

■ Philosophical Differences in Manual Therapy

Within this issue, we are pleased to publish *A Model for Standardizing Manipulation Terminology in Physical Therapy Practice*, a manuscript by Paul Mintken and colleagues, which provides a model for standardized terminology to describe manipulative techniques regardless of individual clinical practices or schools of thought. Mintken and colleagues were charged with this assignment as part of a task force formed by the *American Academy of Orthopedic Manual Physical Therapy* (AAOMPT). We felt the information deserved the widest audience possible, thus the manuscript is jointly published by the *Journal of Orthopedic and Sports Physical Therapy* and JMMT. As the official journal of the AAOMPT, we are honored to disseminate this information to our readership.

It is difficult to argue against the fact that we have a language problem in manual therapy. Techniques, conditions, findings, and documentation all lack a consistent vernacular and this lack of a common vocabulary does not lend itself well to transferable research findings or consistency in care. But I would argue that the language variations in manual therapy expose a more significant dilemma. Manual therapy has a *philosophy* problem.

Albert Einstein once stated, "All religion, arts, and sciences, are branches of the same tree." If this is true, then the tree of manual therapy (as an art and science) is indeed one inimitable and peculiar tree. Nowhere else can one use the same categorical title to describe a number of truly different methods that are rooted in incongruent philosophical theoretical constructs. Techniques are derived from a number of different examination methods that may be uniquely patient-focused, may distill from a purely biomechanical construct or theory, or may be propelled from an algorithm or prediction-based rule. Different philosophical models may advocate examination and intervention techniques that provoke pain, reduce pain, or are applied with a complete disregard for pain of the patient. There is very little concord among us and I haven't seen a tremendous amount of change that demonstrates improvement in standardizing our philosophical models.

Why do we adopt one philosophy and completely ignore the information or evidence from another? Dr. Phil Sizer once stated during a discussion of this topic: "If it doesn't fit their mantra, to them it isn't worth hearing." This explanation implies we have selected inquiry and learning that may be partially rooted in a manual therapy history that financially rewards and acknowledges the innovative clinician, who best communicates a novel concept. It is also entrenched in an inexplicable defensiveness demonstrated by disciples of selected philosophies. Obviously, this is very troublesome, because when we lack the ability to police ourselves and criticize our own weaknesses, we will lose the ability to grow and progress as a specialty.

This philosophical quandary hasn't limited itself to the individual level. I have experienced continuing education programs that have advocated the use of manual therapy for mobilization of cranial sutures, correcting visceral-based pathology or—even more remarkably—tumors, and have been told the incredulous concept that appropriate techniques may foster a visit from a spirit leopard. Selected textbooks still support the use of archaic concepts such as Fryette's law, usefulness of palpation of the sacroiliac joint, dogmatic use of the convex-concave rule for all joints, and the assumption that we can gainfully palpate and correct spinal subluxations. Although evidence has supported that these factors lack credibility, these concepts are still taught, consumed, used in clinical practice, and defended as 'evidence' causing a spillover to conventional practice.

That said, I cannot think of a more exciting time to assume the editorial responsibilities of a manual therapy journal. At present, there is a wealth of new research targeted at explaining the science of manual therapy and obtaining techniques that provide the best evidence for a dedicated population. While we will continue with our primary purpose to advance the profession of orthopaedic manual therapy by publishing high-quality clinically pertinent information from seasoned, regional, international, and aspiring authors, additional goals will be targeted as well.

We are in the process of improving the indexing of JMMT to increase its exposure to a larger readership and to further improve the number of article submissions. We have adopted a clinical perspective for each issue. A clinical perspective is an evidence-based, peer-reviewed manuscript that is designed specifically for practicing clinicians. Roger Kerry and associates have provided the first clinical perspective in their discussion of *Manual Therapy and Cervical Arterial Dysfunction*. Because I very much enjoy controversy, I have and will include more invited commentaries from topical experts and will stimulate the submission of letters to the editor with regard to interesting or contentious topics. We will seek articles that explore nebulous areas within our specialization that attempt to outline order in the evidence. In this issue, Adam Goode's paper investigating the movements of the sacroiliac joint (SIJ), offers evidence that further questions the clinical utility of assessment of palpable movement of the SIJ in normal *or* symptomatic patients. Ellis and Hing's manuscript provide a careful summary of neurodynamic treatments, acknowledging that the beneficial evidence for use at this point is still unknown. Landrum et al provide preliminary evidence of short-term arthrological changes in the ankle after mobilization procedures.

It is also my goal to provide a challenging, at times perhaps divisive but hopefully also stimulating editorial for each issue. My charge is to stimulate the growth of manual therapy reporting and to provide greater awareness, discussion, and debate of critical concepts in our specialization. Future editorials will debate the concept of 'clinical expertise' and will explore 'pitfalls in clinical prediction rules'. Other editorials will expectantly arouse useful and creative discussion regarding hallmarks in our personal manual therapy philosophies. The editorials and the manuscripts selected by the journal will hopefully play a small part toward our effort in standardizing language and philosophy in manual therapy.

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