

We need to debate the value of manipulative therapy and recognize that we do not always understand from what to attribute our success

An interesting post mortem was published after the International Federation of Orthopaedic Manual Physical Therapy (IFOMPT) 2016 conference noting that a ‘pain science conference’ broke out at a manual therapy conference [1]. A not so subtle reality continued at the American Academy of Orthopaedic Manual Physical Therapist (AAOMPT) 2017 annual conference where less than a third of the presentations were specific to manual therapy. Given the trends in emerging evidence that question the reliability, validity and clinical effectiveness of manual therapy as a standalone intervention, perhaps a good whack on the back of our collective hands was appropriate [2–4].

Manual physical therapists possess a variety of tools in their toolbox. The art of manual therapy is knowing which tools will work best for the patient sitting in front of us. Can we all admit that the correct treatment is the one that gives the patient the most benefit and the least harm? There is evidence that including manual therapy care as part of the conservative management of patients with musculoskeletal conditions results in cost effective improvements in pain, function and satisfaction [5–7]. Objectively measuring clinical reasoning is a difficult task and 5 ‘expert’ clinicians may use 5 different approaches to achieve a favorable outcome. The late Dr. Dick Erhard used to say, ‘I appreciate that technique, it’s good, just not in my hands.’ Confirmation bias is a real thing, and we need to embrace that the placebo effect is an active and important mechanism of manual therapy. These ‘nonspecific’ factors are present in any treatment we deliver, and using them to discount a favorable outcome is akin to suggesting that no treatments are effective [8].

We appreciated all the speakers in Salt Lake City and congratulate the organizers of the conference for a job well done. We noticed an interactive group of attendees at two particular hands on workshops reviewing manual therapy interventions for ‘hard to treat’ areas. The interaction was respectful, thoughtful, and spilled out into the hallway onto treatment tables so our practice could continue. We might not be able to define what an ‘expert’ manual therapist is, but we can truly appreciate when we see one. This is not guru worship or an exercise in personal elevation, but a true appreciation for therapists with exceptional skills and an ability to translate their knowledge to a group of educated, dedicated clinicians.

While the exact mechanisms of manual therapy may be elusive [9], it remains a valuable adjunct to other

evidence-based interventions. Manual therapy may be at a crossroads where we must all agree, if we can quote Bob Dylan by way of Eddy Vedder ‘don’t criticize what you can’t understand.’ We should *celebrate our profession and fellow professionals and get back to the work of elevating our profession, even when success may come from ‘nonspecific’ factors that don’t support our clinical equipoise.*

Dialogue and debate at conferences, in the clinic, and in the classroom lead to professional reflection and personal growth. Let us move past the ‘which is better’ debate in regards to clinical treatment and start respecting that *our paradigms may require updating, each individual patient is different, and every individual we treat deserves an evidence-based multifactorial plan of care.* If we do not provide evidence-based, patient-centered care for our patients, someone else will ... maybe they already are.

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