

IFOMPT Educational Standards

A Historical Perspective

COMPILED BY IFOMPT STANDARDS COMMITTEE AND 2008 EXECUTIVE

2011

This document aims to provide an accurate collation of key milestones and documents that evidence the development of the IFOMPT Educational Standards since their inception. The committees are grateful to all contributors and reviewers for their diligence in ensuring the accuracy of the included information, and to our pioneers for keeping accurate and detailed records of their work. All information is presented as written/ agreed at the time.

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Section 1: IFOMPT Educational Standards – chronology of development

The Educational Standards (Standards) of IFOMPT extend the level of basic training received in orthopaedic manual / manipulative Physical Therapy / physiotherapy undertaken in Physical Therapy training programmes so that orthopaedic manipulative Physical Therapists attain an advanced standard of patient care.

- 1974 IFOMT Inaugural Meeting, Montreal, Canada**
IFOMT is formed based on the first international examinations in Gran Canaria 1973
Standards Committee established to set up curriculum, examinations and ethics
Members of the Standards Committee: F Kaltenborn (Chair, Norway), G Grieve (Co-Chair for theory, UK), D Lamb (Canada), B Edwards (Australia)
- 1975 IFOMT First Congress and General Meeting, Gran Canaria, Spain**
Initial draft of Standards document (theoretical component including a comprehensive bibliography) developed and signed by Physical Therapists F Kaltenborn (Norway), G Grieve (UK), D Lamb (Canada) and B Edwards (Australia) [document written by G Grieve, and reviewed by D Lamb and F Kaltenborn]
- 1977 IFOMT General Meeting, Vail, USA**
Standards document (theoretical and practical components) presented at the meeting [practical component mainly written by B Edwards]
- 1978 IFOMT General Meeting, Tel Aviv, Israel**
Standards document ratification at the WCPT meeting
IFOMT formed as a subgroup of the WCPT
Election of Standards Committee: D Lamb (Chair, Canada) , F Kaltenborn (Norway), G Maitland (Australia)
- 1980 IFOMT General Meeting, Christchurch, New Zealand**
It was agreed that an advisory educator be appointed to the Standards Committee
Australia voted in as Member Organisation
- 1982 IFOMT General Meeting, Stockholm, Sweden**
Standards Committee was dissolved for previous members to act as consultants on educational matters to the Executive Committee
Norway, Sweden, and United Kingdom voted in as Member Organisations
- 1984 IFOMT General Meeting, Vancouver, Canada**
Canada, Netherlands (subject to documentation submitted), and South Africa voted in as Member Organisations
- 1988 IFOMT General Meeting, Cambridge, England**
Membership Committee created with G Jull as Chair
Members of membership Committee: G Jull (Chair, Australia), Desley Kettle (UK), Aaron Leung (Hong Kong), David Lamb (Canada). Dan Wallin (Sweden)
New Zealand voted in as Member Organisation

- 1990 IFOMT General Meeting, Gran Canaria, Spain**
 Hong Kong and Finland voted in as Member Organisations
 Terms of reference for a Membership Committee voted in
 Members of Membership Committee: G Jull (Chair), D Kettle (UK), D Lamb (Canada), A Leung (Hong Kong), M Monaghan and D Wallin (Executive Committee representative, Sweden)
- 1992 IFOMT General Meeting, Vail, USA**
 History of IFOMT delivered and signed by D Lamb. Co-signed by F Kaltenborn and S Paris.
 Denmark, Germany (subject to documentation submitted), Switzerland, and USA (subject to documentation submitted) voted in as Member Organisations
 New Standards Document presented by G Jull and voted in
- 1996 IFOMT General Meeting, Lillehammer, Norway**
 Membership Committee charged with reviewing the Standards Document
 Membership Committee renamed Standards Committee
 Members of Standards Committee: G Jull (Chair, Australia), A Leung (Hong Kong), D Kettle (UK), A Porter-Hoke (USA), D Wallin (Sweden)
 Belgium voted in as Member Organisation
- 2000 IFOMT General Meeting, Perth, Australia**
 Standards document revision ratified (development of document by L Wellington (Australia)
 History of IFOMT's educational standards and membership delivered and signed by F Kaltenborn.
 Co-signed by B Sydenham (on behalf of D Lamb) and G Maitland.
 Austria and Portugal voted in as Member Organisations
 Members of Standards Committee: G. Jull (chair, Australia); D. Kettle (UK), A Leung (Hong Kong), D. Wallin (Sweden), J. Pool (The Netherlands), A. Porter Hoke (USA)
- 2001 IFOMT Strategic Meeting, Antwerp, Belgium**
 Plan to review the Standards document every 6 years, with feedback from Member Organisations and external assessors.
- 2002** K Beeton (UK) and L Wellington (Australia) join Standards Committee.
- 2004 IFOMT General Meeting, Cape Town, South Africa**
 Addition to the Standards document of "Part B, International Monitoring Document" following acceptance of the document. Document developed by A Lando (UK) and A Rushton (UK)
 Italy voted in as Member Organisation
 New Chair of Standards Committee appointed following meeting: A Rushton
 Members of Standards Committee: A Rushton (Chair, UK), K Beeton (UK), A Porter-Hoke (USA), L Maffey (Canada), J Pool (Netherlands)
- 2005** Questionnaires to MOs for feedback on the Standards Document to commence the 6 yearly review process
 First nominations from Member Organisations for Standards Committee members
 Greece and Spain voted in as Member Organisations through extraordinary General Meeting
- 2006 Standards Committee Meeting, Charlotte, USA**
 First face to face meeting of committee to discuss review of Standards Document

Members of Standards Committee: A Rushton (Chair, UK), K Beeton (UK), A Porter-Hoke (USA), J Langendoen (Germany), L Maffey (Canada), J Pool (Netherlands), D Rivett (Australia)

2008 IFOMT General Meeting, Rotterdam, Netherlands

Educational Standards Document revision presented at IFOMT meeting, Rotterdam, The Netherlands

Ireland and Japan voted in as Member Organisations

2009 IFOMT name change to IFOMPT

The educational Standards Document continues to be used as an active guide in the membership process and has benefited from feedback from the Member Organisations and being easily available on the IFOMPT web site.

The document has changed from being a 3-page outline of manual therapy approaches to a much longer and comprehensive document describing educational standards, scope of OMT practice, guidelines for formulating programmes and methods for measuring competency.

The following documents provide the evidence of the historical perspective to IFOMPT Educational Standards.

Foreword

"Leading up to the formal inauguration of IFOMT which took place in Montreal Canada June 1974, the Founding Committee of Robin McKenzie (New Zealand), Hanne Thorsen (Denmark) and myself Stanley Paris (USA as Chairman were not entirely agree that Standards should be the basis for membership of nations in IFOMT. There was a concern that the differences in philosophy between the major forces in manipulation could lead to a discourse that would prevent IFOMT being formed. On the other hand there were those who felt strongly that there should be no organization without Standards. While I as Chairman of the Founding Committee opposed Standards for the reasons stated above, our consultants namely Gregory Grieve (UK), Geoffrey Maitland (Australia) and Freddy Kaltenborn (Norway) urged that we have Standards. Thus they became part of the Constitution.

With hindsight I must say that my fears were unfounded and that Standards have been a very positive force in providing credibility to our organization and especially in helping other nations understand what it took to be a manual therapist".

Stanley V. Paris

Chair IFOMT Founding Committee and Inaugural Meeting, Second President of IFOMT

Section 2: 1975, IFOMT First Congress and General Meeting, Gran Canaria, Spain, Standards Committee submission

Enclosure 4.

INTERNATIONAL FEDERATION
of
ORTHOPAEDIC MANIPULATIVE THERAPISTS
75 Sherman Avenue, Waynesburg, Pennsylvania 15370

June 30, 1975

Submission of Standards Committee

The following represents the submission of the Standards Committee of IFOMT of the theoretical, practical, and clinical material which should be considered as a desirable minimum in training manual/manipulative therapists. This presentation is forwarded to the executive for consideration prior to onward transmission to the voting members of the Federation.

All members of the committee would like to express thanks to Mr. Gregory Grieve for the material enclosed under the theoretical section; this comprehensive compilation is entirely his work.

The submission is presented under the following headings:

1. Definition of Name, Standards, and Ethics
2. Theoretical outline with annotated bibliography
3. Practical outline including comments on examinations

It is hoped that this may be used as a guideline to assist in setting up new courses of training or improve existing courses.

The Standards Committee feel that fulltime training with supervised clinical work is vital in the long term development of successful manual therapy training. Training based on attendance on a number of short courses must only be considered as an interim measure although the committee realize that many therapists are receiving clinical instruction in the employing departments.



OFFICERS: RICHARD E. ERHARD, PRESIDENT • PETER EDGELOW, SECRETARY-TREASURER
EXECUTIVE MEMBERS: NEW ZEALAND • NORWAY • UNITED KINGDOM
STANDARDS COMMITTEE: FREDERICK M. KALTENBORN, CHAIRMAN • GREGORY P. GRIEVE, CO-CHAIRMAN • THEORY
DAVID LAMB • BRIAN EDWARDS

DWL
S.P.S. [initials]

Preamble

The Standards Committee recognize that a considerable variety of techniques exist which have to this time been considered belonging to various schools of thought, e.g., Mennell, Norwegian system, South Australian system, British system, osteopathic, chiropractic, etc. Presently considerable diffusion of ideas is taking place and modifications of all "systems" is occurring.

With this in mind the Standards Committee feel that agreement can be reached if guidelines are produced stating broad principles. It is considered desirable however that training systems in various countries make themselves aware of the work of all contributors in this field.

As stated in the "Definition of Name" actual mobilisation techniques are an addition to the available treatments appropriate for neuromusculoskeletal disorders. This section of the presentation will be concerned with principles related to the application of passive movement only, but it in no way infers exclusion of other appropriate techniques.

The Standards Committee feel that the following guidelines should be followed:

1. Thorough understanding of basic examinative techniques for determining neuromusculoskeletal dysfunction, e.g., comprehensive examination for neck and upper limb.

2. Palpatary skill must be developed so that:

(a) Reactivity of the local problem can be determined from point of view of recognising muscle spasm

(b) Applying pressures, gliding and distraction procedures to articular structures to determine the pain/range/resistance ~~relationship~~, e.g., "end feel".

3. Techniques for passive testing of specific joint movement should be included so that hypermobility, hypomobility and possible positional faults may be recognized.

4. The meaning of graded passive movement should be included so that the appropriate degree of movement can be applied to the joint related to pain/limitation/resistance relationship.

5. Techniques of semispecific mobilisation

The teaching of passive movement techniques for therapeutic purposes could conveniently follow the plan below. Learning techniques on peripheral joints prior to vertebral joints would seem a logical sequence.

(a) semispecific mobilisation to enable areas of the spine, e.g., thoracocervical or peripheral joint complexes, e.g., radiocarpal joint to be moved in appropriate directions.

(b) This could be followed by specific mobilisation techniques so that movement in a required direction may be applied to a dysfunctional mobile segment without applying unwanted stress to neighbouring areas. This would include the principles of so-called locking related to physiological combinations of movement.

Manipulation should ^{not} be taught until a thorough understanding of the principles of mobilisation has been achieved and competence in application of specific mobilisation obtained.

committee feel that supervised clinical work is an essential part of training scheme and that the value of training is considerably reduced without such clinical work.

of of competence by examination is essential. Such examination should be based on knowledge of broad principles set out previously:

- Broad basic science principles underlying use of manual therapy
- Principles directly related to mobilisation therapy, e.g., recognition of X-ray features, contraindications to manipulation, etc.
- Examination of a patient or patients
- Demonstration of techniques both spinal and peripheral on a model &/or patients
- Presentation of examples of case work performed by therapist
- Demonstration of knowledge obtained from wide reading of available literature.

Respectfully submitted,

E.P. Dwyer
David W. Lamb

F. Kaitenborn
G. Grieve
B. Edwards
D. W. Lamb

pendix I&II enclosed.

Appendix I

Techniques described in the following texts form a basis of practical techniques:

1. Bourdillon, J. (1973) Spinal Manipulation (2nd Edition) Heinemann, London
2. Cyriax, J. (1971) Textbook of Orthopaedic Medicine Vol. II. Cassell, London.
3. Kaltenborn, F. (1970) Mobilisation of the Spinal Column New Zealand University Press, Wellington, NZ
4. Kaltenborn, F. (1974) Manual Therapy for the Extremity Joints Olaf Norlis Bokhandel, Oslo
5. Maigne, R. (1972) Orthopaedic Medicine Thomas, Springfield, USA
6. Maitland, G.D. (1972) Vertebral Manipulation 3rd Edition Butterworth, London
7. Maitland, G. D. (1970) Peripheral Manipulation Butterworth, London
8. Mennell, J.B. (1945) Physical Treatment by Movement, Manipulation and Massage Churchill, London
9. Mennell, J.B. (1949) Science and Art of Joint Manipulation (Extremities) Churchill, London
10. Mennell, J.B. (1952) Science and Art of Joint Manipulation (Spinal Column) Churchill, London
11. Mennell, J. McM. (1960) Back Pain Little, Brown & Co., Boston, USA
12. Mennell, J. McM. (1964) Joint Pain Little, Brown & Co., Boston, USA
13. Mennell, J. McM. (1969) Foot Pain Little, Brown & Co., Boston, USA
14. Paris, S.V. (1965) The Spinal Lesion Pegasus, New Zealand
15. Stoddard, A. (1962) Manual of Osteopathic Technique Hutchison, London
16. Stoddard, A. (1969) Manual of Osteopathic Practice Hutchison, London

Appendix II

Further detailed training programmes will be included from each submitting country itemizing their programmes once these become available.

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Amendments

Page headed Definition of Name

Last paragraph to become:

The term orthopaedic manual therapist is considered to be synonymous with the term orthopaedic manipulative therapist.

Modifications to Theory Programme

Theory

Page 1, Para 2

- vertebral, with functional interdependence of vertebral regions, physiological combinations of movement and consideration of relationships of direction of gliding movements to configuration of joint surfaces.

Para 19 to be headed RADIOLOGY

- normal appearances
- abnormal appearances and common syndromes
- static and mobility films
- standing weight-bearing films

special tests:

- cineradiography
- myelography
- radiculography
- epidurography
- laminography
- scanagrams
- interosseous vertebral venography
- vertebral artery angiography

Para 20 to be headed ALLIED INVESTIGATION AND DIAGNOSTIC PROCEDURES

- electromyography
- paravertebral ganglion block
- cupolometry
- electronystagmography
- psychometry
- pentothal studies

Present para 20 now becomes 21.

DWJ
PK

Section 3: 1977, IFOMT General Meeting, Vail, USA, Standards Committee report

Agenda item 5B – The Standards Committee Report (from Minutes of IFOMT General Meeting)

Agenda, Item 5B-The Standards Committee Report.

A meeting of the Standards Committee took place on June 7th, 1977 in Vail during the IFOMT seminar. This was chaired by Mr. E. Maltenborn and attended by Mr. Edwards and Mr. Lamb. Mr. Grieve had given prior notice of his absence. A number of proposals set out below were forthcoming from deliberations. All the following proposals had unanimous agreement of the committee. Note. The text of the report below includes the addition of the amendments to the report.

1. The draft of the theoretical and practical recommendations can now be finalised. The theoretical part as present in Gran Canaria in 1975 is that presented by Mr. Grieve with agreed to minor alterations. A submission by Mr. Edwards has been added to the practical recommendations. It is suggested that copies of this document be prepared and circulated to members of the General Assembly prior to next meeting, i.e. 1978.

2. It was agreed that the full spectrum of manual therapy treatment procedures including specific thrust techniques and specific mobilisation applied to peripheral and spinal joints should be included. The recommended educational sequence being techniques applied to peripheral joints before training in specific mobilisation of spinal joints. Thrust techniques should be taught only where supervised clinical work was part of the training process.

The Standards Committee suggest the following regarding membership status:-

Countries seeking full membership status should submit to the Standards Committee details of their proposed programme. This would include covering all branches of manual therapy applied to both spinal and extremity joints.

Before full membership could be applied for, the programme would be in operation and at least three physical therapists in that country would have taken the full examination. It is proposed that details of the proposed programme be submitted to the Standards Committee. After consideration a reply should be sent stating that the committee on behalf of IFOMT have or have not accepted these in principle. Once this acceptance has been received and the training and examinations instituted the countries could apply for full membership status.

Member elect status shall apply to those countries having applied for full membership status, and this application having been approved by the Standards Committee are awaiting ratification by the IFOMT General Assembly.

This ratification should be the first order of business of any General Assembly. It is suggested that Australia, Netherlands, New Zealand, Norway, Sweden and the United Kingdom be asked to submit details of their training programme with numbers of their successful graduates to the Standards Committee prior to the next meeting of the General Assembly after the General Assembly of 1978 or revert to associate member status.

Application by Canada and South Africa was received. Consideration of action was delayed pending consideration of the proposals given above regarding eligibility of countries for full membership status.

The Standards Committee shall not become involved in setting standards for individual countries but rather in establishing standards which countries may use in guiding their own development. The Standards Committee would be involved however in assessing these standards once application for full membership had been received.

*See below.

On request from the national orthopedic manual therapy association or the national physical therapy association of a country the Standards Committee¹⁾ could assist in examinations in manual therapy or refer to countries or organisations with accepted standards, for their assistance. 1) Since 1982 "members of the Standard Comm: act as Consultants on Educational matters" (decided in Stockholm May 30. in 1982)
The secretary of IFOMT should forward all correspondence concerning curriculum, examination and ethics to the Standards Committee for action.

At the present time no mechanism exists for replacing a member of the Standards Committee during the interval between General Assemblies. It is suggested during this interval that a resigning member be permitted to suggest an alternate or a replacement. In the event of this not being done a new member should be assigned by the Executive. The Chairman should notify the Executive of any changes in the Standards Committee.

*This assessment shall consist of the evaluation of submitted documents only and not involve any visit of any member of the Standards Committee to the country involved unless especially ~~requested~~^{requested x)} by the country.

Respectfully submitted,
Chairman-F. Kaltenborn
Members-D. Edwards

D. Lamb

Australia and Canada moved to receive ^(and adopt x) the Standards Committee Report as amended.

The vote was unanimous.

x) Changed in Israel 29. May 1978.

Australia moved a vote of thanks to the Standards Committee for all the work of the two submissions. Seconded by Canada. Vote-unanimous.

Section 4: 1978, IFOMT General Meeting, Tel Aviv, Israel, Standards Committee report

The Standards Committee report consisted of the document from 1977.

The document was discussed and 2 words were amended (see previous section).

The document was agreed.

The Standards Document was ratified at the WCPT meeting in Tel Aviv.

The following excerpt is from the General Meeting minutes:

- b). Standards Committee Report. The enclosed report presented and discussed. It was proposed to accept Standards document (Spinal and Peripheral Joints ~~submitted by Canada for discussion.~~) Proposed Australia. Seconded Norway. Unanimous.

for minutes

Section 5: 1992, IFOMT General Meeting, Vail, USA, Educational Standards document



INTERNATIONAL FEDERATION OF
ORTHOPAEDIC MANIPULATIVE THERAPISTS
IFOMT

1992

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EDUCATIONAL STANDARDS

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PREAMBLE

Orthopaedic Manipulative (manual) Therapy is a specialization within Physical Therapy and provides comprehensive conservative management for pain and other symptoms of neuro-muscular-articular dysfunction in the spine and extremities.

IFOMT is a non-government International Manipulative Therapy Federation, representing international collaboration in Manipulative Therapy and solely concerned with Manipulative Therapy and Physical Therapists, and is a recognised sub group of World Confederation for Physical Therapy (WCPT).

CATEGORIES OF MEMBERSHIP

FULL MEMBER

- A Manual Therapy Association or Manual Therapy Federation or a Manual Therapy Committee from each country, which is recognised by the Parent National Physiotherapists Body, which is a member of WCPT and the members of which hold a qualification recognised at national level in that country, may be admitted to membership provided its by-laws are in harmony with, and standards are these laid down by IFOMT.

REGISTERED INTEREST COUNTRY

- A nationally recognised Manual Therapy Group who have not as yet a training or examination system in place, but wish to achieve full membership in the future.

EDUCATIONAL STANDARDS

An educational curriculum referred to as the "STANDARDS" which was presented in 1977 at the IFOMT meeting in Vail, USA has been effective since ratification in Israel at WCPT in 1978. It covers the post-graduate training of physical therapists in orthopaedic manipulative (manual) therapy (OMT). The educational standards of IFOMT extend the basic training received in OMT in physical therapy training programs so that orthopaedic manipulative physical therapists attain a high standard of patient care.

The acceptance and implementation of the educational standards both theoretical and practical is a mandatory minimum requirement for countries seeking full membership in IFOMT.

Of special note is that formal evaluations to prove competency are prerequisite for this membership status. These cover all aspects of theoretical, practical and clinical knowledge applied to neuro-muscular-articular dysfunction in the spine and the extremities in patients.

The educational aims and objectives are not meant to be absolute but rather they serve as a detailed guide towards standards of education and training acceptable to IFOMT. IFOMT recognizes that there will be differences in strengths and emphases in different OMT courses around the world. These are necessary and encouraged by IFOMT for the future development of OMT. IFOMT also recognizes differences that will exist in methods and delivery of education in various countries.

IFOMT has a commitment to research and recognizes the importance of proof of validity of OMT diagnosis and practice. It fosters enquiry and encourages physical therapists' involvement in a variety of ways such as experimental studies, single case studies, surveys and literature reviews.

AIMS AND OBJECTIVES OF IFOMT EDUCATIONAL STANDARDS

BASIC SCIENCES

AIMS:

- To advance physical therapists' knowledge of the anatomy, physiology and biomechanics of the spinal and peripheral neuro-muscular-articular systems.
- To enhance physical therapists' understanding of aberrations of function of the neuro-muscular-articular system.
- To provide further knowledge for clinical problem solving and for the understanding of the anatomical and physiological bases for techniques used to examine, diagnose and manage neuro-muscular-articular dysfunctions.
- To enhance physical therapists' ability to scientifically evaluate established and new theories on mechanisms, pathogenesis and management of neuro-muscular-articular disorders.

OBJECTIVES:

On completion of the education program, the physical therapist shall be able to demonstrate :

- (i) **Anatomy**
 - a detailed understanding of the structure, function and relationships of the muscular, articular and nervous systems of the axial and appendicular skeleton including the temporomandibular joint.
 - an understanding of developmental and acquired anomalies in the osseous, articular and neural systems.
 - a detailed knowledge of the nature, ranges and interrelationships of spinal and peripheral joint movement.
 - an understanding of the organisation of the central and peripheral nervous systems, the neurology of joints and the anatomical bases for somatic and neuritic pain.
 - an understanding of the structure, mechanics and movement of the central and peripheral nervous systems during normal body movements.
 - an understanding of the vascular system (course and blood supply) of the axial and appendicular structures.
- (ii) **Biomechanics:**
 - an understanding of the biomechanical properties of viscoelastic tissues of the neuro-muscular-articular system and understand the changes that occur with trauma, overuse, immobilisation, age and during the repair process.

- an understanding of how loads and forces are distributed and resisted by the neuro-muscular-articular structures in normal function.
- an ability to analyse the stresses imparted to various structures during injurious activity and discuss how such stress may be involved in the pathogenesis of axial and appendicular neuro-muscular-articular pain and dysfunction.
- an ability to critically evaluate and discuss the anatomical and biomechanical bases for physical examination and treatment techniques.

(iii) Physiology:

- an understanding and ability to evaluate current knowledge on physiological mechanisms of muscle control in normal and abnormal function.
- an ability to discuss current knowledge on the neurophysiological mechanisms underlying pain production, perception and modulation.
- an understanding of the functional organisation of the sympathetic nervous system; the mechanisms of visceral and deep somatic pain; viscerosomatic and somatovisceral relationships; sympathetically maintained pain.
- an understanding of current knowledge of biochemistry and microstructure of collagen, particularly as it pertains to the articular system including the intervertebral disc.
- an understanding of the significance of biochemical reactions in trauma, immobilization, repair and aging to the clinical situation.

MEDICAL SCIENCES

AIMS:

- to advance physical therapists' knowledge of pathology and pathogenesis of disorders of the neuro-muscular-articular system and their clinical features.
- to further knowledge on the clinical presentation of non-mechanical disorders of the neuro-muscular-articular system, their clinical recognition and differential diagnosis.
- to further understanding of the investigative procedures available for differential diagnosis of neuro-muscular-articular pain states.
- to further understanding of the indications for and the nature of surgical intervention for neuro-muscular-articular disorders.
- to advance knowledge of the indications and effects of therapeutic drugs in the management of neuro-muscular-articular disorders.

OBJECTIVES:

On completion of the education program, the physical therapist shall be able to :

(i) Orthopaedics

- discuss current knowledge on the aetiology, pathomechanics, pathogenesis and pathologies of benign mechanical and degenerative disorders of the vertebral column and the extremities.
- discuss congenital and acquired anomalies of the vertebral column and their possible role in spinal pain syndromes.
- discuss the problems and presentations of instability of spinal and peripheral joints.
- demonstrate a knowledge of clinical presentations of orthopaedic conditions where a referral for possible surgical intervention is indicated.

(ii) Rheumatology

- discuss the pathology, pathogenesis and clinical features of degenerative and inflammatory arthropathies.
- discuss the pathology, pathogenesis and clinical features of inflammatory, viral and metabolic disorders affecting connective tissues including bone and fascia.
- display a basic knowledge of the laboratory investigations used to diagnose rheumatic disease.
- discuss the type of therapeutic drugs used in the management of degenerative and rheumatic disorders.

(iii) Medicine

- discuss the clinical and differential diagnostic features of conditions and diseases which may mimic musculoskeletal pain, with particular reference to cardiovascular and visceral disease.

(iv) Neurology

- discuss the nature, early signs and symptoms and differential diagnosis of tumours and other causes of spinal cord compression.
- discuss the clinical presentation and differential diagnosis of vascular disorders mimicking musculoskeletal pain.
- discuss vertebrobasilar insufficiency, disorders with similar presentations and differential diagnosis.
- demonstrate an understanding of the classification and various causes of headache and to identify those which may have a neuro-muscular-articular cause or component.
- discuss the pathology and neurophysiology of nerve entrapment neuropathies.

- demonstrate an understanding of the aetiology, pathology and differential diagnosis of diseases of nerve roots and peripheral nerves.
- (v) Radiology
 - display a knowledge of the current methods of radiological investigation for disorders of the spinal column and peripheral joints.
- (vi) Dentistry
 - discuss disorders of the craniomandibular complex and the dental approach to management.
 - demonstrate an understanding of the roles of the dentist and physical therapist in the management of craniomandibular dysfunction.

BEHAVIOURAL SCIENCES

AIMS

- to enhance physical therapists' communication and interactive skills.
- to enhance physical therapists' awareness of the global aspects of pain, psychological factors and stress management strategies.

OBJECTIVES

On completion of the education program, the physical therapist shall be able to:

- demonstrate effective communication skills for patient assessment, instruction and counselling.
- demonstrate an understanding of the global reactions of pain and disability and strategies that the physical therapist may use to assist the patient in total rehabilitation.
- understand the problems of chronic pain, the team approach to management and management strategies.

ORTHOPAEDIC MANIPULATIVE THERAPY THEORY AND PRACTICE

AIMS

- . To advance physical therapists' knowledge of the physical therapy theory of assessment, diagnosis and management of neuro-muscular-articular disorders.
- . To assist physical therapists to integrate knowledge from the basic, medical and behavioural sciences in the clinical setting.
- . To develop a high level of clinical skill in the assessment, physical diagnosis and management of patients with neuro-muscular-articular disorders.
- . To develop a high level of expertise in the selection and application of orthopaedic manipulative therapy techniques.
- . To develop outcome measures to evaluate the effectiveness of OMT.
- . To enhance knowledge of the theory of manipulative therapy practice and encourage critical review of its scientific merit.
- . To ensure that physical therapists have a comprehensive knowledge of the indications and contra-indications for manipulative therapy practice.
- . To enhance the physical therapists' expertise in preventative programs for neuro-muscular-articular disorders.
- . To enhance physical therapists' knowledge of professional issues relevant to the practice of manipulative therapy.
- . To encourage physical therapists to critically review the recent literature of the basic and applied sciences relevant to neuro-muscular-articular disorders, to draw inferences for orthopaedic manipulative therapy practice and present material logically in both verbal and written forms.

OBJECTIVES

On completion of the education program, the physical therapist shall be able to :

- . critically evaluate the theory and science of orthopaedic manipulative therapy practice.
- . demonstrate an ability to interpret information from the basic, medical and behavioral sciences and apply it the problem solving process of the clinical examination of neuro-muscular-articular disorders.
- . demonstrate a depth of knowledge of the interrelationship of the neuro-muscular-articular structures in normal function and musculoskeletal pain syndromes:
- . demonstrate effective communication skills to gain comprehensive information about the type and nature of the patient's complaint. To be able to interpret information towards physical diagnosis and the indications for and contra-indications to manipulative therapy management.

demonstrate a high level of skill in performing appropriate and effective physical examinations of patients with neuro-muscular-articular injuries or disorders of the axial or appendicular skeleton.

Skills will be demonstrated in :

Analysis of static and dynamic posture

Analysis of the active and passive movements of the articular system

Clinical examination of the nervous system - for conductivity and neural mechanics

Analysis and specific tests for functional status of the muscular system

Special tests for the safety of practice of orthopaedic manipulative therapy

interpret the findings of the physical examination in an accurate manner and relate such findings to any other medical diagnostic tests to make a physical diagnosis.

plan and implement appropriate management strategies which reflect the total needs of the patient.

perform manipulative therapy techniques effectively and accurately, demonstrating high levels of skill in the performance of passive movements (under the control of the patient) and passive movements with impulse (quick controlled manipulation).

demonstrate a high level of skill in other manual and physical therapy techniques required to mobilise the articular, muscular or neural systems.

apply current electrophysical modalities to enhance rehabilitation of neuro-muscular-articular dysfunction.

demonstrate a high level of skill in implementing and instructing patients in appropriate therapeutic rehabilitation exercise programs.

demonstrate knowledge of appropriate ergonomic strategies and advice.

demonstrate the ability to evaluate the results of treatment accurately on the basis of outcome measures and modify and progress treatment as required.

keep clear and accurate clinical records and write appropriate reports for medical and legal consultations.

demonstrate an ability to integrate and apply scientific and clinical data in the presentation of health promotion and preventative care programs.

demonstrate a knowledge of various manipulative therapy approaches as practised within physical therapy, medicine, osteopathy and chiropractic.

RESEARCH PROJECT

AIMS

- to foster enquiry and critical analysis of orthopaedic manipulative therapy practice and its related sciences.
- to extend physical therapists' interests, skill and commitment to research.
- to enhance the physical therapists' ability to identify and pose a research question, to make a critical analysis of the literature relevant to the project, to design and conduct an investigation satisfactorily, to analyse and present results accurately and concisely and to draw logical and valid conclusions.

OBJECTIVES

On completion of the education program, the physical therapist shall be able to :

- present a research project which satisfies the examiners of the physical therapists' ability to undertake and present a research study.

FOOTNOTE

Research has many components which include, for example critical evaluation of the literature on a nominated topic, population surveys, single case patient studies, evaluation of outcome measures, clinical trials and experimental studies.

APPENDIX I

SCOPE OF PRACTICE OF O.M.T.

Orthopaedic manipulative therapy (OMT) is a specialization within physical therapy and provides comprehensive conservative management for pain and other symptoms of neuro-musculo-articular dysfunction in the spine and extremities.

Orthopaedic manipulative therapists work within the orthodox medical system in close liaison with medical practitioners. They are responsible for making a clinical physical diagnosis and for deciding on the suitability of a patient for treatment by observing precautions and recognizing contra-indications.

The application of OMT is based on a thorough examination of the neuro-muscular-articular system. This examination serves to define, in physical terms, the presenting dysfunction in the articular, muscular and nervous systems. Equally, the examination aims to distinguish those conditions which contra-indicate management by OMT or those where anatomical anomalies or pathological processes limit or direct the use of OMT procedures.

The main goal of OMT is to restore maximal and painfree function to the neuro-musculo-articular systems.

This is achieved through several possible methods:¹

- . relief of pain and muscle spasm.
- . restoration of normal tissue fluid exchange, soft tissue pliability and extensibility, normal joint relationship and mobility.
- . correction of muscle weakness and imbalance.
- . restoration of adequate control of motion.
- . stabilization of unstable segments.
- . relief from chronic postural or occupational stress.
- . functional reablement of the patient.
- . prevention of recurrence.
- . restoration of confidence and self reliance.

In more specific terms, OMT means the use of passive movement applied manually or mechanically to help restore normal neuro-musculo-articular function.

Application of passive movement can involve manipulation - passive movement with thrust (high velocity low amplitude) and mobilization - passive movement which is graded the force, speed and amplitude being directed by the pain/range/spasm relationship in the joint (end feel).

REFERENCES

- ¹ Grieve G P, 1988 Common vertebral joint problems, Churchill Livingstone, Edinburgh

OMT is an extension of an extensive repertoire of physical therapy skills.

The following represents a summary of OMT treatment strategies:

PAIN MODULATION

1. Immobilization
 - (i) General: bedrest in antalgic positions.
 - (ii) Local: corsets, collars, casts, braces, taping.
2. Special passive movement procedures applied prior to the tissue resistance barrier being encountered
 - (i) Optimal amplitude motion in painfree ranges.
 - (ii) 3-dimensional traction - distraction in the most pain free combination of joint positions.
 - (iii) Inhibitory pressures.
3. The application of electrophysical agents.

RESTORATION OF MOBILITY

1. Soft tissue
 - (i) Massage: classical, connective tissue, deep transverse frictions.
 - (ii) Muscle relaxation techniques based on specific reflex procedures: post isometric relaxation, reciprocal inhibition.
 - (iii) Specific muscle lengthening procedures to obtain muscle and connective tissue extensibility.
 - (iv) Exercise to maintain or increase in soft tissue extensibility.
2. Joints
 - (i) PASSIVE MOBILIZATION

Passive mobilization is the application of specific passive movements to a joint, either manually or mechanically applied, which are performed at a slow and rhythmical speed such that the patient can prevent the movement if he so chooses. The rhythm can be oscillatory or a sustained stretch.

Passive mobilization may encompass:

 - (a) Translatory or accessory movements
 - (b) Angular movements
 - (c) Distraction, compression

All movements are graded with respect to their amplitude and position in range and are directed by the presence of pain, quality of tissue resistance through range and the joint end feel.

(ii) MANIPULATION

Manipulation is a small amplitude of movement applied, with quick impulse, to a joint showing a suitable end feel to effect joint separation and to restore translatory glide.

Orthopaedic manipulative therapists recognise that this is not a benign procedure. Implicit in this document is acceptance that this must be thoroughly learned. Orthopaedic manipulative therapists have developed some unique procedures which eliminate rotary stresses and emphasize glide and distraction movements. Rotation and extension are recognised as being movements which can provide a hazard especially when applied to the cranio-vertebral region.

Wetherby
1952

APPENDIX 2

GUIDELINES FOR FORMULATING O.M.T. PROGRAMS

The following guidelines should be considered in formulating training schemes:

Fulltime training with supervised clinical work is vital in the long term development of OMT training. Training based on attendance of a sequence of short courses whilst successful in the past must only be considered an interim measure.

(i) THEORETICAL INSTRUCTION

Comprehensive theoretical knowledge is required in the basic and clinical sciences for the development of high level skills in physical diagnosis and clinical management.

Students' theoretical learning can be optimized by careful course planning. Courses are ideally structured so that theoretical instruction complements preclinical and clinical OMT subjects. This assists students' understanding of the relevance of the theory and helps them to integrate and apply it immediately to their clinical practice.

Courses should include a variety of teaching formats and learning strategies. Formats that encourage and extend student problem solving, clinical reasoning skills will enhance their performance in clinical practice.

It is expected that OMT educational programs will contain a minimum of 200 hours of theoretical instruction.

(ii) PRECLINICAL INSTRUCTION IN OMT

The preclinical courses in OMT must emphasize the development of students' clinical reasoning skills to prepare them for clinical practice.

The examination and management of articular dysfunction should be learnt in conjunction with that of muscle and nervous systems so that total patient management is emphasized.

A thorough understanding of the basic examination techniques for physical diagnosis of neuro-muscular-articular dysfunction is essential.

Manual examination skills must be developed so that students can display competency in:

- Recognizing possible positional faults, joint hypermobility and joint hypomobility through the use of specific techniques for testing passive joint movement.

- Determining the pain/range/resistance relationships including joint "end feel" and through range quality of movement by the application of passive manual examination techniques including pressures, gliding, distraction, compression and rotary procedures.

Recognizing the reactivity of the local problem by analysis of local discrete muscle spasm.

Students should understand the meaning of graded passive movement so that the appropriate amount of movement can be applied to the joint related to the pain/range/resistance findings.

It is recommended that the teaching of manipulative therapy procedures (i.e. passive mobilisations and manipulations) follow a progressive plan. The recommended sequence for learning procedures is:

- mobilization procedures for peripheral joints
- mobilization procedures for spinal joints

Once competency is demonstrated in preclinical and clinical situations in these procedures,

- manipulation procedures for peripheral joints
- manipulation procedures for spinal joints.

The application of peripheral and spinal manipulations should be supervised in the preclinical and clinical environments.

It is expected that a minimum of 150 hours will be spent in the preclinical instruction of OMT treatment procedures.

SUPERVISED CLINICAL WORK

Supervised clinical practice is an essential part of the OMT educational program.

Physical therapists in an OMT training program will undertake clinical practice under the direct supervision of an OMT instructor. It is recommended that the supervised clinical work should be undertaken with a ratio of no more than four (4) students to one (1) OMT instructor.

It is recommended that a minimum of 150 hours of clinical instruction be undertaken. This should be distributed throughout the course of theoretical and preclinical instruction to give students the maximum opportunity to develop their clinical skills.

EVALUATION OF COMPETENCY

Proof of competency by formal evaluation is mandatory and should be based on knowledge of broad principles set out in the standards document.

Competency should be demonstrated in:-

- the basic, medical and behavioural sciences underlying the use of manipulative therapy.
- the theory and science of manipulative therapy.
- the clinical examination, physical diagnosis and management of patients.

- . techniques of examination and treatment both to peripheral and spinal joints on a model and/or patients.
- . patient case presentation.
- . research principles and design

The physical therapist should demonstrate a breadth of knowledge obtained from a wide reading of the literature.

APPENDIX 3

GUIDELINES FOR COUNTRIES WITH LEGISLATION TO LIMIT
THE PRACTICE OF MANIPULATION

The scope of practice of the orthopaedic manipulative therapists includes a full spectrum of OMT treatment procedures including specific mobilization and manipulation applied to peripheral and spinal joints.

X In the event that manipulation (thrust techniques) applied to the spine is prohibited by government legislation this would not preclude the OMT group of that country obtaining membership provided manipulation be taught and practised as it can be applied to peripheral joints. Even if thrust techniques cannot be applied to patients with spinal problems, training in the theory and technique should be undertaken as this could be used to change government policy.

If a country states that there is a legal restriction to manipulation, the details of such legislation should be produced with application for membership.

Additional comments to annotations of Educational Standards 1992 from F Kaltenborn (2011) (page numbers refer to this history document):

The original document of the 1992 Educational Standards has disappeared, and this document is F Kaltenborn's original copy and includes some personal notes relating to corrections made before delivery.

Page 17 - 'Manual Therapy' was changed to 'Manipulative Therapy'

Page 25 - 'can' was changed to 'shall'

Page 27 - The note on the left referred to a conversation with G Jull before this draft of the text. The previous version included 'In 1952 Kaltenborn developed some unique.....'. F Kaltenborn requested that this be changed to 'Orthopaedic Manipulative Therapist' which was done.

Section 6: 1992, IFOMT General Meeting, Vail, USA. History of IFOMT

Delivered and signed by D Lamb. Co-signed by F Kaltenborn and S Paris.

Vail 1992

①

HISTORY OF IFOMT

David W. Lamb, M.C.S.P., M.C.P.A.
Freddy M. Kaltenborn
Stanley V. Paris, Ph.D., P.T., N.Z.S.P., F.N.Z.M.T.A., M.C.S.P., R.B.P.

For my part, I consider that it will be found much better by all parties to leave the past to history, especially as I propose to write that history myself.
- by Winston S. Churchill
House of Commons, January 23, 1948

INTRODUCTION

The history of IFOMT is inevitably intertwined with the development and rise of physical therapy.

The growth of physical therapy over the last fifty years has been phenomenal. Paralleling that growth has been the rise of manual and manipulative therapy. Indeed much of the vigor and ideas for growth have come from this group. In each country there have been leaders who have seen the future and striven for it. Manual therapists have been foremost in that leadership and whether pushing for physical therapy or for manual therapy they have in the process elevated the standing and maturity of both. Today, therefore, physical therapy can look with pride on the accomplishments of manual and manipulative therapists.

As in any developing area there emerged leaders. These leaders did not share a common vision of the end point nor of how it should be achieved. But they have shared an energy which has brought us to this celebration here today. We have become in many countries if not the first then the foremost specialty group of our professions and we were indeed the first to be recognized as a clinical sub group of the World Confederation of Physical Therapy in Israel in 1978, based on IFOMT's constitution and standards.

In this paper we the authors have tried to present as best we may the history of the founding of this movement at least at the international level. It has not been an easy task. There were some strong differences of opinion that will be briefly addressed in this presentation. We have provided for two of the authors to express any dissent and we invite others to submit any information they wish for the archives of IFOMT. But to dwell on differences of opinion would miss the main point which is that manual therapists of many nations have worked together to bring us where we are today and that the next

generation which will now assume the leadership is quite rightly less concerned with the past than with the future.

But the history needed to be written and it is appropriate that those who most helped shape it and are privy to the records and the correspondence be those who write this, the first formal history of IFOMT.

THE YEAR 1960

Manual and manipulative therapy, hereinafter referred to by either term, was in its infancy. In many respects the birth of manual therapy was in England where at St. Thomas' Hospital there was a long tradition of joint manipulation being instructed to physical therapists by medical physicians. The first of these was Dr. James Mennell whose son, John, was to continue the tradition in both New Zealand and the United States. But the giant was Dr. James Cyriax who directly influenced all our early and most of our present leaders in manual therapy. Kaltenborn, Grieve, and Paris had all visited him and some worked with him at St. Thomas'. Lamb, Fowler and many others were to follow. These therapists also visited and studied with the medical and osteopathic physician, Dr. Alan Stoddard, who likewise gave freely of his expertise and encouragement. Although Cyriax and Stoddard had little in common in their approach to manual therapy, both recognized the need for physical therapists to upgrade their skills in manual therapy and to be principal players in this field.

In 1954 Kaltenborn in Norway and by 1962 Paris in New Zealand and Maitland in Australia had all become established as leaders in manual therapy. They lectured, gave seminars, courses and began to publish. The future would establish more, such as Evjenth of Norway, McKenzie of New Zealand, Rocabado of Chile, Grieve of the United Kingdom,

From 1900

Elvey of Australia, and researchers such as Twomey, each making unique contributions. But, that's for the future.

In 1967, the Chartered Society of Physiotherapy in England invited Geoffrey Maitland of Australia to come and spend a year giving instruction in his methods to English physiotherapists. Gregory Grieve was associated with Maitland and continued this work after his departure. In the United States, Stanley Paris learned from Maitland of this event and flew to London to meet with him for the first time. Paris invited Kaltenborn and so in the cafeteria of a London hospital Maitland, Grieve, Kaltenborn and Paris in the company of Monica Martin-Jones and Lois Dywer discussed the future of manual and manipulative therapy.

Thus was conceived an association to be called the World Confederation of Manual Therapy. Paris wanted to establish a newsletter within the group and that was agreed to. Agreed also that some movement should be made to an international organization that would bring together all those who were interested in such an association. Paris began to make inquiries and called a meeting at Amsterdam during the WCPT Congress in 1970. At that meeting, called to order by Paris, it was agreed to set up an interim committee of Stanley Paris as secretary with Hanna Thorsen of Denmark and Robin McKenzie of New Zealand as committee members. Also appointed were consultants to the committee, namely Kaltenborn of Norway and Maitland of Australia - thus were the roots laid although not identified at the time of IFOMT. The charge was to meet again four years later in Montreal Canada to form an international body.

Paris began the task of attempting to accomplish this in three years. Contacts were made with national groups that were members of the World Confederation for Physical Therapy who were in turn asked to identify if they recognized any one person, any organizations within their country that could represent manual therapy at the Congress. At that time, individual communications were also welcomed. Through these vehicles, attempts would be made to collect information on the scope and purpose of WCMT and then to formulate a constitution.

It seemed to Paris that not much more was necessary than to call the meeting, and this is how he saw the charge from the Amsterdam meeting. Paris saw this world confederation as a forum for all who were interested in the field. On the question of standards for membership, he and Hanna Thorsen spoke

against, but never voted against them. Essentially he feared that a squabble over standards would bring down the organization before it could be brought to life.

The other view on standards was held by Kaltenborn. He and others felt that without standards for membership, the organization would have no standing and that it may fail to even get started.

In 1973 Kaltenborn, through the International Seminar of OMT, arranged a meeting in Gran Canaria. This was a formidable undertaking of four weeks. One week each, to review advanced techniques of mobilization to the spine and mobilization and manipulation to peripheral joints and two weeks of lecture demonstrations including presentations by orthopaedic physicians and surgeons practicing manual medicine. This would be followed by an examination.

This meeting in 1973 was not unanimously supported by the officers of WCMT and this probably represented their priorities. Kaltenborn seeing proof of competency by examination as a necessity, Paris and Thorsen seeing identification of scope and purpose as the priority.

The 1973 Gran Canaria meeting was the opportunity for 74 experienced manual therapists from 12 countries to meet in a retreat atmosphere and practice and refine techniques and expand their mental horizons by listening to world class leaders.

The examination was arranged. Professor Brodin set the theoretical paper and a board comprising Drs. Cyriax, Brodin, Stoddard and Frisch examined candidates who had passed the theory exam in specific mobilization techniques of the spine and peripheral joints.

From these successful candidates, one or two were chosen as representatives of countries and the board examined these to judge the standard of manipulation (HVT) attained in that country. These exams were a prototype and an attempt to create an international examination. This worthy aim has not proven possible in practice. The major importance was it allowed manual therapists to subject their skill levels to the scrutiny of an outside group of impeccable credentials.

At the conclusion of these examinations, the candidates successful in the manipulation section formed the International Federation of Manual Therapy. This group communicated with the World

Confederation. There were strong differences of opinion and matters could have been handled better; fortunately maturity prevailed and the two groups fused at the Montreal meeting in 1974 recognizing the need for both process, a constitutional framework and the need for standards.

In June 1974, a credentials committee was appointed consisting of Stanley Paris as chair, and the consultants Maitland and Kaltenborn, with Grieve added later, to decide which countries should be the first voting members in IFOMT at the inaugural meeting in Montreal.

Montreal in 1974 was a celebration. Some 12 countries were present with representatives. The following 10 countries were initially approved as voting members; Australia, Canada, Denmark, Finland, Netherlands, New Zealand, Norway, South Africa, Sweden, United Kingdom, and the United States of America. To their credit, they admitted only 6 of their numbers as having met the principles of Standards for the purpose of voting at future meetings. Those six were Australia, Netherlands, Norway, New Zealand, Sweden and the United Kingdom. This was only an interim measure. The countries would eventually have to submit their standards to a committee scrutiny.

Thus, The International Federation of Manipulative Therapy was founded. The inaugural meeting, including finalizing the constitution, was chaired by Paris. The meeting also decided to formulate and develop educational standards. A Committee consisting of F. Kaltenborn - Chairman, G. Grieve - Co-Chairman, Edwards and D. Lamb as members, were instructed to accomplish this task. This committee was a committee of General Assembly. Richard Erhard of the United States was elected as the first President of IFOMT and Peter Edgelow of the United States as the first secretary. The formation of IFOMT was marked by a joyful celebration dinner.

IFOMT has had several very successful Congresses since the first in Montreal:

Vail, Colorado, USA	1977
Christchurch, New Zealand	1980
Vancouver, Canada	1984
Cambridge, England	1988
Vail, Colorado, USA	1992

In 1976, Paris of the United States and Searle of New Zealand became President and Secretary respectively. In 1984 Robert Elvey of Australia was

elected President. Searle has remained as Secretary since 1976.



Montreal 1974. From left to right, Gregory Grieve, U.K., Freddy Kaltenborn, Norway., Stanley Paris, USA., and Geoffrey Maitland, Australia. Picture taken in the closing minutes of the Inaugural IFOMT Meeting.

The Standards Committee from their original mandate have continued to play a significant role in IFOMT.

In 1976, Kaltenborn and the Int seminar organized another practical / theoretical seminar in G.C. which gave the standards committee opportunity to meet face to face and refine the theoretical components of the Educational Standards.

These were largely developed by Greg Grieve assisted by Barbara Grieve and based on the UK system.

By the Vail Congress in 1977, the practical component largely compiled by Edwards, based on his experience with the Australian and Norwegian systems, had been added and the standard document was finalized and accepted together with rules for future membership by the G.A.

The original mandate of the Standards Committee being completed, Grieve stepped down. In 1978, the Standards Committee was changed with Lamb as Chairman, Kaltenborn and Maitland as members. These 3 later became consultants to the Executive - their role was largely matters of membership.

These resigned in 1988 to allow the development of the Membership Committee, chaired by Gwen Jull

who has presided over a major restructuring of the Standards document to formulate it in modern educational terms.

The constitutions and bylaws have also been subject to scrutiny and change. David Iles of Canada completed the first revision, the latest has been achieved by Bob and Gaye Sydenham.

Over the years IFOMT has become a mature and solid organization. Its strength in numbers, its diversity of nations and races testify to its strength. Beginning with the six interim members in 1974, it now has 10 members who have met the Standards with more to be considered at this meeting. By responding to the needs of its members, IFOMT will remain a potent organization. In addition there are RIC. Later this week, IFOMT will begin, through its awards process, to recognize those who have done so much for so many.

I shall close with these comments written by a contributor coming later in the week.

"The future of the practice of manipulation, be it by chiropractic physicians, osteopathic physicians, medical physicians or physical therapists, is dependent on the knowledge base of each of its practitioners. Rivalry between the professions which practice manipulation still exists, though it has changed to a very healthy competition to gain excellence. Determining which profession(s) will be allowed to practice manipulation in the future will depend on the scientific knowledge and the clinical skills of its practitioners."

- by Scott Haldeman, D.C., M.D., Ph.D.

That is why we must strive for proven levels of excellence and for each country to be very supportive of their own groups, of other countries be the members or RIC. We are a world-wide family w/ should be the epitome of excellence in manipulative therapy.

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Section 7: 2000, IFOMT General Meeting Perth, Australia.

History of IFOMT's educational standards and membership.

Delivered and signed by F Kaltenborn. Co-signed by B Sydenham (on behalf of D Lamb) and G Maitland.

HISTORY OF IFOMT'S EDUCATIONAL STANDARDS AND MEMBERSHIP

by the former consultants F. Kaltenborn, D. Lamb, G. Maitland -

based on IFOMTs minutes and the SCs notes and Consultants' reports to IFOMT.

Dedicated to D. Lamb¹

In addition to the official "History of IFOMT 1992" more detail is given on IFOMT's EDUCATIONAL STANDARDS and MEMBERSHIP.

The following abbreviations are used:

IFOMT: International Federation of Orthopaedic Manipulative Therapists, founded 1974 as a combination of the two intermediate organizations:

WCMT: World Confederation of Manual Therapy, founded 1970 (based on interest) and
IFOMT: International Federation of Manual Therapy, founded 1973 (based on an exam).

SC: Standards Committee (of the IFOMT Executive) 1974-1982 and again from 1996.
Consultants replaced the SC from 1982-1988, and the
Membership Committee (MC) replaced the Consultants from 1988-1996.

HVT: High Velocity Thrust /Techniques

OMT: Orthopaedic Manipulative Therapy

Before the formation of IFOMT in 1974 (referred from "History of IFOMT") there were some Physical Therapists (PTs) that indicated, that IFOMT would be an interest organisation, with no educational standards. The argument was that standards could bring down the organisation before it could be brought to life. Others felt, that without standards for membership, the organisation would have no standing and that it may fail to even get started. However, at the inaugural meeting in Montreal in 1974 a Standards Committee was elected with F. Kaltenborn as chairman, G. Grieve as co-chairman for theory, B. Edwards and D. Lamb as members.

The history of IFOMTs Educational Standards and membership can be summarised as follows:

- 1907 The late James Mennell started to teach Physiotherapists in massage and manipulation at St. Thomas Hospital London, England.
- 1917 James Mennell wrote his first book, "Physical Treatment by Movement, Manipulation and Massage". F. Kaltenborn studied with him in 1952 and 1954.
- 1954 The late James Cyriax, who followed James Mennell, continued to teach PTs and directly influenced all our early Manual Therapy leaders.

¹ David Lamb's friend, Bob Sydenham, former president of IFOMT, has fulfilled David Lamb's part of this article due to his sudden death in August 1996.

The physiotherapists, Freddy Kaltenborn in Norway and Geoffrey Maitland in Australia started courses in manual therapy (MT) for PTs with the aim of further education, followed by an examination, to establish standards.

1967 Stanley Paris, who taught courses in New Zealand and USA, arranged a meeting with F. Kaltenborn, G. Maitland, Gregory Grieve, and others in the West Middlesex Hospital, London to discuss an international association.

1970 In connection with WCPT's meeting in Amsterdam, 16 PTs from 7 countries met under the leadership of S. Paris. They elected an Interim Committee of a World Confederation of MT (WCMT) with S. Paris (USA) as secretary, Hanne Thorsen (DK) and R. McKenzie (NZ) (in absence), and with F. Kaltenborn and G. Maitland (in absence) as consultants. A three year plan was developed before the next meeting in Europe.

1973 F. Kaltenborn, of the International Seminar of OMT (ISOMT), in consultation with Maitland, invited interested therapists to a 4-week-course in Gran Canary (Spain), which should end with an international examination.

G. Maitland had other commitments and was represented by Brian Edwards.

Robin McKenzie could not come because of health reasons. Some members of the WCMT did not agree with the organisation having an international examination.

Seventy-four PT's from 12 countries attended the course, and took part in the first international examinations. During the course a written examination was prepared by Prof. Harald Brodin (Sweden), and 42 passed.

Later in the course a practical examination board was elected, by the 42 PTs who had passed, consisting only of MD's (to avoid prejudice): H. Brodin, Sweden, J. Cyriax and Alan, Stoddard, England and Herbert Frisch, Germany.

A mid-term examination, without specific mobilization and manipulation (HVT) was arranged and 35 passed.

Thereafter each country's representative, who was elected by their countries participants, was asked to elect one or two PTs for a final OMT examination, including HVT, in order to judge the standards of the different countries. Two passed from Australia (B. Edwards and D. Morphett), Canada (D. Lamb and J. Oldham) and Norway (O. Evjenth and F. Kaltenborn) and one from USA (R. Erhard) and New Zealand (I. Searle).

The successfully examined OMTs then founded an International Federation of Manual Therapy (IFOMT), based on educational standards with examination. John Oldham was elected president. It was decided that IFOMT should meet the WCMT Interim Committee (of 1970) the following year in Montreal and ask S. Paris to run this combined meeting. It was decided, that future examinations should be conducted by examined PTs.

At the end of the course an additional examination was conducted and a further four PTs, one from Australia (P. Kelly) and Canada (C. Fowler) and two from Norway (O. Bihaug and K. Johannessen) were successful.

1974 The inaugural meeting of IFOMT was held in Montreal, Canada. The Interim Committee and Consultants of WCMT (of 1970) met with the IFOMT (of 1973) Saturday evening, June 15th, to solve the problem of having educational standards. They finally agreed to

recommend to the inaugural meeting the next day, that the "Manual" in IFOMT be changed to "Manipulative" (as suggested by G. Maitland and G. Grieve) and that the final IFOMT should be founded, based on educational standards with examination.

Twenty PTs from 11 countries met to found IFOMT on Sunday, June 16th and elected a Credentials Committee which decided the first 11 countries to get a vote. Of these countries, 9 were present and later recognized 6 countries as "Elected Members" with future voting rights (Australia, Netherlands, Norway, New Zealand, Sweden and United Kingdom) and the rest as "Associate Members". The first officers in IFOMT were to have passed either the Norwegian/Kaltenborn-Evjenth or Australian/Maitland-examination. Thereafter, the Standards Committee was elected to prepare educational standards for membership.

Freddy Kaltenborn, Geoffrey Maitland, Gregory Grieve and Stanley Paris were recognized as the founders of IFOMT (see official picture in the "History of IFOMT"). The IFOMT body and constitution were formalized.

1975 IFOMT-meeting in Gran Canary, Spain. Five voting members were present. The United Kingdom was not present.

The SC presented IFOMT's theoretical standards (developed mainly by G. Grieve), which were adopted. IFOMT acknowledged the significant contribution by Gregory Grieve in the development of IFOMT. Subsequently, G. Grieve resigned his position on the SC.

1977 IFOMT-meeting in Vail, USA. Five voting Members were present. The Netherlands was not present.

The SC presented IFOMT's practical standards, largely compiled by B. Edwards. These included 300 hours of supervised clinical training with examination. These standards were adopted. Now IFOMT had theoretical and practical standards and decided that the 6 Elected Members had to fulfil the accepted standards including examination by 1982 to be Members, otherwise they would revert to Associate Members.

1978 IFOMT-meeting in Tel Aviv, Israel. All 6 Elected Members were present.

The World Confederation of Physical Therapists (WCPT) [in official relationship with the World Health Organization] accepted IFOMT, with its constitution and educational standards, as its first official subgroup. David Lamb was elected chairman of the SC with F. Kaltenborn and G. Maitland as members.

1980 IFOMT-meeting in Christchurch, New Zealand. All Elected Members were present. The Manipulative Therapists Association of Australia (MTAA) applied for Membership and was accepted as the first Member, recommended by the SC (Maitland - Lamb).

1982 IFOMT-meeting in Stockholm, Sweden. All Elected Members were present.

None of the Elected Members had applied for Membership as decided in 1977. The SC desolved and was replaced by the 3 Consultants, F. Kaltenborn, D. Lamb and G. Maitland, to evaluate the educational standards for new Member applicants.

The OMT-organisations of Norway (Spesialgruppen for Medisinsk Manipulasjon) and Sweden based on the Norwegian/Kaltenborn-Evjenth System and IFOMT standards were accepted as Members, recommended by consultant F. Kaltenborn. The OMT-organisation in the United Kingdom (MACP) based

on the Australian/Maitland system and IFOMT standards, was accepted as a Member, recommended by consultant G. Maitland. Both recommendations were unanimously recommended by the consultants.

IFOMT then had 4 voting Members.

Sweden (with educational training performed in Norway) was accepted on the condition the OMTs perform their educational training and examination in Sweden. This condition was fulfilled 1988.

- 1984 IFOMT-meeting in Vancouver, Canada. All 4 voting Members were present. The OMT-organisations in Canada and South Africa were accepted as Members on the unanimous recommendation of the consultants. The Netherlands applied for Membership and was accepted, pending approval of their educational standards by the consultants. Their educational standards were delivered to this meeting instead of four months in advance of the meeting. The consultants, F. Kaltenborn and D. Lamb deemed their standards to be inadequate. In spite of this, the Netherlands was accepted as a Conditional Member, since their representative argued, that their governmental acceptance and payments from the national health system were dependent upon IFOMT Membership. They had already confirmed their IFOMT Membership to the government health authorities in spite of having only Associate Membership status. The representative of the Netherlands was verbally informed at the meeting of the requirements for membership, in English and German, by representatives from the IFOMT executive (Secretary, Norway and Sweden) and consultants (F. Kaltenborn and D. Lamb). These requirements were later confirmed in writing by the Secretary of IFOMT, Ian Searle.

IFOMT now had 7 voting Members.

- 1988 IFOMT-meeting in Cambridge, England. All 7 voting Members were present.

The New Zealand OMT-organisation applied for and was accepted as a Member, based on the unanimous recommendation of the consultants.

IFOMT now had 8 voting Members.

The IFOMT Secretary had written letters to the Netherlands and 2 consultants had travelled to the Netherlands to review their educational standards. The Netherlands had not fulfilled the requirement, stipulated at the 1984 meeting in Vancouver. Thus, the minutes of the General Meeting indicate, "...the Netherlands was asked to fulfil the condition before the next meeting...".

A Membership Committee (MC), with Gwen Jull as the chair, was created. The consultants retired and were thanked for their valuable contributions. The role of this MC was to judge educational standards for the Executive.

- 1990 IFOMT-meeting in Gran Canary, Spain. All 8 voting Members were present.

The OMT-organisations in Finland, based on the Norwegian/Kaltenborn-Evjenth-standards, and Hong Kong, based on the Australian/Maitland system, applied for membership, were recommended by the MC (Gwen Jull) and accepted as Members by the meeting. The Netherlands were again asked to meet the requirements for membership.

IFOMT then had 10 voting Members.

- 1992 IFOMT-meeting in Vail, USA. All 10 voting Members were present.

The OMT-organisations of Denmark and Switzerland applied for and were accepted as Members. Germany and the USA applied for and were accepted as Conditional Members. Germany was asked to form an umbrella-organisation and seek acceptance from their national body, which they fulfilled with the formation of their umbrella-organisation DFAMT (German Federation of Manual Therapy) in 1994. A revised Constitution was approved by the General Meeting.

The umbrella-organisation, the Academy of American Orthopaedic Manipulative Physical Therapists (AAOMPT) of USA was asked to seek representative status from their national body.

However, according to IFOMT's Constitution (accepted by WCPT in June 1995) this is no longer necessary and thus the AAOMPT is an unconditional Member of IFOMT.

IFOMT now had 14 voting Members based on the 1977-educational standards.

The IFOMT Executive once again asked the Netherlands to fulfill the educational requirements for Membership.

The MC presented new Educational Standards for IFOMT, which were accepted. The theoretical requirement was extended with the addition of a research project.

It is the responsibility of the national (or umbrella) OMT-organisation to ensure its Membership requirements.

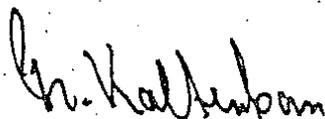
- 1996 IFOMT-meeting in Lillehammer, Norway. All 14 voting Members were present. The 1992-Educational Standards were now the basis for new Membership. The Membership Committee was renamed the Standards Committee (SC). The role of the SC is to give recommendations to the IFOMT Executive regarding educational standards of the applicants for Membership. The Belgian OMT group (umbrella-organisation) applied for and was accepted as a Member, recommended by the SC.

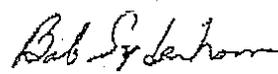
IFOMT now had 15 voting Members.

The Netherlands delegate promised to satisfy IFOMT's requirements for their membership including the formation of an umbrella-organization. Thus an unnamed umbrella-organization became the Member representative of the Netherlands. The title of the organization must be reported to IFOMT and its curriculum judged by the SC (Gwen Jull).

Austria's application for Membership was delivered too late (according to the four-months-in-advance-rule) for acceptance at the General Meeting. Their curriculum was to be forwarded to the SC.

- 1998 Austria was accepted as a Provisional Member by the IFOMT Executive and will be proposed as a Member (# 16) at the next General Meeting in Perth, Australia in November 2000.


F. Kaltenborn


for D. Lamb
B. Sydenham


G. D. Maitland
Febr. 1999

IFOMT member countries in sequence of admittance:

(enclosure to “History of IFOMT’s educational Standards and Membership”)

01	Australia	1980 (conditioned, fulfilled 1982) <i>Before the meeting it was agreed that the first full members would be elected in 1982 Stockholm by all three members of the Standards Committee (F Kaltenborn was absent in New Zealand, 1980). The condition was fulfilled with confirmation from F Kaltenborn in 1982.</i>
02	Norway	1982
03	Sweden	1982 (conditioned, fulfilled 1986) <i>Accepted with educational training in Norway on condition that their training and examination will be in Sweden. The condition was fulfilled in 1986.</i>
04	United Kingdom	1982
05	Canada	1984
06	South Africa	1984
07	Netherlands	1984 (conditioned) <i>Accepted with standards below the required level owing to governmental acceptance and payments from the national health system dependent upon IFOMT Membership, on condition of raising standards to the required level. The condition was fulfilled in 1996.</i>
08	New Zealand	1988
09	Finland	1990
10	Hong Kong	1990
11	Denmark	1992
12	Switzerland	1992
13	Germany	1992 (conditioned, fulfilled 1994)
14	USA	1992 <i>Accepted on condition of seeking representative status from their national body. This requirement was not necessary post 1995. The condition was therefore fulfilled in 1995, and their membership confirmed in 1996.</i>
15	Belgium	1996
16	Austria	2000
17	Portugal	2000
18	Italy	2004
19	Greece	2005
20	Spain	2005
21	Ireland	2008
22	Japan	2008

Section 8: 2000, IFOMT General Meeting, Perth, Australia, Standards Committee report

History of IFOMT's Educational Standards and Membership Authors: Kaltenborn F, Sydenham B (For Lamb D), Maitland G (signed 1999)

IFOMT Educational Standards (1996, page 20) with minor clarification in italics.

An IFOMT educational curriculum referred to as the "Standards" has been effective since ratification in Israel in 1979. Since that time, the document has been reviewed and modified in keeping with the growth and development of OMT.

The original educational standards of IFOMT were the result of deliberations of the standards committee which comprised of *(the following physiotherapists)*:

Mr. Freddy Kaltenborn (Norway) – Chairman, Mr. Brian Edwards (Australia),
Mr. Gregory P. Grieve (U K), Mr. David W. Lamb (Canada)

At that time the committee acknowledged the particular contribution made in formulating:

- (i) The theoretical syllabus which was based on the presentation (with minor alterations) by Mr. G.P. Grieve. This included an annotated bibliography. This was based on the UK system.
- (ii) The practical syllabus which was based on the presentation of Mr. B. Edwards. This was based on the Australian system.

The original standards committee was replaced by the educational consultants which comprised: Mr. David W. Lamb (Canada) – chair, Mr. Freddy Kaltenborn (Norway) Mr. Geoffrey D. Maitland (Australia). This group modified the original standards in minor ways largely to clarify and emphasize meaning.

From the outset there was recognition of the considerable variety of approaches both in concept and technique existing in countries practising orthopaedic manipulative (manual) therapy – OMT. These were, variously named after the originator, the country of origin, or professional organization i.e. Cyriax, Mennell, Norwegian system, South Australian system, osteopathic, chiropractic etc. A considerable amount of common ground existed and diffusion had occurred through courses and the reading of a variety of technical journals devoted to OMT produced by the various groups.

The standards committee felt considerable agreement could be reached if the guidelines stated broad principles and avoided a partisan approach. It was considered essential that various countries' OMT groups make themselves aware of the work of all contributors in the field. Recognizing the importance of the different approaches reflects the depth of experience and increasing body of knowledge in manual therapy.

At the IFOMT meeting in Gran Canaria Spain, 1990, the IFOMT Membership Committee was formed. This internationally representative committee was given a mandate to review the educational standards for membership and to review and process applications for membership of IFOMT.

This committee has continued the process of updating the IFOMT Standards and reformatted the educational standards document upholding the principles of IFOMT standards of education and training.

Members of the Education Standards Committee (1996): G. Jull (chair); D. Kettle (UK), A Leung (Hong Kong), D. Wallin (Sweden), J. Poole (The Netherlands), A. Porter Hoke (US).

Section 9: 2000, IFOMT General Meeting, Perth, Australia, Educational Standards Part A

**INTERNATIONAL FEDERATION OF
ORTHOPAEDIC MANIPULATIVE THERAPISTS**

IFOMT

EDUCATIONAL STANDARDS

Part A

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PREAMBLE

Orthopaedic Manipulative (manual) Therapy is a specialization within Physical Therapy and provides comprehensive conservative management for pain and other symptoms of neuro-muscular-articular dysfunction in the spine and extremities.

IFOMT is a non-government International Manipulative Therapy Federation, representing international collaboration in Manipulative Therapy and solely concerned with Manipulative Therapy and Physical Therapists, and is a recognized sub group of World Confederation for Physical Therapy (WCPT).

CATEGORIES OF MEMBERSHIP

FULL MEMBER

- A Manual Therapy Association or Manual Therapy Federation or a Manual Therapy Committee from each country, which is recognized by the Parent National Physiotherapists Body, which is a member of WCPT and the members of which hold a qualification recognized at national level in that country, may be admitted to membership provided its by-laws are in harmony with, and standards are these laid down by IFOMT.

REGISTERED INTEREST COUNTRY

- A nationally recognized Manual Therapy Group who have not as yet a training or examination system in place, but wish to achieve full membership in the future.

EDUCATIONAL STANDARDS

An educational curriculum referred to as the "STANDARDS" which was presented in 1977 at the IFOMT meeting in Vail, USA has been effective since ratification in Israel at WCPT in 1978. It covers the post-graduate training of physical therapists in Orthopaedic Manipulative (manual) Therapy (OMT). The educational standards of IFOMT extend the basic training received in OMT in physical therapy training programs so that orthopaedic manipulative physical therapists attain a high standard of patient care.

The acceptance and implementation of the educational standards both theoretical and practical is a mandatory minimum requirement for countries seeking full membership in IFOMT.

Of special note is that formal evaluations to prove competency are prerequisite for this membership status. These cover all aspects of theoretical, practical and clinical knowledge applied to neuro-muscular-articular dysfunction in the spine and the extremities in patients.

The educational aims and objectives are not meant to be absolute but rather they serve as a detailed guide towards standards of education and training acceptable to IFOMT. IFOMT recognizes that there will be differences in strengths and emphases in different OMT courses around the world. These are necessary and encouraged by IFOMT for the future development of OMT. IFOMT also recognizes differences that will exist in methods and delivery of education in various countries.

IFOMT has a commitment to research and recognizes the importance of proof of validity of OMT diagnosis and practice. It fosters enquiry and encourages physical therapists' involvement in a variety of ways such as experimental studies, single case studies, surveys and literature reviews.

AIMS AND OBJECTIVES OF IFOMT EDUCATIONAL STANDARDS

BASIC SCIENCES

AIMS:

- To advance physical therapists' knowledge of the anatomy, physiology and biomechanics of the spinal and peripheral neuro-muscular-articular systems.
- To enhance physical therapists' understanding of aberrations of functions of the neuro-muscular-articular system.
- To provide further knowledge for clinical problem solving and for the understanding of the anatomical and physiological bases for techniques used to examine, diagnose and manage neuro-muscular-articular dysfunctions.
- To enhance physical therapists' ability to scientifically evaluate established and new theories on mechanisms, pathogenesis and management of neuro-muscular-articular disorders.

OBJECTIVES:

On completion of the education program, the physical therapist shall be able to demonstrate:

(i) **Anatomy**

- a detailed understanding of the structure, function and relationships of the muscular, articular and nervous systems of the axial and appendicular skeleton including the temporo-mandibular joint.
- an understanding of developmental and acquired anomalies in the osseous, articular and neural systems.
- a detailed knowledge of the nature, ranges and interrelationships of spinal and peripheral joint movement.
- an understanding of the organization of the central and peripheral nervous systems, the neurology of joints and the anatomical bases for somatic and neurotic pain.
- an understanding of the structure, mechanics and movement of the central and peripheral nervous systems during normal body movements.
- an understanding of the vascular system (course and blood supply) of the axial and appendicular structures.

(i) Biomechanics

- an understanding of the biomechanical properties of viscoelastic tissues of the neuro-muscular-articular system and understand the changes that occur with trauma, overuse, immobilization, age and during the repair process.
- an understanding of how loads and forces are distributed and resisted by the neuro-muscular-articular structures in normal function.
- an ability to analyze the stresses imparted to various structures during injurious activity and discuss how such stress may be involved in the pathogenesis of axial and appendicular neuro-muscular-articular pain and dysfunction.
- an ability to critically evaluate and discuss the anatomical and biomechanical bases for physical examination and treatment techniques.

(i) Physiology:

- an understanding and ability to evaluate current knowledge on physiological mechanisms of muscle control in normal and abnormal function.
- an ability to discuss current knowledge on the neurophysiological mechanisms underlying pain production, perception and modulation.
- an understanding of the functional organization of the sympathetic nervous system; the mechanisms of visceral and deep somatic pain; viscerosomatic and somato-visceral relationships; sympathetically maintained pain.
- an understanding of current knowledge of biochemistry and microstructure of collagen, particularly as it pertains to the articular system including the intervertebral disc.
- an understanding of the significance of biochemical reactions in trauma, immobilization, repair and aging to the clinical situation.

MEDICAL SCIENCES

AIMS:

- To advance physical therapists' knowledge of pathology and pathogenesis of disorders of the neuro-muscular-articular system and their clinical features.
- To further knowledge on the clinical presentation of non-mechanical disorders of the neuro-muscular-articular system, their clinical recognition and differential diagnosis.

- To further understanding of the investigative procedures available for differential diagnosis of neuro-muscular-articular pain states.
- To further understanding of the indications for and the nature of surgical intervention for neuro-muscular-articular disorders.
- To advance knowledge of the indications and effects of therapeutic drugs in the management of neuro-muscular-articular disorders.

OBJECTIVES:

On completion of the education program, the physical therapist shall be able to:

(i) Orthopaedics

- discuss current knowledge of the aetiology, pathomechanics, pathogenesis and pathologies of benign mechanical and degenerative disorders of the vertebral column and the extremities.
- discuss congenital and acquired anomalies of the vertebral column and their possible role in spinal pain syndromes.
- discuss the problems and presentations of instability of spinal and peripheral joints.
- demonstrate a knowledge of clinical presentations of orthopaedic conditions where a referral for possible surgical intervention is indicated.

(i) Rheumatology

- discuss the pathology, pathogenesis and clinical features of degenerative and inflammatory arthropathies.
- discuss the pathology, pathogenesis and clinical features of inflammatory, viral and metabolic disorders affecting connective tissues including bone and fascia.
- display a basic knowledge of the laboratory investigations used to diagnose rheumatic disease.
- discuss the type of therapeutic drugs used in the management of degenerative and rheumatic disorders.

(i) Medicine

- discuss the clinical and differential diagnostic features of conditions and diseases which may mimic musculoskeletal pain, with particular reference to cardiovascular and visceral disease.

(i) Neurology

- discuss the nature, early signs and symptoms and differential diagnosis of tumours and other causes of spinal cord compression.
- discuss the clinical presentation and differential diagnosis of vascular disorders mimicking musculoskeletal pain.
- discuss vertebrobasilar insufficiency, disorders with similar presentations and differential diagnosis.
- demonstrate an understanding of the classification and various causes of headache and to identify those which may have a neuro-muscular-articular cause or component.
- discuss the pathology and neurophysiology of nerve entrapment neuropathies.
- demonstrate an understanding of the aetiology, pathology and differential diagnosis of diseases of nerve roots and peripheral nerves.

(i) Radiology

- display a knowledge of the current methods of radiological investigation for disorders of the spinal column and peripheral joints.

(i) Dentistry

- discuss disorders of the craniomandibular complex and the dental approach to management.
- demonstrate an understanding of the roles of the dentist and the physical therapist in the management of craniomandibular dysfunction.

BEHAVIOURAL SCIENCES

AIMS:

- To enhance physical therapists' communication and interactive skills.
- To enhance physical therapists' awareness of the global aspects of pain, psychological factors and stress management strategies.

OBJECTIVES:

On completion of the education program, the physical therapist shall be able to:

- demonstrate effective communication skills for patient assessment, instruction and counselling.
- demonstrate an understanding of the global reactions of pain and disability and strategies that the physical therapist may use to assist the patient in total rehabilitation.
- understand the problems of chronic pain, the team approach to management and management strategies.

ORTHOPAEDIC MANIPULATIVE THERAPY THEORY AND PRACTICE

AIMS:

- To advance physical therapists' knowledge of the physical therapy theory of assessment, diagnosis and management of neuro-muscular-articular disorders.
- To assist physical therapists to integrate knowledge from the basic, medical and behavioural sciences in the clinical setting.
- To develop a high level of clinical skill in the assessment, physical diagnosis and management of patients with neuro-muscular-articular disorders.
- To develop a high level of expertise in the selection and application of orthopaedic manipulative therapy techniques.
- To develop outcome measures to evaluate the effectiveness of OMT.
- To enhance knowledge of the theory of manipulative therapy practice and encourage critical review of its scientific merit.
- To ensure that physical therapists have a comprehensive knowledge of the indications and contra-indications for manipulative therapy practice.
- To enhance the physical therapists' expertise in preventative programs for neuro-muscular-articular disorders.
- To enhance physical therapists' knowledge of professional issues relevant to the practice of manipulative therapy.
- To encourage physical therapists to critically review the recent literature of the basic and applied sciences relevant to neuro-muscular-articular disorders, to draw inferences for orthopaedic manipulative therapy practice and present material logically in both verbal and written forms.

OBJECTIVES:

On completion of the education program, the physical therapist shall be able to:

- critically evaluate the theory and science of orthopaedic manipulative therapy practice.
- demonstrate an ability to interpret information from the basic, medical and behavioural sciences and apply it to the problem solving process of the clinical examination of neuro-muscular-articular disorders.
- demonstrate a depth of knowledge of the interrelationship of the neuro-muscular-articular structures in normal function and musculoskeletal pain syndromes.

- demonstrate effective communication skills to gain comprehensive information about the type and nature of the patient's complaint. To be able to interpret information towards physical diagnosis and the indications for and contra-indications to manipulative therapy management.
- demonstrate a high level of skill in performing appropriate and effective physical examinations of patients with neuro-muscular-articular injuries or disorders of the axial or appendicular skeleton.

Skills will be demonstrated in:

- Analysis of static and dynamic posture
 - Analysis of the active and passive movements of the articular system
 - Clinical examination of the nervous system - for conductivity and neural mechanics
 - Analysis and specific tests for functional status of the muscular system
 - Special tests for the safety of practice of orthopaedic manipulative therapy.
- interpret the findings of the physical examination in an accurate manner and relate such findings to any other medical diagnostic tests to make a physical diagnosis.
 - plan and implement appropriate management strategies which reflect the total needs of the patient.
 - perform manipulative therapy techniques effectively and accurately, demonstrating high levels of skill in the performance of passive movements (under the control of the patient) and passive movements with impulse (quick controlled manipulation).
 - demonstrate a high level of skill in other manual and physical therapy techniques required to mobilize the articular, muscular or neural systems.
 - apply current electrophysical modalities to enhance rehabilitation of neuro-muscular-articular dysfunction.
 - demonstrate a high level of skill in implementing and instructing patients in appropriate therapeutic rehabilitation exercise programs.
 - demonstrate knowledge of appropriate ergonomic strategies and advice.
 - demonstrate the ability to evaluate the results of treatment accurately on the basis of outcome measures and modify and progress treatment as required.
 - keep clear and accurate clinical records and write appropriate reports for medical and legal consultations.
 - demonstrate an ability to integrate and apply scientific and clinical data in the presentation of health promotion and preventative care programs.
 -

- demonstrate a knowledge of various manipulative therapy approaches as practised within physical therapy, medicine, osteopathy and chiropractic.

RESEARCH PROJECT

AIMS:

- To foster enquiry and critical analysis of orthopaedic manipulative therapy practice and its related sciences.
- To extend physical therapists' interests, skill and commitment to research.
- To enhance the physical therapists' ability to identify and pose a research question, to make a critical analysis of the literature relevant to the project, to design and conduct an investigation satisfactorily, to analyze and present results accurately and concisely and to draw logical and valid conclusions.

OBJECTIVES:

On completion of the education program, the physical therapist shall be able to:

- present a research project which satisfies the examiners of the physical therapist's ability to undertake and present a research study.

FOOTNOTE:

Research has many components which include, for example, critical evaluation of the literature on a nominated topic, population surveys, single case patient studies, evaluation of outcome measures, clinical trials and experimental studies.

APPENDIX 1

SCOPE OF PRACTICE OF OMT

Orthopaedic Manipulative Therapy (OMT) is a specialization within physical therapy and provides comprehensive conservative management for pain and other symptoms of neuro-musculo-articular dysfunction in the spine and extremities.

Orthopaedic manipulative therapists work within the orthodox medical system in close liaison with medical practitioners. They are responsible for making a clinical physical diagnosis and for deciding on the suitability of a patient for treatment by observing precautions and recognizing contra-indications.

The application of OMT is based on a thorough examination of the neuro-muscular-articular system. This examination serves to define, in physical terms, the presenting dysfunction in the articular, muscular and nervous systems. Equally, the examination aims to distinguish those conditions which contra-indicate management by OMT or those where anatomical anomalies or pathological processes limit or direct the use of OMT procedures.

The main goal of OMT is to restore maximal and painfree function to the neuro-musculo-articular systems.

This is achieved through several possible methods.¹

- relief of pain and muscle spasm.
- restoration of normal tissue fluid exchange, soft tissue pliability and extensibility, normal joint relationship and mobility.
- correction of muscle weakness and imbalance.
- restoration of adequate control of motion.
- stabilization of unstable segments.
- relief from chronic postural or occupational stress.
- functional reablement of the patient.
- prevention of recurrence.
- restoration of confidence and self reliance.

¹ Grieve G P, 1988 Common vertebral joint problems, Churchill Livingstone, Edinburgh

In more specific terms, OMT means the use of passive movement applied manually or mechanically to help restore normal neuro-musculo-articular function.

Application of passive movement can involve manipulation - passive movement with thrust (high velocity low amplitude) and mobilization - passive movement which is graded, the force, speed and amplitude being directed by the pain/range/spasm relationship in the joint (end feel).

OMT is an extension of an extensive repertoire of physical therapy skills.

The following represents a summary of OMT treatment strategies:

PAIN MODULATION

1. Immobilization:

- (i) General: bed rest in analgic positions.
- (ii) Local: corsets, collars, casts, braces, taping.

2. Special passive movement procedures applied prior to the tissue resistance barrier being encountered

- (i) Optimal amplitude motion in pain-free ranges.
- (ii) 3-dimensional traction - distraction in the most pain free combination of joint positions.
- (iii) Inhibitory pressures.

1. The application of electrophysical agents.

RESTORATION OF MOBILITY

1. Soft tissue

- (i) Massage: classical, connective tissue, deep transverse frictions.
- (ii) Muscle relaxation techniques based on specific reflex procedures: post isometric relaxation, reciprocal inhibition
- (iii) Specific muscle lengthening procedures to obtain muscle and connective tissue extensibility.
- (iv) Exercise to maintain or increase in soft tissue extensibility.

1. Joints

- (i) **PASSIVE MOBILIZATION**
Passive mobilization is the application of specific passive movements to a joint, either manually or mechanically applied, which are performed at a slow and rhythmical speed

such that the patient can prevent the movement if he so chooses. The rhythm can be oscillatory or a sustained stretch.

Passive mobilization may encompass:

- (a) Translatory or accessory movements
- (b) Angular movements
- (c) Distraction, compression

All movements are graded with respect to their amplitude and position in range and are directed by the presence of pain, quality of tissue resistance through range and the joint end feel.

(i) **MANIPULATION**

Manipulation is a small amplitude of movement applied, with quick impulse, to a joint showing a suitable end feel to effect joint separation and to restore translatory glide.

Orthopaedic manipulative therapists recognize that this is not a benign procedure. Implicit in this document is acceptance that this must be thoroughly learned. Orthopaedic manipulative therapists have developed some unique procedures which eliminate rotary stresses and emphasize glide and distraction movements. Rotation and extension are recognized as being movements which can provide a hazard especially when applied to the cranio-vertebral region.

1. Neural tissues

- (i) Neuraxis mobilization.
- (ii) Nerve root, trunk and peripheral nerve mobilization.

CONTROL OF MOVEMENT - STABILISATION

- (i) External support e.g. braces, collars, taping.
- (ii) Enhance intrinsic joint support and reduce unwanted movement by retraining the activation and motor programming of muscles, both segmentally and regionally, which have a primary stabilizing function.

FUNCTIONAL REABLEMENT - to train and instruct

- (i) Exercises (muscle strength, endurance and coordination)
- (ii) Correction of resting, working, sports postures etc.
- (iii) Job analysis and ergonomic retraining.
- (iv) Prophylactic procedures (ADL handling, lifting retraining and advice).

APPENDIX 2

GUIDELINES FOR FORMULATING O.M.T. PROGRAMS

The following guidelines should be considered in formulating training schemes:

Fulltime training with supervised clinical work is vital in the long term development of OMT training. Training based on attendance of a sequence of short courses whilst successful in the past must only be considered an interim measure.

(i) THEORETICAL INSTRUCTION

Comprehensive theoretical knowledge is required in the basic and clinical sciences for the development of high level skills in physical diagnosis and clinical management.

Students' theoretical learning can be optimized by careful course planning. Courses are ideally structured so that theoretical instruction complements preclinical and clinical OMT subjects. This assists students' understanding of the relevance of the theory and helps them to integrate and apply it immediately to their clinical practice.

Courses should include a variety of teaching formats and learning strategies. Formats that encourage and extend student problem solving, clinical reasoning skills will enhance their performance in clinical practice.

It is expected that OMT educational programs will contain a **minimum** of 200 hours of theoretical instruction.

(ii) PRECLINICAL INSTRUCTION IN OMT

The preclinical courses in OMT must emphasize the development of students' clinical reasoning skills to prepare them for clinical practice.

The examination and management of articular dysfunction should be learnt in conjunction with that of muscle and nervous systems so that total patient management is emphasized.

A thorough understanding of the basic examination techniques for physical diagnosis of neuro-muscular-articular dysfunction is essential.

Manual examination skills must be developed so that students can display competency in:

- Recognizing possible positional faults, joint hypermobility and joint hypomobility through the use of specific techniques for testing passive joint movement.
- Determining the pain/range/resistance relationships including joint "end feel" and through range quality of movement by the application of passive manual examination techniques including pressures, gliding, distraction, compression and rotary procedures.

- Recognizing the reactivity of the local problem by analysis of local discrete muscle spasm.

Students should understand the meaning of graded passive movement so that the appropriate amount of movement can be applied to the joint related to the pain/range/resistance findings.

It is recommended that the teaching of manipulative therapy procedures (i.e. passive mobilizations and manipulations) follow a progressive plan. The recommended sequence for learning procedures is:

- mobilization procedures for peripheral joints
- mobilization procedures for spinal joints

Once competency is demonstrated in preclinical and clinical situations in these procedures,

- manipulation procedures for peripheral joints
- manipulation procedures for spinal joints.

The application of peripheral and spinal manipulations should be supervised in the preclinical and clinical environments.

It is expected that a **minimum** of 150 hours will be spent in the preclinical instruction of OMT treatment procedures.

SUPERVISED CLINICAL WORK

Supervised clinical practice is an essential part of the OMT educational program.

Physical therapists in an OMT training program will undertake clinical practice under the direct supervision of an OMT instructor. It is recommended that the supervised clinical work should be undertaken with a ratio of no more than four (4) students to one (1) OMT instructor.

It is recommended that a **minimum** of 150 hours of clinical instruction be undertaken. This should be distributed throughout the course of theoretical and preclinical instruction to give students the maximum opportunity to develop their clinical skills.

EVALUATION OF COMPETENCY

Proof of competency by formal evaluation is mandatory and should be based on knowledge of broad principles set out in the standards document.

Competency should be demonstrated in:

- the basic, medical and behavioural sciences underlying the use of manipulative therapy.

- the theory and science of manipulative therapy.
- the clinical examination, physical diagnosis and management of patients.
- techniques of examination and treatment both to peripheral and spinal joints on a model and/or patients.
- patient case presentation.
- research principles and design.

The physical therapist should demonstrate a breadth of knowledge obtained from a wide reading of the literature.

APPENDIX 3

GUIDELINES FOR COUNTRIES WITH LEGISLATION TO LIMIT

THE PRACTICE OF MANIPULATION

The scope of practice of the orthopaedic manipulative therapists includes a full spectrum of OMT treatment procedures, including specific mobilization and manipulation applied to peripheral and spinal joints.

In the event that manipulation (thrust techniques) applied to the spine is prohibited by government legislation this would not preclude the OMT group of that country obtaining membership provided manipulation be taught and practised as it can be applied to peripheral joints. Even if thrust techniques cannot be applied to patients with spinal problems, training in the theory and technique should be undertaken as this could be used to change government policy.

If a country states that there is a legal restriction to manipulation, the details of such legislation should be produced with application for membership.

Section 10: 2003, Editorial, Journal of Manual and Manipulative Therapy

EDITORIAL

*David W. Lamb, MCSP, MCPA
Freddy M. Kaltenborn
Stanley V. Paris PhD, PT*

■ History of IFOMT

The history of IFOMT is inevitably intertwined with the development and rise of physical therapy. The growth of physical therapy over the last fifty years has been phenomenal. Paralleling that growth has been the rise of manual and manipulative therapy. Indeed much of the vigor and ideas for growth have come from this group. In each country there have been leaders who have seen the future and striven for it. Manual therapists have been foremost in that leadership and whether pushing for physical therapy or for manual therapy they have elevated the standing and maturity of both. Today, therefore, physical therapy can look with pride on the accomplishments of manual and manipulative therapists.

As in any developing area there emerged leaders. These leaders did not share a common vision of the end point nor of how it should be achieved. But they have shared an energy. We have become in many countries if not the first then the foremost specialty group of our professions and we were indeed the first to be recognized as a clinical sub group of the World Confederation of Physical Therapy in Israel in 1978 based on IFOMT's constitution and standards.

In this lecture we, the authors, have tried to present as best we may the history of the founding of this movement at least at the International level. It has not been an easy task. There were some strong differences of opinion on that will be briefly addressed in this presentation. But to dwell on differences of opinion would miss the main point which is that manual therapists of many nations have worked together to bring us where we are today and that the next generation which will now assume the leadership is quite rightly less concerned with the past than with the future.

But the history needed to be written and it is appropriate that those who most helped shape it and are privy to the records and the correspondence be those who write this, the first formal history of IFOMT.

The Year 1960

Manual and manipulative therapy, herein after referred to by either, was in its infancy. In many aspects the birth of manual therapy was in England where at St. Thomas' Hospital there was a long tradition of joint manipulation being instructed to physical therapists by medical physicians. The first of these was Dr. James Mennell whose son, John was to continue the tradition of both New Zealand and the United States. But the giant was Dr. James Cyriax who directly influenced all our early and most of our, present leaders in manual therapy: Kaltenborn, Grieve, and Paris had all visited him and some worked with him at St. Thomas'. Lamb, Fowler and many others were to follow. These therapists also visited and studied with the medical and osteopathic physician, Dr. Allan Stoddard, who likewise gave freely of his expertise and encouragement. Although Cyriax and Stoddard had little in common in their approach to manual therapy, both recognized the need for physical therapists to upgrade their skills in manual therapy and to be principal players in this field.

In 1954 Kaltenborn in Norway and by 1952 Paris in New Zealand and Maitland in Australia had all become established as leaders in manual therapy. They lectured, gave seminars and courses and

began to publish. The future would establish more, such as Evjenth of Norway, McKenzie of New Zealand, Rocabado of Chile, Grieve of the United Kingdom, Elvey of Australia, and researchers such as Twomey, each making unique contributions. But, that's for the future.

In 1967, the Chartered Society of Physiotherapy in England invited Geoffrey Maitland of Australia to come and spend a year giving instruction in his methods to English physiotherapists. Gregory Grieve was associated with Maitland and continued this work after his departure. In the United States, Stanley Paris learned from Maitland of this event and flew to London to meet with him for the first time. Paris invited Kaltenborn and so in the cafeteria of a London hospital Maitland, Grieve, Kaltenborn and Paris in the company of Monica Martin-Jones and Lois Dywer discussed the future of manual and manipulative therapy.

Thus was conceived an association to be called the World Confederation of Manual Therapy. Paris wanted to establish a newsletter within the group and that was agreed to. Agreed also that some movement should be made to an international organization that would bring together all those who were interested in such an association. Paris began to make inquiries and called a meeting at Amsterdam during the WCMT Congress in 1970. At that meeting it was agreed to set up an interim committee of Stanley Paris as secretary with Hanna Thorsen of Denmark and Robin McKenzie of New Zealand as committee members. Also appointed were consultants to the Committee, namely Kaltenborn of Norway and Maitland of Australia thus the roots were laid, although not identified at the times for IFOMT. The charge was to meet again four years later in Montreal, Canada to form an international body.

Paris began the task of attempting to accomplish this in three years. Contacts were made with national groups that were members of the World Confederation for Physical Therapy who were in turn asked to identify if they recognized any one person or any organization of their country that could represent manual therapy at the Congress. At that time, individual communications were also welcomed. Through these vehicles, attempts would be made to collect information on the scope and purpose of WCMT and then to formulate a constitution.

It seemed to Paris that not much more was necessary than to call the meeting, and this is how he saw this world confederation as a forum for all who were interested in the field. On the question of standards for membership, he and Hanna Thorsen spoke against, but never voted against them. Essentially he feared that a squabble over standards would bring down the organization before it could be brought to life.

The other view on standards was held by Kaltenborn. He and others felt that without standards for membership, the organization would have no standing in that it may fail to even get started.

In 1973 Kaltenborn, through the International Seminar of OMT, arranged a meeting in Gran Canaria. This was a formidable undertaking of four weeks. One week each, to review advanced techniques of mobilization to the spine and mobilization and manipulation on to peripheral joints and two weeks of lecture demonstrations including presentations by orthopaedic physicians and surgeons practicing manual medicine. This would be followed by an examination.

This meeting in 1973 was not unanimously supported by the officers of WCMT and this probably represented their priorities. Kaltenborn seeing proof of competency by examination as a necessity, Paris and Thorsen seeing identification of scope and purpose as the priority.

The 1973 Gran Canaria meeting was the opportunity for 74 experienced therapists from 12 countries to meet in a retreat atmosphere and practice and refine techniques and expand the mental horizons by listening to world class leaders.

The examination was arranged. Professor Brodin set the theoretical paper and a board comprising Drs. Cyriax, Brodin, Stoddard and Frisch examined candidates who had passed the theory exam in specific mobilization techniques of the spine and peripheral joints.

From these successful candidates, one or two were chosen as representatives of countries and the board examined these to judge the standard of manipulation. attained in that country.

These exams were a prototype and an attempt to create an international examination. This worthy aim has not proven possible in practice. The major importance was it allowed manual therapists to subject their skill levels to the scrutiny of an outside group of impeccable credentials.

At the conclusion of these examinations, the candidates successful in the manipulation section formed the International Federation of Manual Therapy. This group communicated with the World Confederation. There were strong differences of opinion but fortunately maturity prevailed and the two groups fused at the Montreal meeting in 1974 recognizing the need for both process, a constitutional framework and the need for standards.

In June 1974 there was a celebration. Some 12 countries were present with representatives. The following 11 countries were initially approved as voting members:

- Australia
- Canada
- Denmark
- Finland
- Netherlands
- New Zealand
- Norway
- South Africa
- Sweden
- United Kingdom
- United States of America

To their credit, they admitted only 6 of their numbers as having met the principles of Standards for the purpose of voting at future meetings. Those six were:

- Australia
- Netherlands
- Norway
- New Zealand
- Sweden
- United Kingdom

This was only an interim measure. The countries would eventually have to submit their standards to a committee scrutiny.

Thus, The International Federation of Manipulative Therapy (IFOMT) was founded. The inaugural meeting, including finalizing the constitution was chaired by Paris. The meeting also decided to formulate and develop educational standards. A Committee consisting of F. Kaltenborn - Chairman; G. Grieve - Co- Chairman; B. Edwards and D. Lamb as members, were instructed to accomplish this task. This committee was a committee of General Assembly. Richard Erhard of the United States was elected as the first President of IFOMT and Peter Edgelow of the United State the first secretary. The formation of IFOMT was marked by a joyful celebration dinner.

IFOMT has had several very successful Congresses since the first in Montreal:

- Vail, Colorado, USA: 1977
- Christchurch, New Zealand: 1980
- Vancouver, Canada: 1984
- Cambridge, England: 1988
- Vail, Colorado, USA: 1992
- Lillehammer, Norway: 1996

The next conference is scheduled to be in Perth Australia in the year 2000.

In 1976, Paris of the United States and Searle of New Zealand became President and Secretary respectively. In 1984 Robert Elvey of Australia was elected President continuing until 1992, when he was succeeded by Robert Sydenham and he by Jan Eric Endresen in 1996. Ian Searle remained as secretary until succeeded by Barb Heatherington of New Zealand in 1996.

The Standards Committee from their original mandate have continued to play a significant role in IFOMT.

In 1976, Kaltenborn and the International seminar organized another practical/theoretical seminar in Gan Canaria which gave the standards committee an opportunity to meet face to face and refine the theoretical components of the Educational Standards. These were largely developed by Greg Grieve assisted by Barbara Grieve and based on the UK system.

By the Vail Congress in 1977, the practical component largely compiled by Edwards, based on his experience with the Australian and Norwegian systems, had been added and the Standards Document was accepted together with rules for future membership.

The original mandate of the Standards Committee being completed, Grieve stepped down. In 1978, the Standards Committee was changed with Lamb as Chairman, Kaltenborn and Maitland as members. These three later became consultants to the Executive - their role was largely matters of membership.

The consultants resigned in 1988 to allow the development of the Standards Committee, chaired by Gwen Jull who has presided over a major restructuring of the Standards document to formulate it in modern educational terms.

The constitutions and bylaws have also been subject to scrutiny and change. David Iles of Canada completed the first revision, and Bob and Gaye Sydenham carried out further revisions from 1988 to the present.

Over the years IFOMT has become a mature and solid organization. Its strength in numbers, its diversity of nations and races testify to its strength. Beginning with the six interim members in 1974, it now has 14 members have met the Standards (this includes Canada). By responding to the needs of its members, IFOMT will remain a potent organization. However, as Scott Hlademan DC.MD.Ph.D. stated:

"The future of the practice of manipulation, be it chiropractic physicians, osteopathic physicians, medical physicians or physical therapist, is dependant on the knowledge base of each of its practitioners. Rivalry between the professions which practice manipulation still exist, though it has changed to a very health competition to gain excellence. Determining which profession(s) will be allowed to practice manipulation in the future will depend on the scientific knowledge and the clinical skills of its practitioners."

That is why IFOMT must strive for proven levels of excellence and for each country to be very supportive of their own groups, and of other countries. We are a world-wide family who should be the epitome of excellence in manipulative therapy.

■ The Journal of Manual and Manipulative Therapy is indexed in the Cumulative Index to Nursing and Allied Health Literature (CINAHL), EBSCO databases, and in EMBASE, the Excerpta Medica database.

Section 11: Abridged history of IFOMT written by Agneta Lando for the launch of the new IFOMT website

ABRIDGED HISTORY OF THE INTERNATIONAL FEDERATION OF ORTHOPAEDIC MANIPULATIVE THERAPISTS.

In the latter part of the 1960's and early 1970's a number of eminent physiotherapists, with an interest and expertise in Manual/Manipulative Therapy, started to perceive a need for an international forum in this area of physiotherapy. Their geographic dispersion notwithstanding, the first meeting of the International Federation of Orthopaedic Manipulative Therapists, IFOMT, was held in Montreal in 1974. Some of those present were: Stanley Paris, David Lamb, Gregory Grieve, Brian Edwards, Freddy Kaltenborn and Geoffrey Maitland. The first President of IFOMT was Richard Erhard, followed by S. Paris in 1976, R.Elvey in 1984, R.Sydenham in 1992, J Endresen in 1996 and A.Lando in 2000.

The importance of a firm link with the World Confederation of Physical Therapy (WCPT) was necessary to maximise the contacts within the profession and with professions allied to physiotherapy. To that effect IFOMT applied for, and was granted, subgroup status to WCPT in 1978. IFOMT was the first subgroup of WCPT.

The principle aims for the instigation of IFOMT, was to achieve a world forum for exchange of expertise and information, to hold seminars and lectures and for the setting of standards, academic and clinical in the field of Manipulative Physiotherapy. The ultimate objective being to improve the treatment outcome for patients suffering with neuro-musculo-skeletal disorders. These aims are represented in the constitution, in which regular conferences no less than every four years are stipulated, and the criteria for membership are laid down. The IFOMT Standards Document, originally developed by Gregory Grieve, and updated by Gwen Jull, most recently in 2000, forms the foundation for the educational programs which have to be submitted by any Manual Therapy Group aspiring to membership. This document also provides The International Standards of Manipulative Physiotherapy.

In 2004 a new website for IFOMT was launched. This is a further step towards enabling IFOMT to fulfil its aims and objectives. Amongst many diverse areas of information, the website provides information on latest publications, research and clinical guidelines from the membership groups of IFOMT. In addition there are names of people with particular areas of expertise relevant to Manipulative Therapy, who also have a working knowledge of the IFOMT Standards. These experts have offered to assist developing groups to formulate their post-graduate educational programs. An organisation such as IFOMT has a tremendous wealth of expertise within its member organisations. This wealth of knowledge will increase with an expansion of our membership, facilitating the dissemination of information around the world. The benefit of the existence of the International Federation of Orthopaedic Manipulative Therapists to our patients is clear for all to see. The vision of the founders is being enacted.

Agneta Lando
President of IFOMT

For further information regarding the History of IFOMT see the Journal of Manual & Manipulative Therapy, Vol 11 No2 (2003) 73-76:Paris,D; Kaltenborn,F; Lamb,D.

Section 12: Abridged version of IFOMPT History for the new 2010 website

The inaugural meeting of the International Federation of Orthopaedic Manipulative Therapists (IFOMT) was hosted in Montreal, Canada in 1974. This meeting provided the first international forum for this specialist area of physical therapy following a period of growth and dissemination of Orthopaedic Manipulative Therapy through courses throughout the world by a group of eminent physical therapists.

The first President of IFOMT was Richard Erhard (USA), followed in 1976 by Stanley Paris (USA), in 1984 by Robert Elvey (Australia), in 1992 by Robert Sydenham (Canada) in 1996 by Jan Erik Endresen (Norway), in 2000 by Agneta Lando (UK), in 2004 by Michael Ritchie (Canada), and in 2008 by Annalie Basson (South Africa).

With great foresight, the inaugural meeting of IFOMT established a Standards Committee to set up a curriculum of study and examinations. In 1975 the first IFOMT Congress and General Meeting was held in Gran Canaria, Spain. An initial draft of the Standards Document (theoretical component) was developed and signed by the Standards Committee of Freddy Kaltenborn (Chair, Norway), Gregory Grieve (UK), David Lamb (Canada) and Brian Edwards (Australia). At the IFOMT General Meeting in 1977 hosted in Vail, USA, the Standards Document (with theoretical and practical components) was presented, to be subsequently ratified at the World Confederation of Physical Therapy (WCPT) meeting hosted in Tel Aviv, Israel in 1978.

Very importantly for IFOMT with its international physical therapy focus and mission, it was also granted status as a subgroup of the WCPT at the meeting in 1978. IFOMT was the first subgroup of WCPT.

In 1988 Gwen Jull (Australia) became the Chair of the Standards Committee (then named membership committee). In 1992 a new Standards Document was presented by Gwen Jull (Australia) at the General Meeting hosted in Vail, USA and voted in. The Standards Document was subsequently reviewed and in 2000 the Standards Document revision was ratified at the General Meeting in Perth, Australia (development of document by L Wellington, Australia). The Standards Document forms the foundation for the educational programmes which have to be submitted by any Manual Therapy Group aspiring to membership.

An IFOMT strategic meeting in 2001 hosted in Antwerp, Belgium has been important for the development and direction of IFOMT in the past decade; in line with its vision for 'worldwide promotion of excellence and unity in clinical and academic standards for manual/musculoskeletal physiotherapists'. The mission and vision of IFOMT are represented in the constitution, in which regular conferences no less than every four years are stipulated, and the criteria for membership are laid down. The items identified as important areas for development in the strategic plan of 2001 were: funding, website development, education, communication and a resource centre. The first IFOMT website went live in 2004 and was updated in 2010.

At the General Meeting hosted in Perth, 2000, the Member Organisations of IFOMT voted for a process of International Monitoring to ensure ongoing quality of educational programmes and continued achievement of the IFOMT standards by Member Organisations. The document was developed by Agneta Lando (UK) and Alison Rushton (UK), and provided an addition to the Standards document of 'Part B, International Monitoring Document'. The document was accepted at the General Meeting in Cape Town, 2004. In 2004 Alison Rushton (UK) took over as Chair of the Standards Committee. In 2008 a further Educational Standards Document revision was presented and accepted at the General Meeting hosted in Rotterdam, Netherlands.

In 2009 IFOMT changed its name to incorporate the term Physical Therapist to become the International Federation of Orthopaedic Manipulative Physical Therapists (IFOMPT).

IFOMT started out with 6 'voting' member countries (Australia, Netherlands, Norway, New Zealand, Sweden and United Kingdom) and five 'associate member countries'. Currently IFOMPT consists of 22 Member Organisations and 7 Registered Interest Groups. IFOMPT is an active and growing federation of countries passionate about further development of Orthopaedic Manipulative Therapy throughout the world.

Annalie Basson and Dr Alison Rushton, October 2010

Section 13: Personal reflections

All personal reflections are very welcome – please forward any contributions to the IFOMPT office.

Stanley Paris, 2010

Chair IFOMT Founding Committee and Inaugural Meeting, Second President of IFOMT

I, Stanley Paris was the chairman of the steering committee that led to the formation of IFOMT. I chaired its inaugural meeting in Montreal on 1974 and became its second president for 8 years and immediate past president still on the executive for a further 8 years.

In the months leading up to the formation there were strong discussions principally between Kaltenborn and myself over the purpose of IFOMT. I felt that it should be a meeting that would bring together the leaders and the students for the exchange of ideas. Kaltenborn insisted there be standards or the organization would be meaningless. I opposed the push for standards on the grounds that I could not see how the like of he and Maitland, to mention but two, could possibly come to agree on standards and that the disagreements that I felt would ensure could cause IFOMT to be unglued.

However the majority of viewpoints were that there should be standards and so they were voted in and from the start we had a standards committee. By the time I became president four years later I was pleased to admit that I had been wrong.

Agneta Lando, 2010
President of IFOMT 2000-2004

The IFOMT conference in Perth, Western Australia, in November 2000 saw the election of an executive committee to take the organisation into the new millennium. Right from the first meeting the committee agreed that there was not enough feedback from member organisations between the General Meetings, every four years. The role of an executive committee is to move the organisation forward in accordance with the wishes of its membership.

To this effect we circulated a comprehensive questionnaire to the membership (this had never previously been done by IFOMT), collated the response and scheduled a brainstorming session based on the responses, for the 11th September 2001.

Given the now historic events of that date it was remarkable that so many member organisations were represented. The meeting went well and the main outcomes were:

- We needed to improve communications within the organisation and reach more physiotherapists and related clinicians/educationalists/ academics and research workers with the ultimate end to improve musculo skeletal treatment and management around the world.*
- We needed to find a way to improve the financial support for IFOMT.*
- We needed to grasp the thorny nettle of monitoring educational standards of existing member organisations.*

The obvious medium for the first two points was a website.

Apart from opening IFOMT up to the World Wide Web to let people know of its existence, we developed the web site so that it could provide a resource centre.

- It was aimed at physiotherapists with an interest in Manual Therapy whether for personal development or in relation to developing post-graduate courses in this field.*
- In addition it provided contact information of leading educationalists, research workers, clinicians and academics in each of the member organisations, to facilitate communications and exchange of information.*
- The website also provided advertising opportunities with the potential to generate financial funds for IFOMT.*
- The International Monitoring document was formulated during this period with the help of Dr Alison Rushton (UK), to whom we were very grateful. It was loosely built on an existing document already in use in the UK. There was therefore evidence that the monitoring process was possible.*

The first IFOMT website was up and running January 2004 and was presented at the opening of the IFOMT conference in Cape Town, 2004. The International Monitoring Document was voted in at this meeting and has been operational since.

To have been President during this period was an honour and privilege, not least because the executive committee, Peter Boelens, Marina Wallin, Elaine Maheu and Trudy Rebbeck, were all committed to the ethos of IFOMT and a real delight to work with.

Bob Sydenham, 2011

On the Conceptualization and Formation of the International Federation of Manipulative Physical Therapy (IFOMPT) Umbrella Groups:

The historical aspect of IFOMPT, formerly the International Federation of Manipulative Therapy (IFOMT), is more than adequately described in this document; however, what needs to be described for perpetuity is the qualification of membership in IFOMPT, which was initially faced with the dilemma of having educational standards.

After much debate by potential Member Organizations' (MOs') representatives and significant other individuals in the development of Manual Therapy educational programmes, it was decided at the inaugural meeting of IFOMT held in Montreal in 1974 that the 'M' in IFOMT be changed from representing 'Manual' to 'Manipulative' and that IFOMT membership be based upon acceptable educational standards including examination.

In 1978, IFOMT submitted its constitution and educational standards to the World Confederation of Physical Therapy (WCPT), and was accepted as its first official subgroup. One of the qualifications required by WCPT of subgroups was that they be MOs or a recognised Section of a MO, approved by their Parent Body.

Despite best intentions of all individuals and organisations involved, it soon became apparent that this organisational structure was becoming problematic, despite its advocated purpose of the interchange of scientific knowledge and the advancement of Physical Therapy.

Firstly, membership in recognized Subsections of Parent Bodies (National Bodies), whether they be Orthopaedic Divisions, Orthopaedic Manual Therapy groups, etc, was generally based on individual interest and the payment of an annual fee or dues. There was no educational component attached to membership requirement.

Secondly, and not surprisingly, various educational programmes of interest groups developed, that were deemed to meet the educational requirements of IFOMT, but the interest groups were not the recognised sub-groups of their Parent Bodies, who were members in WCPT.

The conundrum that was developing, not only was counter to the intent of IFOMT, but of WCPT and their respective Parent Bodies.

It was most fortuitous, not only for IFOMT, but for all Manual Therapists, OMT Organisations, and in fact, Physical Therapy in general, that the then President of IFOMT, Bob Elvey, presented the concept of an 'umbrella organisation' which would allow more than one organisation with recognised educational standards from a country to have representation in IFOMT, as the Umbrella Organisation would be the MO of IFOMT. Upon clarification of a few details, this resolved membership issues in many countries, such as, but not limited to: USA, Germany, Netherlands, Belgium, Austria, Switzerland, and Italy.

This resolved only half of the membership issue, albeit a significant half. It should be noted, that it took a great deal of effort and professionalism on the part of many to achieve acceptance of this membership concept by all those involved with IFOMT.

The requirements for Sub-Group status in WCPT had to be addressed, with this new proposed IFOMT membership definition. Members of the IFOMT Executive met with the WCPT Executive in Washington D.C. at the World Confederation for Physical Therapy congress, in June 1995, to discuss and propose amendments to the WCPT Constitution regarding subgroups. These

amendments would enable the new description of an IFOMT MO to become the recognised member of IFOMT and for IFOMT to maintain Sub Group status in WCPT.

The requirement by WCPT, as we negotiated in 1995, was that EVERY individual member of the IFOMT MO (umbrella or otherwise) had to hold membership in the Parent Body, which was the member in WCPT. The IFOMT MO no longer had to be recognised by or be a subsection/group of the Parent Body.

The Parent Body does not have to, nor is required, to recognise the Member in IFOMT (for what became self/financial reasons, at the expense/occlusion of others)

It needs to be stated that the Executive of WCPT, fully understood the developing problem in complying with the existing wording of the articles of their Constitution, and the need for change in order to continue to perpetuate the aims, goals and objectives of not only IFOMT, but of WCPT and Physical Therapy Associations globally. Their support and professionalism towards initiating these significant changes cannot be overstated.

The voting delegates at the 1995 WCPT General Meeting voted almost unanimously for the changes to their Constitution, and thus enabled IFOMT to maintain their status as a WCPT Subgroup and to develop their educational standards and expand the scientific knowledge of manual therapists in the numerous countries that enjoy the benefits of this clinical specialty.

The MO of IFOMPT HAS to recognise ALL manual therapy/orthopaedic groups in a country providing their individual members are members of their National Parent Body, and that they have passed an educational programme that is recognised by IFOMPT. These are very important obligations by the IFOMPT MO. Failure to organise into what is known as an UMBRELLA GROUP, if there is more than one group, will result in notification from the IFOMPT Executive, to the current MO, that their membership in IFOMPT could be rescinded, as per the process laid out in the IFOMPT constitution.

Freddy Kaltenborn, 2011

In the years leading up to the formation of IFOMT in 1974, physical therapists in many countries were not allowed to practice manipulative thrusts. For almost two centuries joint manipulation had been an integral part of physical therapy practice, however physical therapists were now in danger of losing their right to practice manipulative therapy altogether. Our profession had failed to develop educational standards and professional certification that included manipulative thrust, and because of this we were losing our right to practice this specialty. I believed that the only way for us to regain our right to practice manipulative therapy, was to develop and maintain education and practice standards that were recognized by medical doctors. At the time, few of my colleagues agreed this was necessary or even possible.

In 1970, four years before the formation of IFOMT, physical therapists with an interest in manipulative therapy met under the leadership of Stanley Paris and formed the World Confederation of Manual Therapists (WCMT). This was the first international association for physical therapists practicing manipulative therapy. I was disappointed that the WCMT organization had no interest in standards development nor in practitioner certification. Therefore, I formed a separate organization to teach OMT courses, develop OMT educational standards, and to certify OMT practitioners. My organization was called The International Seminar in Orthopedic Manual Therapy (ISOMT).

The founding members of ISOMT were myself, Olaf Evjenth, and five physicians representing the fields of orthopedic surgery, orthopedic medicine, chiropractic, and osteopathy (Drs. Brodin, Cyriax, Frisch, Hinsén, and Stoddard). These five doctors administered the first international OMT examinations for physical therapists in 1973 at an ISOMT meeting in the Canary Islands. 120 manual therapists from 12 countries took the written examination. Those who passed the written examination were allowed to take the Level I Mobilization practical examination. Those who passed the Level I examination were then eligible to take the Level II OMT examination that included manipulative thrusts. 35 physical therapists were successfully certified in Level 1 Mobilization; 14 physical therapists were also certified in Level 2 OMT.

When IFOMT was founded in 1974, the first officers of IFOMT had all been certified by ISOMT. IFOMT formed an Educational Standards Committee and continued the development of educational and practice standard in OMT. Because of their relationship with ISOMT, their work also carried the recognition of the world-renowned physicians who conducted the first ISOMT examinations. I sometimes wonder whether IFOMPT would have educational standards today if physicians had not approved the first OMT examinations administered by ISOMT.

IFOMT was the first specialty group in physical therapy recognized by the WCPT (World Confederation of Physical Therapy) in 1978. However the recognition did not come easy. Initially many members of the WCPT were against specialization within physical therapy. IFOMT's efforts to promote specialization were the beginning of a movement toward specialization that has raised the level of practice for physical therapists worldwide.

Today's physical therapists worldwide realize the importance of independent practice and in some countries have been successful in achieving this level of independence. However, this was not always the case. Before 1978, the WCPT bylaws refused membership to countries where physical therapists practiced without medical referral. In 1978 there was an effort to ban Australia from

WCPT membership on these grounds. IFOMT's education and practice standards were set at a very high level and were designed to support independent practice by physical therapists. IFOMT members worked in support of Australia's membership in WCPT and argued the importance of independent practice. In the end, WCPT modified their bylaws and Australia maintained their membership status.

Independent practice by physical therapists can be traced back to the origins of physical therapy in 1813, when Per Henrik Ling, "Father of Swedish Gymnastics," founded the Gymnast Central Institute (GCI) in Sweden.² Ling's curriculum combined two courses of study: "medical gymnastics" included exercise, manipulative thrusts and massage for treatment of the sick and injured; "pedagogic gymnastics" involved physical education and athletic training. These practitioners were called "gymnasts." These gymnasts practiced autonomously without medical referral.

Toward the end of the 19th Century there was a split in gymnast practice. Male practitioners continued on as gymnasts in sports and physical education and no longer treated patients. Female practitioners continued to treat patients in different professions as masseuses and as physician assistants, but could now only practice under the direction medical doctors. The male gymnasts did not become involved with patient treatment again for 50 years, when in 1948 they gained acceptance into the Physical Therapy School Oslo Orthopaedic Institute (OOI), at that time the only school in Norway.

Over time, the divided profession merged together again with a new name: Physical Therapy. Modern physical therapy encompasses therapeutic exercise, sports training and many forms of manual therapy including manipulative thrusts (OMT). In 2013 we can celebrate 200 years of physical therapy practice. Physical Therapy has come full circle back to its roots.

References:

- *Anders Ottosens PhD work in Gothenborg University, Sweden. 2007 (in Swedish)*
- *My textbook „Manual Mobilization of the Joints, Volume III, Traction-manipulation.“ Appendix: History. 2008.*

² The Gymnast Central Institute (GCI) in Sweden was known as The Royal Central Institute of Gymnastics (RCIG) in English speaking countries.