

# Acceptance Speech for the John McMillan Mennell Service Award of the American Academy of Orthopaedic Manual Physical Therapy

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*Ann Porter Hoke, PT, OCS, FCAMT, FAAOMPT*

**M**r. President of the American Academy, members of the Executive, Mr. President of the International Federation of Orthopaedic Manual Therapists (IFOMT), IFOMT Standards Committee, distinguished guest speakers, past recipients of this award, fellows and members of the Academy, I was surprised and am deeply honored to be the 2006 recipient of the John McM. Mennell Service Award.

I would like to thank the 1996 recipient of this award, Carol Jo Tichenor, PT, as it was her charm and flattery that on three occasions persuaded me to join a task force to create a document important to manual physical therapists. Driving through snow in Colorado (with Patty McCord, PT) to be sequestered in a hotel room for the weekend in 1997 was part of the process of the creation of the first DACP-OMPT (Description of Advanced Clinic Practice in Orthopaedic Manual Physical Therapy) and the building of many friendships. One of the hot discussions that weekend was whether the word “manipulation” should be used in that document. Memories of the late physiotherapist, David Lamb, helped us with that decision.

David Lamb was passionate that manipulation should be part of the practice of physiotherapy/physical therapy and he frequently asked regarding manipulation, “. . . What is all the fuss about . . .?” Along with physiotherapists Brian Edwards, Gregory Grieve, and Freddy Kaltenborn, David Lamb had been part of the development of the IFOMT Standards, which were first ratified in 1978, and he was the chair and the “glue” of the Education Consultant Group, together with Freddy Kaltenborn and Geoffrey Maitland. David Lamb passed away so suddenly in 1996. That same year I was invited to join the IFOMT Standards Committee and it has been an honor to serve on the same committee that he pioneered.

My 39-year career in physiotherapy/physical therapy has been shaped by many inspirational people and by being at the

right place at the right time. I am one of a few of my generation for whom spinal manipulation and diagnosis were part of my vocabulary and my training as a physiotherapy student. It is only recently that manipulation has become a required part of the curriculum for physical therapy training in the United States<sup>1,2</sup>. Many of you had to wait until the mid-1980s for Shirley Sahrman, PT, PhD, FAPTA, to encourage physical therapists to use the word “diagnosis” in the US<sup>3</sup>. However, we still shy away from using the words “diagnosis” and “manipulation” in our patient documentation.

While I was in high school in England, my teachers were directing me towards a career as a mathematics teacher. The thought of teaching did not excite me (fortunately that changed) and talking in front of a group of people scared me (that has not changed!). My father had experienced physiotherapy and obtained some career information booklets. On the cover was a picture of a physiotherapist with short stubby hands like mine, so it looked to be a good career choice for me! During my interview at St Thomas’ Hospital, School of Physiotherapy in London, my hand strength and flexibility were evaluated because deep transverse friction techniques were part of the curriculum. This was another sign that this was indeed the right career for me.

St Thomas’ Hospital is across the River Thames from the Houses of Parliament and Big Ben. My uniform was a starched white lab coat (sometimes it was so starched that I had to bend the coat around me to button it up) and a long brown cloak that hung 11 inches from my sensible brown laced-up shoes. Fortunately hats or caps were not required. The Florence Nightingale School of Nursing was housed at St Thomas’ Hospital and the nursing students wore lace caps shaped like the nightingale bird.

Many of the pioneers in the teaching of manipulation to physiotherapists were at St Thomas’ Hospital. Dr. James Cyriax, MD, started training physiotherapists in manipulation in 1938, but he stated that this was no novelty, as his predecessor at St Thomas’, Dr. James Mennell, had, since 1916<sup>4</sup>, been teaching joint and soft tissue manipulation to trained masseuses (later to be called physiotherapists)<sup>5</sup>. Dr. James Mennell (1880–1957) had been assisted by a physiotherapist, Edgar Cyriax (1874–1955), who had studied with Kellgren (his future father-in-law), a major figure in Swedish Remedial Gymnastics and Exercise. Edgar Cyriax went on to

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Address all correspondence and requests for reprints to:

Ann Porter Hoke  
New Heights Integrative Therapy  
1423 SE 23rd Avenue  
Portland, OR 97214  
United States  
E-mail: aphoke@comcast.net

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obtain his medical degree and practice manipulative therapy<sup>6</sup>. Utilization of differential diagnosis and spinal manipulation would be a major part of the practice of both their sons, John McMillan Mennell, MD (1916–1992), and James Henry Cyriax, MD (1904–1985), and they would become the medical names most associated with teaching manipulation to physiotherapists<sup>4</sup>. Although to my regret I never met John Mennell, it was James Cyriax, who shaped my career.

Physiotherapy in the late 1960s in England was a 3-year diploma program one entered immediately after high school. In our second year, we began the differential diagnosis classes with Dr. Cyriax. Up to that point, I was frustrated that we appeared to be learning so much, but the treatments were recipes requiring little thought and primarily utilizing modalities. If the class was talking when we should have been listening, the after-school detention was to practice PNF for 15 minutes. Into this atmosphere came Dr. Cyriax, who taught us that “. . . you girls will show the physicians what to do . . .” He was referring primarily to his great gift of diagnosis by selective tissue tension testing, which before the days of magnetic resonance imaging was the only way to diagnose a lesion not visible on standard X-rays, except for undergoing exploratory surgery. He used the term “his girls” with great pride. We were an all-female school and he only worked with female physiotherapists (with one exception, F. Preastner)<sup>7</sup>. Cyriax did teach manipulation to physicians and male physical therapists during his many national and international workshops or when they observed him in his private practice at 38 Wimpole Street in London.

His greatest gift to us was the training in diagnosis by selective tissue tension testing to differentiate the inert from the contractile tissues<sup>8,9</sup>. If it was a contractile tissue, deep transverse frictions were the treatment, delivered on alternate days for two or three weeks. If the selective tissue tension testing suggested an inert structure, the presence of a capsular pattern with no history of injury would alert the examiner to a possible systemic condition that might need a referral to rheumatology. The assessment of the capsular pattern was through interpretation of the passive end feel and by visual range of motion assessment. I never saw him use a goniometer.

When teaching, Dr. Cyriax would simulate a soft tissue lesion and, in front of the whole class, you would examine him by systematically testing the structures. If your hand strayed distal to the wrist joint while examining the shoulder, he would respond with a false positive and let you struggle to find the correct diagnosis. It was then that those heavy eyelids would lift, you would see his eyes, and your error would be explained in detail so the whole class could learn.

By my third year (1969), I had been trained in spinal manipulation—including to the cervical spine—and I was using it under supervision in the clinical setting. By comparison, on the pediatric neurology rotations, we were only allowed to sit and watch the physiotherapist utilizing the

methods of the Bobaths, as it was considered a post-professional advanced skill.

The treatment for low back pain or referred leg pain was one of three non-surgical choices: an epidural, traction, or manipulation (high velocity/thrust)<sup>8-11</sup>. If the condition was severe or acute, we would assist Dr. Cyriax in the clinic with the preparation of the patient and the parting of the buttocks for the epidural, followed by a straight leg raise reassessment. If there was a history of slow onset and neurological symptoms were present, the treatment was 30 minutes of continuous traction using half their body weight (in the form of weights), performed daily for a fortnight (two weeks)<sup>9</sup>. The straight leg raise was re-tested each Friday.

After recognition of the “disc displacement,” the indication for lumbar spinal manipulation was . . . if there was no contraindication<sup>9</sup>. Manipulation was not used in the presence of bladder or bowel disturbance, saddle paraesthesiae, neurological signs, an acute kyphosis, or if the onset of symptoms had been slow. Pain below the knee, especially when exacerbated by extension, was not a contraindication for manipulation but Dr. Cyriax felt the clinical prediction for success was low<sup>9,11</sup>. If manipulation created pain in the lower limb, it was to be abandoned immediately<sup>8</sup>. Manipulation was considered not dangerous but was seldom found to be successful post-laminectomy<sup>10</sup>.

Acuity was not a factor in the selection, except that manipulation was considered unlikely to be effective if root pain had lasted longer than six months in a patient under 60 years of age<sup>10,11</sup>. The patient would ideally present with 3 or 4 lumbar motions hurting and limited<sup>11</sup>. If all six lumbar motions were limited and/or painful and if there was significant stiffness in the hips, there was a chance of a serious or systemic disorder and manipulation was deferred until X-rays and blood tests had been reviewed. Many of Dr. Cyriax’s observations remained unchanged and appear in successive editions of his publications.

The initial rotatory manipulation was performed with the painful side uppermost and the top hip being taken forward and the shoulders backwards<sup>8,10</sup>. Strong traction was always applied before the manipulative thrust and it was considered that the disc in dysfunction would be the one reduced by the manipulation and that other (normal) joints and discs would be unaffected. The motion restriction was re-tested, and then the manipulation was repeated one or two times that day until full or pain-free lumbar motion was achieved. Dr. Cyriax felt that “. . . manipulation succeeds in a few sessions or not at all; one to four sessions suffice. If relief has not been secured by then, alternative measures come to the fore . . .”<sup>4</sup>. In 1965, Dr. Cyriax suggested that manipulation would be effective in one-half of all patients at best and wrote, “. . . Patients with backache or lumbago are more likely relieved by manipulation than those with sciatica. The actual figures are 58% in patients with lumbar pain, 31% in those with root pain . . .”<sup>8</sup>.

Like many physiotherapists, I abandoned the non-specific so-called “million-dollar roll” in favor of specific segmental techniques. With the recent surge in teaching regional manipulation to the lumbar spine, I have asked myself why I spent three decades trying to master the focused or specific technique.

Firstly, the lumbar techniques were always difficult for me with my short arms. I did not have a large enough “wing span.” One of my clinical instructors at St Thomas’ was the wonderful Jennifer Hickling, PT. I can still hear her infectious laugh. She had trained with Dr. Cyriax and spent time with Geoffrey Maitland designing Movement Diagrams to assist students in interpreting joint feel<sup>12,13</sup>. She tried to find ways to assist me with lumbar manipulation techniques, which usually resulted in her holding down the shoulders while I manipulated via the pelvis.

After retiring from St Thomas’ Hospital, Dr. Cyriax held orthopaedic clinics every Tuesday at St Andrews’ Hospital in East London. During my time there from 1971–1972, he would regularly bring us donuts and Cornish pasties so we would get heavier and therefore would become more effective with manipulation. Those donuts took effect about a decade later.

The precise techniques of the Norwegian system of Kaltenborn<sup>14</sup> were taught to physiotherapists in Canada during the early 1970s. Thrust manipulation was considered the pinnacle after learning the skill of mobilization. Alan Stoddard, DO, and other osteopathic physicians had influenced these joint-specific and direction-specific manipulations<sup>15</sup>. During that same time, we were also heavily influenced by the theories on spinal instability of Drs. Farfan and Kirkaldy-Willis<sup>16-18</sup>, so we took great care to protect the adjacent potentially vulnerable, unstable, and sensitive joints during spinal manipulation. The teachings of numerous other physical therapists and osteopathic physicians further refined our skills to ones of decreased force and theoretically greater safety, precision, and specificity.

Clinical experience showed us that the patient describes less soreness after these precise techniques and there is a patient preference for the more gentle techniques. I am still thrilled when the patient tells me that my manipulation did not hurt compared to the “other” practitioner’s technique

and that it was less scary, especially in the cervical spine. I always carefully screen, pre-warn, and never surprise my patient with a high-velocity technique.

In a 1984 letter, addressed to the *Journal of the Royal Society of Medicine*<sup>19</sup>, Dr. John Mennell wrote:

“. . . Over a span of 75 years, my father, the late James Mennell, and I have tried to encourage the use of manipulative therapeutic techniques [. . .] to allow the painless restoration of functional movements very readily and comfortably. . . .” I encourage you to teach others well and modify as necessary for the individual practitioner so these techniques are safe and comfortable, and so even the small therapist with small hands can do them well.

My career has been blessed with the incredible diagnostic base taught by Dr. Cyriax, which he developed over decades of clinical observation. My “addiction” to manual physical therapy was then fostered by my first Canadian physiotherapy mentors in the mid 1970s: David Lamb, Cliff Fowler, and John Oldham. I have continued to be challenged and inspired by many amazing people (too numerous to mention) including my current North American Institute of Orthopaedic Manual Therapy (NAIOMT) colleagues.

My father led me into this profession by being impressed by the physiotherapist who had tried to help his back condition with mechanical spinal traction. Ironically, it was a manipulation by an osteopathic physician that restored his ability to return to work. As I selected my career, my father’s advice was to “. . . find something you really like doing and give it your best effort . . .” I believe I did and I plan to continue to follow his advice. I also believe I am surrounded by physical therapists who have found in manual physical therapy something they really like doing and who are giving it their best effort. My father would have been so proud of me receiving this award. Thank you so much.

## Acknowledgement

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