Heavyweight Championship

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It's like the heavyweight championship of the orthopaedic physio world ... and I can just hear the ring announcer now ...

"In this corner, wearing the white trunks ... from various authorities worldwide ... weighing in at 180 pounds ... 'Manual Therapy' ...

"And in this corner, wearing the blue trunks ... the challenger ... also weighing in at 180 pounds ... hailing from New Zealand ... 'Mechanical Diagnosis and Therapy' ...

There is a roar from the crowd ... and ...

... the bell rings ... Manual Therapy comes out with the strong left hook, Mechanical Therapy responds with the right jab ..."

And so it goes ... and clinicians get bent out of shape ... in clinics far and wide ...

It might be one of the most hotly-contested debates that we as physical therapists experience on a daily basis. For some reason, clinicians seem to be very polarized when it comes to their approach to orthopaedics. One must be better, yes? Isn't that the way it has to be? Someone has to lose, no?

Of course not.

The conceptual elements behind them are very similar. Manually-trained therapists will move the patient passively, assessing symptomatic and mechanical responses to their movements. McKenzie-trained therapists, on the other hand, also have the patient move passively, assessing symptomatic and mechanical responses to their movements.

The difference - is that the former perform the movement FOR the patient as a first intervention ... and the latter, ALLOW the patient to perform the movements themselves as a first intervention.

There is good literature to support the use of manual therapies in the first 2 to 4 weeks post-injury. There is growing evidence to support the notion that finding a directional preference may in fact guide the prescription of exercises for the patient.

So what's the big deal?

In my years as a McKenzie-trained clinician, I have watched the debate ... participated in the discussion ... and finally

come to one elemental conclusion. This issue really comes down to your perception of your role as clinician in the patient's care. Do they need to come to me to be "fixed" ... or are they coming to me to gain an understanding of their own self-generated forces (via movements and postures)? Am I a "healer" or am I a "mentor"?

This is why it becomes an emotional issue. Many refuse to relinquish their "hands-on" role in the care of the patient. Many have their own personal belief systems built around the "I am the fixer" mentality. Whether we realize it or not, our perceptual mechanisms drive our comfort zone - and for many therapists and clinicians alike, relinquishing control over the patient is a difficult (and emotionally challenging) task. And stepping out of that comfort zone can be a very awkward and difficult proposition - full of potential for growth, but also laden with emotion.

I fully understand this perspective - because I've experienced it myself. Years ago, I was "the man with the plan" ... all this newfound education of how to fix the problems of the world. I went to courses, I was well-educated, you came to me to have your problem fixed. Then, at my first McKenzie course, I had to face the music - that much of what we've been taught either isn't supported in the scientific literature or it was just fostering patient dependence. It was a hard pill to swallow, and caused much internal consternation, but ultimately made me a better clinician, a better coach, a better mentor.

But let's remove ourselves from the equation - because as I am always heard to say, "it's not about me - it's about the patient". From the patient side of the equation, it all boils down to the old adage - "Give a man some fish and you feed him today ... teach a man to fish and you feed him for a lifetime". The confronters, those actively involved in their self care, will be adept at "learning how to fish". The avoiders - will always gravitate towards more passive forms of care as they are already in a world that fosters dependence.
That being said ... evidence or no evidence - I suspect there will always be a place for both approaches. Should it be a battle? Absolutely not ... as there are some very distinct similarities of importance. Should it truly involve some reflection on the clinician's part to establish their own perceived role in the (long-term) care and independence of the patient and the costs associated with this? Yes. Should it involve some reflection regarding the long-term impact on patient self-responsibility and a system of effective "health" (care)? Yes. Unfortunately, it's the self-perception of the clinician's role that will prove to be the biggest battle that we face. And until that is resolved, the other issues will be slow to follow - evidence or no evidence.

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