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Orthopaedic manual physical therapy: it's not what you do, it's how you do it

Manual therapy (MT) use and research have grown significantly in recent decades. Guidelines support MT for musculoskeletal conditions, yet it faces criticism for limited effectiveness and unclear mechanisms [1,2]. While thoughtful critique is necessary, it is equally important to clarify what is actually being criticized.

Although MT has been practiced for centuries, its definition and application remain inconsistent. Defined as force-based input to the body, MT studies often lack reproducibility, pragmatic relevance, and consistent definitions [3–5]. Clinicians also describe MT as isolated techniques rather than integrated care. This narrow framing fails to reflect the scope of Orthopaedic Manual Physical Therapy (OMPT), which is defined not by technique but by a reasoning-driven, person-centered approach.

Confusing MT with OMPT adds to confusion in practice, undermines the rigor of post-professional training, and obscures the unique value OMPT brings to musculoskeletal care. This perspective aims to clarify the distinction between MT and OMPT and to advocate for more accurate and consistent use of terminology across the profession.

What is OMPT?

OMPT is defined as '*a subspecialty of physical therapy featuring a systematic active approach for the management of a broad spectrum of physical disorders. Based on a patient-centered advanced clinical reasoning model taught in fellowship training, OMPT has key distinguishing characteristics that include expertise in hands-on iterative examination and treatment strategies inclusive of thrust and non-thrust manipulation. Essential to OMPT is a focus on continuous reassessment through all aspects of care, synergistic application of carefully designed and dosed exercise, and a patient-centered long-term mindset driven by the available scientific and clinical evidence, and the biopsychosocial framework of each individual patient*' [6].

OMPT relies on a conceptual model requiring systematic reasoning to guide treatment, load management, exercise, activity/behavioral interventions, education, and communication. This conceptual model is objective and prescriptive and demonstrates the actions taken during patient care that align with the Description of Advanced Specialty Practice (DASP) [7], which sets the standards for how this model of care is taught. This model allows observers to recognize care as 'OMPT' or not. In other words, these actions allow us to measure the fidelity of care as measured against a standard. This understanding of fidelity to a treatment model is understood in behavioral health care, where like physical rehabilitation, there are overlapping and similar paradigms of care used. The understanding of this objective conceptual model helps us distinguish patient care that is delivered in this reasoning model (i.e. OMPT) versus exercise therapy care during which a few manual techniques are sprinkled in like salt over a meal.

OMPT also has characteristics that are subjective for the purpose of delivering education and training and describing the overarching mind-set present when delivering this care. The distinguishing characteristics are that OMPT is the result of advanced subspecialty training, focused on clinical judgment, involves expertise in examination, expertise in treatment, and is used with a person-centered long-term mind-set [6].

The use and understanding of both the objective prescriptive conceptual model of actions and the subjective descriptive distinguishing characteristics of principles provides a comprehensive view of this framework of care that is centered on a reasoning model and does not require any one particular word or action. For example, an episode of OMPT care may *not* involve any hands-on treatment at all, or any exercise therapy at all. Many OMPT practitioners have described situations in which their interventions consisted of education and activity guidance alone in an episode of care that was aligned both with the conceptual model and its distinguishing characteristics.

The term 'MT' is a general term for hands-on techniques applied by several different groups of practitioners, whereas the term 'OMPT' is a specific term for a paradigm of care in physical therapy based on a reasoning model which may or may not involve hands-on care for any particular person at any particular time. One way to see this difference is in cooking. While MT might be salt sprinkled on a meal *after* cooking to suit the taste of the diner, OMPT uses MT like an ingredient *in the recipe itself*, used to achieve an overall effect. Some may consider MT as a superficial addition rather than an integral component of the overall framework.

Process vs. product

It is important to acknowledge that OMPT is much more than a discrete skill or technique (i.e. thrust or

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non-thrust mobilizations, soft tissue manipulation). In a 2012 Letter to the Editor titled 'Manual Therapy: Process or Product?' an argument was made that OMPT is beyond techniques, rather a systematic clinical reasoning approach that integrates the use of hands-on techniques in conjunction with other evidence-informed interventions (i.e. exercise, education) [8]. OMPT has been framed less as a component of a systematic clinical reasoning approach and more as a passive tool to be applied in isolation. This approach is not OMPT. Critiques that MT promotes passive care, relies on outdated models, or fosters dependence are valid, but they do not apply to OMPT.

When MT is used and regarded as an independent technique rather than a system of reasoning, it oversimplifies complex clinical interactions. It risks reinforcing passive treatment models, where the provider acts and the patient receives. More importantly, it neglects the defining features of OMPT: advanced clinical reasoning, adaptability, and person-centered care applied with a long-term mind-set.

Why this distinction matters

We consider the splitting of MT out of a reasoning model a 'fallacy of composition' in which a part (MT) is misrepresented as the whole (OMPT). This creates ambiguity in research, education, clinical practice, and reimbursement and a distinction is warranted. Systematic reviews [9,10] of MT have shown small/modest effect sizes, however these reviews do not distinguish between MT used in a reasoning model (OMPT) and MT used as an ancillary addition to care. Efficacy-focused MT research also limits the pragmatic reasoning central to OMPT. This narrow framing not only limits research validity but also risks obscuring the broader economic value of comprehensive PT models. The APTA's *Economic Value of Physical Therapy in the United States* report reinforces that when PT is delivered in reasoning-driven, integrated frameworks, it produces measurable downstream cost savings and improved value across the health system [11].

Clinically, a common and valid critique is that practitioners using MT often focus on the 'law of the instrument' or the overreliance on MT because it is familiar and comfortable. We believe education/training in MT might incorporate elements of OMPT but is also at the mercy of what learners deem salient (i.e. learning a technique has greater perceived importance than the reasoning behind the decision to use it or not). We are concerned this could lead to a form of 'professional deformation' where patients are potentially receiving suboptimal MT and/or might achieve better results with appropriate or beneficial care (OMPT).

Finally, performing MT is a reimbursable service in most payment models. More MT provided over more visits generates more revenue. OMPT, on the other hand, has been associated with fewer visits per episode of care despite achieving positive patient outcomes [12]. This duality runs the risk of OMPT, and the advanced specialty training required to perform it, being devalued by employers. It would be a concerning misalignment if financial incentives discouraged shorter episodes of care that offer greater value to patients.

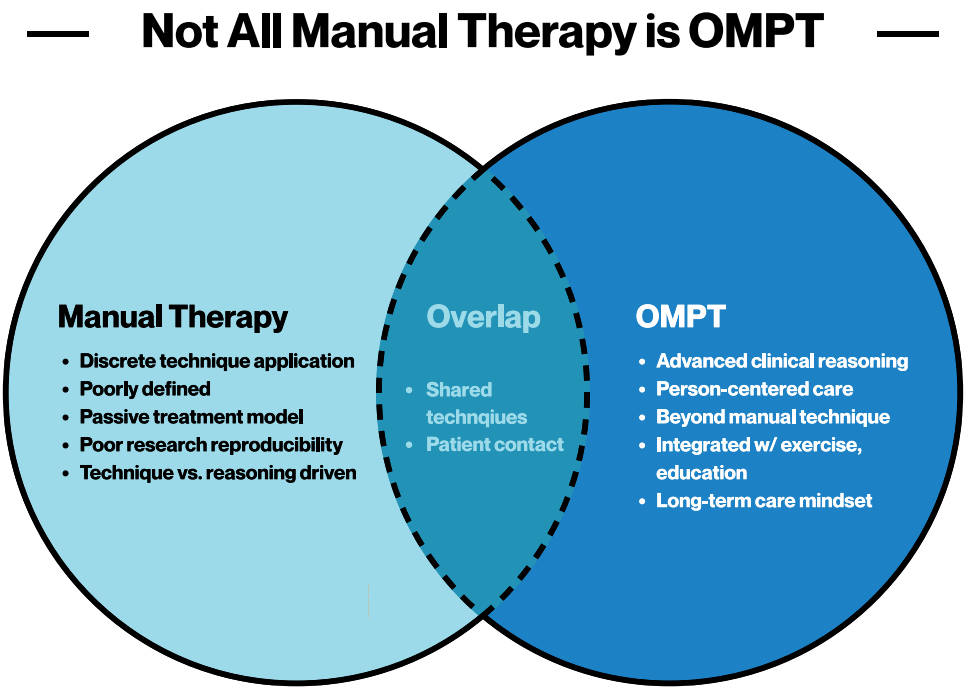

Figure 1. Distinctions between manual therapy and OMPT.

Reclaiming OMPT

To provide clarity to patients and providers alike, it is important that the term 'OMPT' be used only when the full scope of the subspecialty is present. MT is a component of the greater OMPT approach, and this approach is not defined by the performance of manual techniques. Rather, it reflects a reason-driven process that integrates touch-based care within a comprehensive framework that includes exercise, education, communication, and long-term planning. (Figure 1)

Educators, clinicians, and researchers must be intentional with their language. Referring to MT as OMPT dilutes its meaning and contributes to confusion in both professional discourse and clinical implementation. Likewise, researchers should clearly distinguish between studies investigating discrete manual therapy techniques and those evaluating the outcomes of comprehensive OMPT-informed care.

This distinction also has implications for continuing education providers, journal editors, and licensing and regulatory bodies. Endorsing or approving content under the label of OMPT should require adherence to accepted definitions and standards such as those articulated in the updated OMPT definition.

Closing

This paper clarifies the OMPT – MT distinction to preserve consistency, quality, and value in subspecialty practice. If OMPT is to remain relevant in modern musculoskeletal practice, its language and identity must be used deliberately. Future work should focus on clearer operational definitions in research and educational standards, and dissemination strategies that reinforce OMPT's distinct role in musculoskeletal care.

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Author contributions

CRediT: **Mark H. Shepherd:** Conceptualization, Supervision, Visualization, Writing – original draft, Writing – review & editing; **Jason Silvernail:** Visualization, Writing – original draft, Writing – review & editing; **Thomas Adderley:** Writing – original draft, Writing – review & editing; **Elaine Lonnemann:** Writing – original draft, Writing – review & editing.

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