Medibank Private

Names and details of eligible ATMS members will be sent to Medibank Private on a monthly basis. The provider eligibility requirements for Medibank Private are located on the ATMS website **www.atms.com.au.** Medibank Private requires Clinical Records to be taken in English. Medibank Private generates Provider Numbers after receiving the list of eligible practitioners from ATMS. Medibank Private sends these provider numbers directly to ATMS. ATMS will then forward this information to the provider. Please note that Medibank has placed a restriction of up to a maximum 3 clinic addresses that will be recognised for Remedial Massage. There are no restrictions on the number of recognised clinics for other modalities.

NIB

Names and details of eligible ATMS members will be sent to NIB on a weekly basis. The provider eligibility requirements for NIB are located on the ATMS website **www.atms.com.au.** Your ATMS Number will be your provider number, unless your client wishes to claim online. Your client will need to contact NIB directly or search by your surname and postcode on the NIB website **www.nib.com.au** for your provider number for online claiming purposes.

HICAPS

ATMS members who wish to activate these facilities need to register directly with HICAPS. HICAPS do not cover all health funds and modalities. Please go to **www.hicaps.com.au** or call 1800 805 780 for further information.

HEALTH FUND UPDATE

Health Fund	Acupuncture	Alexander Technique (No longer ATMS Accredited)	Aromatherapy	Bowen Therapy	Chinese Herbal Medicine	Counselling	Deep Tissue Massage (No longer ATMS Accredited)	Herbal Medicine	Homoeopathy	Hypnotherapy	Iridology (No longer ATMS Accredited)	Kinesiology	Lymphatic Drainage	Naturopathy	Nutrition	Reflexology	Remedial Massage (Certificate IV)	Remedial Massage (HLT Diploma or higher level qualification)	Remedial Therapies (No longer ATMS Accredited)	Rolfing (No longer ATMS Accredited)	Shiatsu	Sports Massage (No longer ATMS Accredited)	Traditional Chinese Remedial Massage (Certificate IV)	Traditional Chinese Remedial Massage (HLT Diploma or higher level qualification)
Australian Health Management	✓	✓	✓	✓	✓			✓	✓			✓		✓	✓	✓		✓			✓			
Australian Regional Health Group																								
ACA Health Benefits Fund	✓				✓			✓	✓					✓			✓	✓	◆				●	●
Cessnock District Health	✓		✓		✓			✓	✓					✓			✓	✓	◆				●	●
CUA Health *(Credicare)*	✓		✓	✓					✓			✓		✓		✓		✓	◆				●	
Defence Health Partners	✓		✓		✓			✓	✓					✓				✓	◆				●	●
GMHBA *(Geelong Medical)*	✓								✓					✓			✓	✓	◆				●	●
Frank Health Fund	✓								✓					✓			✓	✓					●	●
Health Care Insurance Limited	✓		✓	✓	✓			✓	✓					✓			✓	✓	◆				●	●
HBF	✓		✓		✓			✓	✓					✓			✓	✓	◆				●	●
GMF	✓				✓				✓					✓		✓	✓						●	
Health.com.au	✓				✓			✓	✓					✓			✓	✓	◆				●	●
HIF *(Health Insurance Fund of WA)*	✓				✓				✓					✓			✓	✓	◆				●	●
Latrobe Health Services	✓								✓					✓			✓	✓	◆				●	●
MDHF (Mildura District Hospital Fund)	✓													✓			✓						●	
Navy Health Fund	✓		✓		✓			✓	✓					✓			✓	✓	◆				●	●
Onemedifund	✓				✓			✓	✓					✓			✓	✓	◆				●	●
Peoplecare Health Insurance	✓				✓			✓	✓					✓			✓	✓	◆				●	●
Phoenix Health Fund	✓		✓		✓			✓	✓					✓			✓	✓	◆				●	●
Police Health Fund	✓		✓		✓			✓	✓					✓			✓	✓	◆				●	●
Queensland Country Health	✓			✓					✓					✓			✓	✓						●
Railway and Transport	✓				✓			✓	✓					✓			✓	✓	◆				●	●
Reserve Bank Health Society	✓				✓			✓	✓					✓		✓	✓	✓	◆				●	●
St Lukes	✓				✓			✓	✓					✓			✓	✓	◆				●	●
Teachers Health	✓		✓	✓	✓			✓	✓			✓		✓		✓	✓	✓	◆		✓		●	●
Teachers Union Health	✓		✓						✓					✓			✓	✓	◆				●	●
Transport Health	✓		✓	✓	✓			✓	✓					✓			✓	✓	◆				●	●
Westfund	✓		✓		✓				✓					✓			✓	✓	◆				●	●
Australian Unity	✓	✓	✓	✓	✓			✓	✓	✓		✓		✓	✓	✓		✓			✓			
BUPA	✓	✓	✓	✓	✓			✓	✓			✓		✓		✓		✓			✓			✓
CBHS Health Fund	✓		✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Doctors Health Fund																		✓						
*GU Health (Grand United)**	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	✓	✓		✓			✓		✓	✓
Health Partners	✓	✓		✓	✓			✓	✓			✓		✓		✓	✓	✓			✓			
HCF	✓		✓		✓			✓	✓			✓		✓	✓	✓		✓			✓	✓		
Medibank Private	✓		✓	✓	✓	✓		✓	✓	✓		✓		✓	✓	✓		✓			✓			✓
NIB	✓			✓	✓			✓	✓					✓	✓			✓			✓			✓

✓ *Therapy covered by Fund*

* *Need to Apply directly to Fund*

Please note that this table is only a guide to show what funds cover ATMS accredited modalities. If the modality that you are accredited for is not listed, this means that no health fund covers the modality. The only exceptions are Chiropractic and Osteopathy. ATMS accreditation in a modality does not guarantee provider status as all funds have their individual set of strict eligibility requirements. Please see our website www.atms.com.au or contact our office for current requirements. Rebates do not usually cover medicines, only face to face consultations. For further rebate terms and conditions, patients should contact their health fund. Policies may change without prior notice.

◆ ARHG are only recognising Remedial Therapists who are accredited for this modality and were approved for ARHG Provider status under their old criteria.

● ARHG are recognising Chinese Massage, however the eligibility requirements and provider number is exactly the same as Remedial Massage. See ARHG Health Fund Information for further information.

Let's continue to work together towards a stronger profession

By BioMedica Nutraceuticals

A profession such as ours has a tendency to attract caring, giving and like-minded individuals, which is of great benefit to our patients, and also to our profession as a whole.

A great example of this is practitioners actively giving back to their profession, by offering their own private mentoring services in order to help support students, graduates and existing practitioners to increase their clinical confidence.

This can only be a good thing for our profession, as the more capable practitioners there are in practice the more weight our profession carries in government and society overall.

In an effort to support the mentoring offerings and opportunities available, BioMedica is sponsoring a new program to encourage practitioners to accept graduates for in-clinic observation and mentoring, providing a pathway to enable practitioners to give back to their community and support a culture of greater professionalism in natural medicine. This program now forms part of a community of mentors, who see it as part of their role to contribute to the greater good and strength of natural medicine.

Once such practitioner is naturopath Kira Sutherland: *"I have lectured or been a supervisor at student clinic in Naturopathy/Nutrition for over 15 years and I love the education and mentoring aspect of teaching. I am a practitioner who specialises in sports nutrition and thus have often had many students or new practitioners wanting mentoring from me. To mentor one-on-one, which I do on occasion, is great fun but around a year ago I decided to create on online/ group mentoring class. I have ten students per group and we meet once a month over six months in a live, case-based discussion/lecture. I am loving the process of mentoring and also creating connection between the students. Having been in practice for 20 years now it is a great way to give back to my industry as well as helping practitioners become aware of the difference between clients needing general nutrition and sports nutrition."*

Mentoring is known to develop professional attributes and help facilitate socialisation into a profession, with its benefits reported in the literature.1 At BioMedica we very much see it as part of our role to invest in the future growth of our profession. One way of achieving this is by increasing the number of graduates who go on to become confident, experienced and competent practitioners.

Others who are joining us in this aim include highly experienced and well known practitioners such as Rachel Arthur, who has been a leader in this area, offering both individual and group mentoring programs since 2011. These live interactive sessions work through case studies, solving real clinical problems presented by the mentees. Rachel offers varying levels of mentoring, with some geared towards practitioners who are either just getting back into consulting after a break or have just graduated, while other programs take the approach of supporting practitioners to strengthen their clinical skills and knowledge, providing comprehensive support for all aspects of case analysis, client management and treatment. Thanks to their popularity, all group mentee positions have been taken for the year but opportunities to join the program for 2017 will be offered again before the end of 2016.

"Having delivered education to naturopaths and integrative health professionals for over ten years in different formats, from classrooms to conferences and everything in between, the superior outcomes I have seen in practitioners undertaking regular mentoring have been striking. Based on my cumulative experience, I would have to say that mentoring offers practitioners the most accelerated growth as clinicians and as a result it has been absolutely thrilling for me to be a part of so many people's exciting journeys. For example, some of my longest standing mentees are now part of our 'Invitational' group and, where just a couple of years ago I felt very much the teacher, now these sessions feel more like talking with a group of peers who are all on the same level as me, and the learning goes both ways!" Rachel Arthur, naturopath.

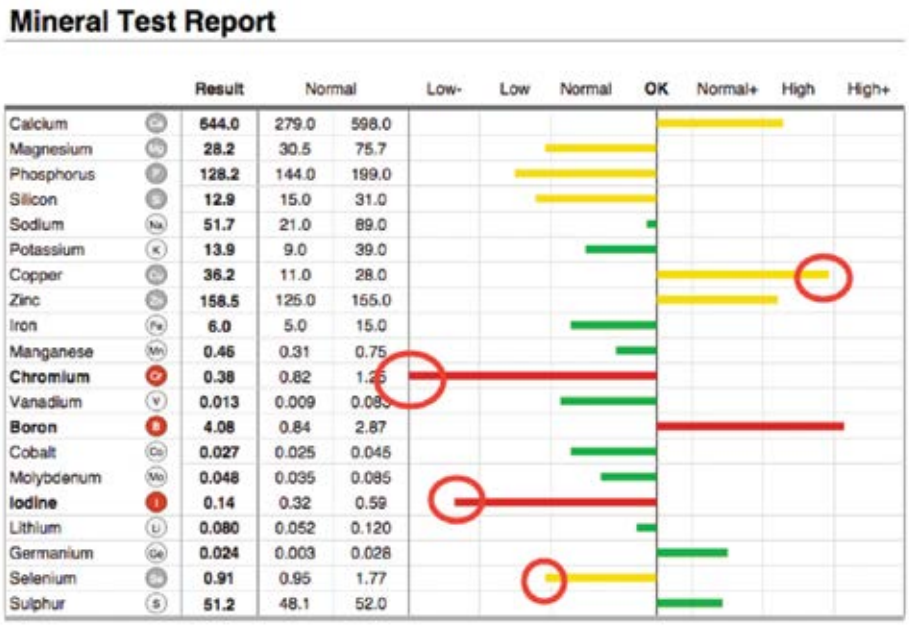
Mentoring is a genuinely rewarding and worthwhile experience, and can be a terrific way to grow your business whilst assisting in the valuable education of your mentee. To make the process as simple and effective as possible BioMedica have prepared and made available all of the necessary documentation and processes for both mentors and mentees. To find out more, including eligibility requirements and practitioner benefits, please visit **www.biomedica.com.au**

The Thyroid Epidemic

By Jon Gamble | ATMS 1190

How many patients do you see with fatigue, weight gain and obesity, irregular periods, brain fog, hair loss, fibromyalgia, or joint pain? All of these symptoms can be attributed to a single condition - hypothyroidism, but chances are, your patient has had a 'normal' Thyroid Stimulating Hormone (TSH) blood test.

Before the 1970s thyroid conditions were diagnosed from history, the above presenting symptoms, and tendon reflex tests. However, since then the TSH has become the key diagnostic test for thyroid disease. Since less than twenty percent of thyroxin is found in blood, this narrow diagnostic aperture is causing large numbers of patients, with an array of endocrine-related symptoms, to remain undiagnosed.



Consider this common scenario: Jane, a 30 year old woman with two children, despite being on a low carb diet, is obese, has heavy and irregular periods, hair loss and fatigue. Her TSH is 'normal' and her doctor tells her she needs to exercise more and eat less.

As natural therapists our treatments will be far more successful if we suspect a thyroid problem using the pre-1970s diagnostic criteria. When we see weight gain despite sensible diet; hair loss; foggy thinking; temperature sensitivity; fatigue, muscle cramps and pain; constipation, thinning hair and eyebrows, every practitioner should start thinking about hypothyroidism.

Jane has most of these symptoms, plus there is a family history of thyroid disease. In another ten years, her TSH may show hypothyroidism, but that's another ten years of suffering if she is not correctly diagnosed. Oligoscan readings show real pointers to thyroid disease - low chromium and iodine. Selenium and zinc are also essential minerals for normal thyroid function, so low readings can help point to this diagnosis.

Oligoscan tests take only a few minutes, so finding the underlying cause of certain clusters of symptoms is quick and efficient.

Specifically in Jane's case:

- High copper blocks zinc, interfering with thyroid hormone function
- Chromium deficiency causes insulin resistance, contributing to obesity
- Iodine deficiency directly relates to poor thyroid function
- Selenium deficiency aggravates hypothyroidism because it is essential for adequate T4 to T3 conversion, the active form of thyroxin.

This patient did not need to go on thyroid replacement therapy. Our treatment centred on restoring mineral deficiencies and removing her toxicities, one of which was high copper. Her fatigue improved, her weight slowly came down, her hair stopped falling out and her periods became normal.

For more information about using Oligoscan in clinic go to **www.oligoscan.net.au**

Clinical Orthopaedic Massage Therapy

By Dr. Joe Muscolino

Competent orthopaedic massage therapy requires that we possess assessment skills and the critical thinking necessary to apply them to form an accurate assessment of the client. Next, along with the critical thinking, we must have a tool box of treatment techniques that we can use to treat the client. There are four fundamental treatment approaches that form the foundation of most massage treatment techniques: hydrotherapy (heat and cold therapy), soft tissue manipulation strokes, stretching, and joint mobilization.

The first approach, hydrotherapy, is used to apply hot and/or cold therapy to the client.

The second approach is soft tissue manipulation, a broad term that can be used to incorporate most types of massage strokes. These include cross-fibre, compression, and deep stroking, to name a few. The benefits of each stroke vary depending on the condition being treated and the individual preferences of the client receiving the work. What is common to all these strokes is the introduction of pressure onto the client. Although deep pressure is not always the appropriate or best treatment option for every condition or every client, it is an extremely valuable tool for the clinical massage therapist.

The third fundamental approach is stretching, which is a critically important aspect of our massage session. Because it is most effective when the client's tissues are already warmed up, stretching is best performed after heat and/or after massage. This means that stretching is usually incorporated into the treatment toward the end of the session. Common to all stretching techniques is that soft tissues are lengthened.

The fourth fundamental treatment is joint mobilisation, which is rarely utilised by massage therapists. It is such a powerful and effective treatment tool, and it is important to point out that no thrust is introduced during joint mobilisation. It is always applied slowly and evenly.

As a rule, our treatment should always be specific and tailored to the client who is on the table; treatment should never be applied in a cookbook manner. However, it is generally wise to follow the following guidelines: when we are looking to loosen taut soft tissues (including tight musculature), use a combination of heat, massage, stretching, and joint mobilization. The best order to apply these techniques is heat and/or massage first, followed by stretching and then joint mobilisation.

If you do not currently use these four techniques you may want to consider adding them to your practice. However, as with all new techniques, it is best to become proficient with them before trying them out on your clients. Although these techniques can be learned from books, journal articles, and video, in-person hands-on workshops with personal attention by a skilled instructor is recommended for advanced stretching techniques. The addition of these tools to your therapeutic tool box will increase not only your therapeutic success, but the success of your practice as well!

Dr. Joe Muscolino has been a massage therapy educator over 25 years. He is author of 8 books in Anatomy and massage therapy. He will be travelling to Australia in July 2016 and teach Clinical Orthopedic Massage therapy workshops. More info at **www.terrarosa.com.au**

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Feel the difference, from AM to PM appointments you will look and feel fresh. … I designed your uniforms with a genuine desire to make a difference, aesthetically and practically.

Academy of Integrated Therapies (AOIT)

ACADEMY OF INTEGRATED THERAPIES

info@aoit.com.au | www.aoit.com.au | 07 3359 8523

About 15 years ago Neil Skilbeck, a Chiropractor and Osteopath made a valuable discovery integrating soft tissue and bones together. This has led to our course of Musculoskeletal Therapy (MST).
We believe in integrating knowledge as it leads to very powerful solutions such as we have demonstrated through our courses. We also provide CE workshops to fill in gaps in basic training of most body therapy courses.
These consist of foot corrections, nerve dynamics, limb neurology, axial and appendicular assessment and treatment and our specialty of pelvic mechanics.

BioMedica Nutraceuticals

BioMedica NUTRACEUTICALS

info@biomedica.com.au | www.biomedica.com.au | 1300 884 702

BioMedica is an Australian owned company dedicated to the research, development and production of high quality, low excipient and efficacious practitioner formulations. Our products are developed by practitioners for practitioners. As a 'Strictly Practitioner Only' company, BioMedica is strongly dedicated to preserving and enhancing the role of the holistic practitioner. Our products are only sold to practitioners in a clinical setting, this has been our long standing policy since our inception in 1998, and remains firmly in place to this day. We also aim to provide highly relevant technical education materials and seminars, with practical research and insights that can be immediately integrated into clinical practice.

The ATMS Products & Services Guide will appear in every issue of JATMS

The cost is **$150 for one issue** or **$500 for 4 consecutive issues.** Listing comprises of – Logo, 100 word profile and contact information.
If you wish to list your company, practice, products, services or training course to appear in the next issue's ATMS Products & Services Guide, please contact Yuri Mamistvalov on 0419 339 865.

Bio-Practica

Bio-Practica

www.bio-practica.com.au | 08 8130 8700

Bio-Practica believes that natural healthcare practitioners should play a fundamental role in preventative healthcare. We believe in a holistic methodology for medicine, drawing knowledge from traditional uses, clinical experience, scientific-based research and clinical trials.
Our formulations are based on leading-edge research and traditional evidence to obtain optimal clinical results. Please join your peers for upcoming seminars and webinars: Acid-Base Balance in Action Masterclass with Rachel Arthur, September 2016. This presentation takes you through the whole journey of ACID-BASE BALANCE in clinical practice; from theory to application, from diagnosis through initial treatment and maintenance management.
For upcoming Webinars or more information visit our website.

Cathay Herbal

CATHAY HERBAL

orders@cathayherbal.com | www.cathayherbal.com | 1800 622 042

Established in 1986, Cathay Herbal is a company that is run by practitioners who constantly work to ensure they understand and meet the needs of you, the practitioner. All products sold by Cathay Herbal undergo rigorous development and investigation before being offered as part of their range. With one of the largest ranges of Chinese Classical formulas outside of China, they don't just stock the popular ones. Cathay's range is large and comprehensive. As well as the classical Black Pill range they also have many formulas available in tablet and capsules and a range of herbal granules, liquids and plasters.

Chi-Chinese Healing College

admin@chihealing.com.au | www.chihealing.com.au | 0416 286 899

Established since 1990 in Australia founded and directed by Master Zhang Hao, offering quality courses in nationally accredited qualifications of Diploma of Traditional Chinese Medicine Remedial Massage (An Mo Tui Na) and Diploma of Remedial Massage. The College is also conducting the short CE skill update courses and workshops throughout the year specially for professional massage therapists and health care workers. The College now also trading under the name - Australian School of Remedial Therapies to specialize in delivering Vocational Training Programs. If you still like the caring, practical and personalised traditional study model and environment - Try us!

Health World Limited

HEALTH WORLD LIMITED
Helping People Live Happier, Healthier Lives

www.healthworld.com.au | 07 3117 3300

Health World Limited is recognised as a Leading Natural Health Science Company and the innovators in Natural Health products and Healthcare professional education. Health World Limited and Metagenics have invested in cutting edge manufacturing technology and equipment in order to expand production of the highest quality Natural Medicines. This level of commitment ensures that Health World Limited produces products that you and your patient can trust for quality and effectiveness.

Helio Supply Co

tcm@heliosupply.com.au | **www.heliosupply.com.au** | 02 9698 5555

Helio Supply Co is a wholesaler of Acupuncture and TCM supplies. We distribute nationally as well as internationally and pride ourselves on our service to customers. Established in 2000, we are committed to providing educational opportunities, a practitioner support line and sourcing the best domestic and international equipment and materials.

Herbs of Gold Pty Ltd

info@herbsofgold.com.au | **www.herbsofgold.com.au** | 02 9545 2633

Herbs of Gold has been dedicated to health since 1989, providing premium and practitioner strength herbal and nutritional supplements. Formulated by qualified, clinical and industry experienced naturopaths, herbalists and nutritionists, our formulations are based on current scientific research and traditional evidence. We take great care in all aspects of our business; right from the selection of raw materials through to the finished product, reviewing our environmental impact and sustainability of ingredients. All Herbs of Gold products meet stringent regulations for safety, quality and efficacy.

HESTA

hesta@hesta.com.au | **hesta.com.au** | 1800 813 327

For more than 25 years, HESTA has focused on helping those in the health and community services sector reach their retirement goals. We now have more than 785,000 members, 155,000 employers and more than $28 billion in assets. HESTA's size means we can offer many benefits to members and employers. These include: low fees, a fully portable account, easy administration, access to low-cost income protection and death insurance, limited financial advice (at no extra cost), super education sessions and transition to retirement options. We also provide access to great value health insurance, banking and financial planning. For more information visit **hesta.com.au** or call 1800 813 327.

Issued by H.E.S.T. Australia Limited ABN 66 006 818 695 AFSL No. 235249,Trustee of Health Employees Superannuation Trust Australia (HESTA) ABN 64 971 749 321. For more information about HESTA, call 1800 813 327 or visit hesta.com.au for a copy of a Product Disclosure Statement which should be considered when making a decision about HESTA products.

Oligoscan Australasia

jon@karunahealthcare.com.au | **www.oligoscan.net.au** | 02 4228 0977

For practitioners of CAM to adequately treat patients with chronic diseases, it is essential to have at your fingertips to investigative tools to give the answers you need to create a viable treatment plan. Using the Oligoscan we can detect in only a few minutes the patient's heavy metal load in addition to the bio-availability of their nutritive minerals. We can show patients why they have their symptoms, and help them to see a way out and back to health. Oligoscan is non-invasive, requires no tissue biopsy, and uses state of the art technology called Spectrophotometry. For the next practitioner training day go to **http://oligoscan.net.au/events.html**.

Oncology Massage Training

info@oncologymassagetraining.com.au
www.oncologymassagetraining.com.au | 0410 486 767

Are you turning away clients with cancer? Oncology Massage Limited provide internationally recognised training for therapists who want to work safely with clients with cancer, in treatment for cancer or a history of cancer. Courses are held nationally around Australia, and we will schedule courses in regional areas where there is enough interest. We also maintain a national listing of therapists, trained by OM Ltd, which is accessed by cancer support organisations and hospitals nationally.

Don't turn clients with cancer away, or refer them on. Improve your skills and get the confidence you need to improve client wellbeing.

Contact us at **info@oncologymassagetraining.com.au** for more information or check out the website.

Sun Herbal

info@sunherbal.com.au | **www.sunherbal.com** | 1300 797 668

The No. 1 supplier of prepared Chinese herbal medicine in Australia and New Zealand. Your clinical success is our bottom line.

BLACK PEARL® pills • ChinaMed® capsules • Red Peony® granules for KIDS

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Sun Herbal supports you with:

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- Detailed reference manuals
- Seminars & webinars
- Samples & bonus offers
- Regular Sun Herbal 'Extracts' (research and case studies)
- Patient brochures & posters
- Practitioner dispensing only

Terra Rosa

terrarosa@gmail.com | **www.terrarosa.com.au** | 0402 059 570

Terra Rosa specialised in educational massage DVDs and books. It has the largest collection of massage DVDs in Australia and the world, covering all modalities from Anatomy, Swedish Massage, Reflexology, Sports Massage to Myofascial Release and Structural Integration. We also provide the best in continuing education with workshops by international presenters including Orthopaedic Massage, Taping, Fascial Fitness and Myofascial Therapy.

The Pharmaceutical Plant Company

sales@ppcherbs.com.au | **www.ppcherbs.com.au** | 03 9762 3777

Where nature, science and health come together. PPC offers healthcare professionals a choice of either traditionally made herbal extracts from dried plant materials; or fresh plant tinctures that are all grown in Tasmania and processed within hours of harvest. PPC uses Organically certified herb where possible, with the entire Fresh Plant Tincture range being Australian Certified Organic. The Pharmaceutical Plant Company has 25 years experience in manufacturing and distributing traditional herbal extracts, fresh plant tinctures and listed medicines in Australia.

Australian company wins top gong for ongoing commitment to natural therapy research

MediHerb awarded 2015 ABC Varro E. Tyler Commercial Investment in Phytomedical Research Award

Leading Australian natural therapies brand MediHerb, an Integria Healthcare brand, has been awarded the 2015 ABC Varro E. Tyler Commercial Investment in Phytomedical Research Award by The American Botanical Council (ABC). The 11th Annual ABC Botanical Celebration and Awards Ceremony took place on 10 March 2016 in Anaheim California where Professor Kerry Bone (MediHerb) and Dr Hans Wohlmuth (Integria Healthcare) accepted the award via video message.

The prestigious international award recognises companies with the highest level of scientific and product integrity who are dedicated to extensive evaluation of their products' quality, safety and efficacy in the phytomedicinal healthcare sector.

MediHerb and Integria Healthcare have supported around 25 human clinical trials of MediHerb products, 22 of which have been published in peer-reviewed journals. In addition to clinical trials, MediHerb has funded a large number of phytochemistry and in vitro studies on botanicals. Much of this work has focused on quality issues, an area in which MediHerb has always been a leader.
Professor Kerry Bone, MediHerb's Director of Research and Development and visionary behind the company's research program, was thrilled to be recognised for MediHerb's dedication to more than 15 years of conducting clinical research.

"This is a greatly appreciated reward for our many years of research into the phytochemistry, quality and therapeutic properties of medicinal plants. The ABC is to be commended on the way it supports the development and status of the global herbal industry through such awards."

"There is now a compelling argument for new drug research to be looking at developing and using the whole plant as the therapeutic agent, rather than just an isolated chemical from it. Previously such an approach was frowned on because of the variability and uncertainty created by the chemical complexity of plants. Now we have such advances in phytochemical analysis and pharmacodynamics that these obstacles are readily overcome. It is indeed an exciting time to be doing phytomedicinal research."

Dr Hans Wohlmuth, Research and Development Manager for Integria Healthcare said the award was a testament to the company's commitment to leading the market in safety, quality and efficacy.

"From the outset 30 years ago, MediHerb has embodied Professor Tyler's vision of applying science to traditional botanical medicine with the sole aim of providing practitioners with high quality and clinically efficacious products. We are thrilled to be recognised for our work," said Dr Wohlmuth.

Integria Healthcare, which owns the MediHerb brand along with other leading natural healthcare brands, invests more than $5 million annually in research and development and technical projects.

Continuing *Education*

Continuing education (CE) is a structured program of further education for practitioners in their professional occupations.

The ATMS CE policy is designed to ensure its practitioners regularly update their clinical skills and professional knowledge. One of the main aims of CE is to keep members abreast of current research and new developments which inform contemporary clinical practice.

The ATMS CE policy is based on the following principles:

- Easily accessible to all members, regardless of geographic location
- Members should not be given broad latitude in the selection and design of their individual learning programs
- Applicable to not only the disciplines in which a member has ATMS accreditation, but also to other practices that are relevant to clinical practice which ATMS does not accredit (e.g. Ayurveda, yoga)
- Applicable to not only clinical practice, but also to all activities associated with managing a small business (e.g. book-keeping, advertising)
- Seminars, workshops and conferences that qualify for CE points must be of a high standard and encompass both broad based topics as well as discipline-specific topics
- Financially viable, so that costs will not inhibit participation by members, especially those in remote areas
- Relevant to the learning needs of practitioners, taking into account different learning styles and needs
- Collaborative processes between professional complementary medicine associations, teaching institutions, suppliers of therapeutic goods and devices and government agencies to offer members the widest possible choice in CE activities
- Emphasis on consultation and co-operation with ATMS members in the development and implementation of the CE program

ATMS members can gain CE points through a wide range of professional activities in accordance with the ATMS CE policy. CE activities are described in the CE policy document as well as the CE Record. These documents can be obtained from the ATMS office (telephone 1800 456 855, fax (02) 9809 7570, or email **info@atms.com.au**) or downloaded from the ATMS website at **www.atms.com.au.**

It is a mandatory requirement of ATMS membership that members accumulate 20 CE points per financial year. CE points can be gained by selecting any of the following articles, reading them carefully and critically reflecting on how the information in the article may influence your own practice and/

or understanding of complementary medicine practice. You can gain one (1) CE point per article to a maximum of three (3) CE points per journal from this activity:

- **Muscolino J. Table Mechanics Part 1**
- **Malaguti-Boyle M. Evidence for the effectiveness of clinical nutrition therapy in diabetes mellitus type 2 management in primary care**
- **Pope C. Practice management 101. Building a client base**
- **Medhurst R. Further research in homoeopathy**
- **Badawi A. Boundaries in therapeutic practice.**
- **McHugh B. The childhood obesity epidemic**
- **Pagura I. Work Health and Safety: Managing workplace incidents and injuries**

As part of your critical reflection and analysis, answer in approximately 100 words the following questions for each of the three articles:

1. What new information did I learn from this article?
2. In what ways will this information affect my clinical prescribing/techniques and/or my understanding of complementary medicine practice?
3. In what ways has my attitude to this topic changed?

Record your answers clearly on paper for each article. Date and sign the sheets and attach to your ATMS CE Record. As a condition of membership, the CE Record must be kept in a safe place, and be produced on request from ATMS.

CONTINUING EDUCATION
Calendar 2016

DATE/S	EVENT	PRESENTER	LOCATION
4/06/16 5/06/16	Seminar: Musculoskeletal assessment and palpation techniques	Raymond Smith	Kogarah, NSW
5/06/16	Seminar: Understanding a Natural Medicine Practitioners Requirement for Clinical Practice (Massage & Bodywork practitioners)	Maggie Sands	Gold Coast, QLD
7/06/16	Webinar: Clinical Applications of B Vitamins (Part 3)	Brad McEwen	N/A
10/06/16	Seminar: Seven Simple Tweaks to Create a Sustainable Business	Christine Pope	Brisbane, QLD
18/06/16 19/06/16	Seminar: Exercises for Correcting Musculo-Skeletal Misalignment	Chris Beazley	Charmhaven, NSW
19/06/16	Seminar: Nutritional Deficiencies, Body Signs and Clinical Signs in Clinical Practice	Brad McEwen	Glenelg North, SA
20/06/16	Webinar: Dietary Treatments for Acne	Stephen Eddey	N/A
25/06/16 26/06/16	Seminar: Acupressure for the Emotions	John Kirkwood	Glenelg North, SA
26/06/16	Seminar: Understanding a Natural Medicine Practitioners' Requirement for Clinical Practice (Massage & Bodywork practitioners)	Maggie Sands	Charmhaven, NSW
27/06/16 28/06/16	Seminar: Integrating Muscle Energy Techniques (METs) and Positional Release into your Treatments	Chris Beazley	Randwick, NSW
13/07/16	Webinar: Prescribing Ayurvedic Herbs (Part 1)	Shaun Matthews	N/A
20/07/16	Webinar: Nutritional Treatments for Type II Diabetes	Stephen Eddey	N/A
24/07/16	Seminar: Nutritional Deficiencies, Body Signs and Clinical Signs in Clinical Practice	Bradley McEwen	Perth, WA
31/07/16	Seminar: Seven Simple Tweaks to Create a Sustainable Business	Christine Pope	West Ryde, NSW
2/08/16	Webinar: Clinical Applications of Vitamins A, C, D, E and K	Brad McEwen	N/A
7/09/16	Webinar: Prescribing Ayurvedic Herbs (Part 2)	Shaun Matthews	N/A
10/09/16 11/09/16	Seminar: Acupressure for the Immune System	John Kirkwood	Glenelg North, SA
11/09/16	Seminar: Substance and Shadow	Julia Kalytis	Qld (area to be advised)
11/09/16	Seminar: Ayurvedic Holistic Detoxing	Shaun Matthews	Sydney, NSW
13/09/16	Webinar: Nutritional Treatments for the Ageing	Stephen Eddey	N/A
20/11/16	Seminar: Understanding a Natural Medicine Practitioners' Requirement for Clinical Practice (Massage & Bodywork practitioners)	Maggie Sands	Melbourne, VIC

The proposed seminar and webinar topics, dates and locations (for seminars) are subject to change. Please keep an eye on the ATMS website **www.atms.com.au** for the latest information and to book online.

Looking to improve your overall health and wellbeing?

atms.com.au/find-a-practitioner

Join hundreds of thousands of Australians who consult ATMS' trusted, qualified and professional natural medicine practitioners.

The Australian Traditional-Medicine Society (ATMS) proudly represents more than 12,000 natural medicine practitioners across a vast range of disciplines including remedial massage and bodywork, traditional Chinese medicine, acupuncture, naturopathy and nutrition.

To safeguard the public, every ATMS practitioner is individually assessed to ensure the high standards of ATMS are satisfied before becoming accredited.

Leader of the natural medicine industry

ATMS

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