

EDITORIAL

Is orthopaedic manipulative physical therapy not fashionable anymore? Lessons learned from 2016 IFOMPT meeting and future directions

The International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT) is the professional body for countries that follow postgraduate manual and manipulative physical therapy curricula. Currently, IFOMPT is comprised of 22 member countries, whose programs are accredited by IFOMPT and comply with internationally accepted standards. The mission statement of IFOMPT embraces the promotion of international excellence and unity in clinical and academic standards for manual/musculoskeletal physiotherapists (<http://www.ifompt.org/>).

Every four years IFOMPT hosts a conference to promote this mission. Presentations at the conference are peer-reviewed, competitively vetted and often consist of cutting edge evidence in support (or in opposition) of key tenants associated with orthopaedic manual physical therapy (OMPT) practice, education and research. At the 2016 IFOMPT conference in Glasgow there were formal and informal robust discussions on the current purpose and utility of OMPT in contemporary health care, in contrast with the increasing levels of interest in pain sciences and exercise therapies. Ironically, many attendees suggested that the conference's flavour was more likened to a pain science conference versus an OMPT conference. Considering there were as many courses accepted by the scientific committee that were dedicated to pain sciences as OMPT supports this perception.

One particular session that took place was a debate that asked the question 'is manual therapy an effective intervention in the management of low back pain?' At first glance, one might think that this is an ironic or senseless debate, especially when occurring at an IFOMPT conference full of manual physical therapists. Interestingly, the results of the debate were very close, where the votes from the attending delegates narrowly supported the motion and team that promoted OMPT as an effective treatment strategy. However, one emergent idea was certain at the conclusion of the debate: we, as advocates of a specific treatment specialization, have NOT done an adequate job in providing sufficient and sound evidence that OMPT demonstrates high clinical utility. In other words, we have failed to tell our story.

Certainly, there is a wealth of information implying benefit and cost-effectiveness for OMPT management of musculoskeletal conditions [1]. Most low back clinical practice guidelines worldwide advocate OMPT management of low back pain [2]. Reviews by Bialosky et al. [3] and others provide a model of how OMPT influences pain, outlining the most common mechanisms associated with the procedures. Sizer et al. [4] developed a sequence for assessment and management linked to clinical reasoning and appropriate

use of OMPT that was previously published in this journal. Others have demonstrated positive effects associated with OMPT, when compared against other interventions. However, identifying when, how much and what type of OMPT still remains a mystery to the practicing community. Moreover, whether these elements of dosage matter continues as a key question that demands an answer if manual therapy is to continue as a treatment of choice for contemporary physical therapy practitioners.

There is a paucity of OMPT fundamental research, which is almost exclusively supported by outcomes derived from applied sciences. It is time to initiate the next great wave of OMPT research. Such investigations should examine mechanisms of action more at cellular and mechanistic level. For example, Zein-Hammoud & Standley [5] have been investigating the effects of on fascia and fibroblastic activity, showing that fibroblasts respond differently to various strain patterns, secreting various anti-inflammatory chemicals and growth factors. Such findings provide implications for wound healing and muscle repair, among other physiologic processes. By exposing fibroblast-rich tissues to manual therapy-patterned inputs, changes or reversal of detrimental fibroblastic responses to those inputs could be examined. Additionally, there is a need to better compare OMPT to other low-cost interventions from a clinical and functional standpoint. Equally, we need to further identify those patients who are best responders to the litany of OMPT strategies, so treatments can focus on the most appropriate groups. Likewise, there is a strong need to investigate the role of the physical therapist's clinical reasoning in patients' rehabilitation outcomes. Finally, we should better understand the roles and values of OMPT training and specialization, so OMPT approaches can be refined and learning/application strategies can become more efficient and effective.

In past decades, OMPT served as a rudder that guided clinicians in managing patients with musculoskeletal pain and dysfunction. Even though OMPT appears to have temporarily declined from being the 'sexy' management approach of the decade, we should not simply replace it with a new vogue science or the novel practice measure of the day. Rather, we should find ways to strategically merge successful OMPT management strategies with other new discoveries on the horizon. Just because a particular approach is new does not merit using it to replace a successful OMPT strategy because that strategy has been deemed outdated. Clinicians can use OMPT to provide patients with the capacity to move and exercise to empower that movement. Similarly, clinicians can use pain science to reduce the

patient's fear of their symptoms and redirect their cognitive processes towards recovery, while using OMPT to restore their movement capacity and exercise to increase their movement confidence. Let us keep developing new learning and research venues to teach and assess the timing, dosage, benefits and cost-effectiveness of treatment strategies that merge education, OMPT and movement science. It is not one intervention but a combination of interventions that may best direct the patient towards recovery, based on the practitioner's sound clinical reasoning and the patient's trust in both the clinician's skill and their own capacity to recover. This is the practice and research that JMMT wants to promote for physiotherapists in collaboration with other disciplines.

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