

Int'l Strategy Consensus Meeting



The new FIMM Guidelines v5.0

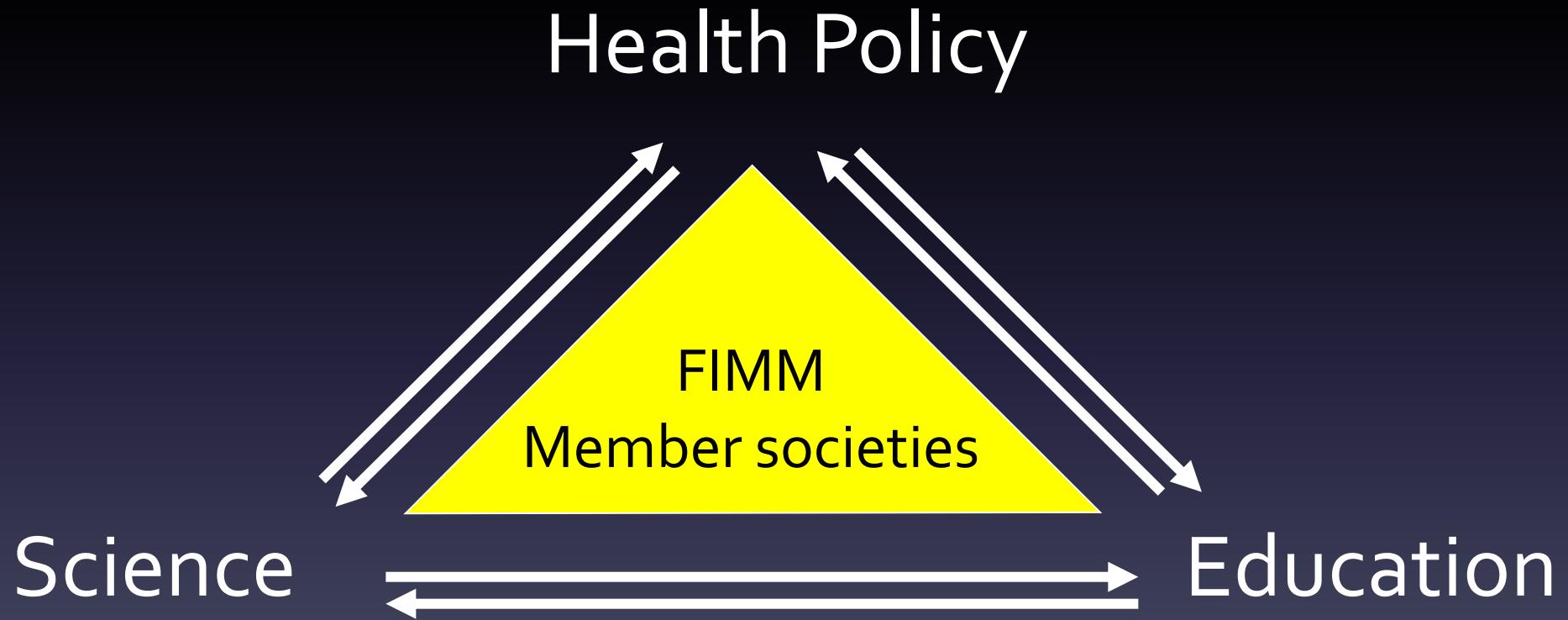
Discussion and debate

FIMM Health Policy Board

History of the FIMM Guidelines

- The establishment of an HPB was proposed to the GA in 2005
- Passed the FIMM GA in 2006 with a change of the FIMM Statutes

History of the FIMM Guidelines



History of the FIMM Guidelines

1. WHO project (WHO team)

World Health Organisation

2. UEMS project (UEMS team)

Union Européenne des Médecins Spécialistes

The task of the WHO team in 2007

WHO Guidelines on Basic Training and Safety in MM Medicine

- To develop an extensive consensus document presented by FIMM
- Accepted and published by WHO
- Which encourages and supports countries in the proper education and use of safe, effective practices in M/M Medicine as a part of national health services

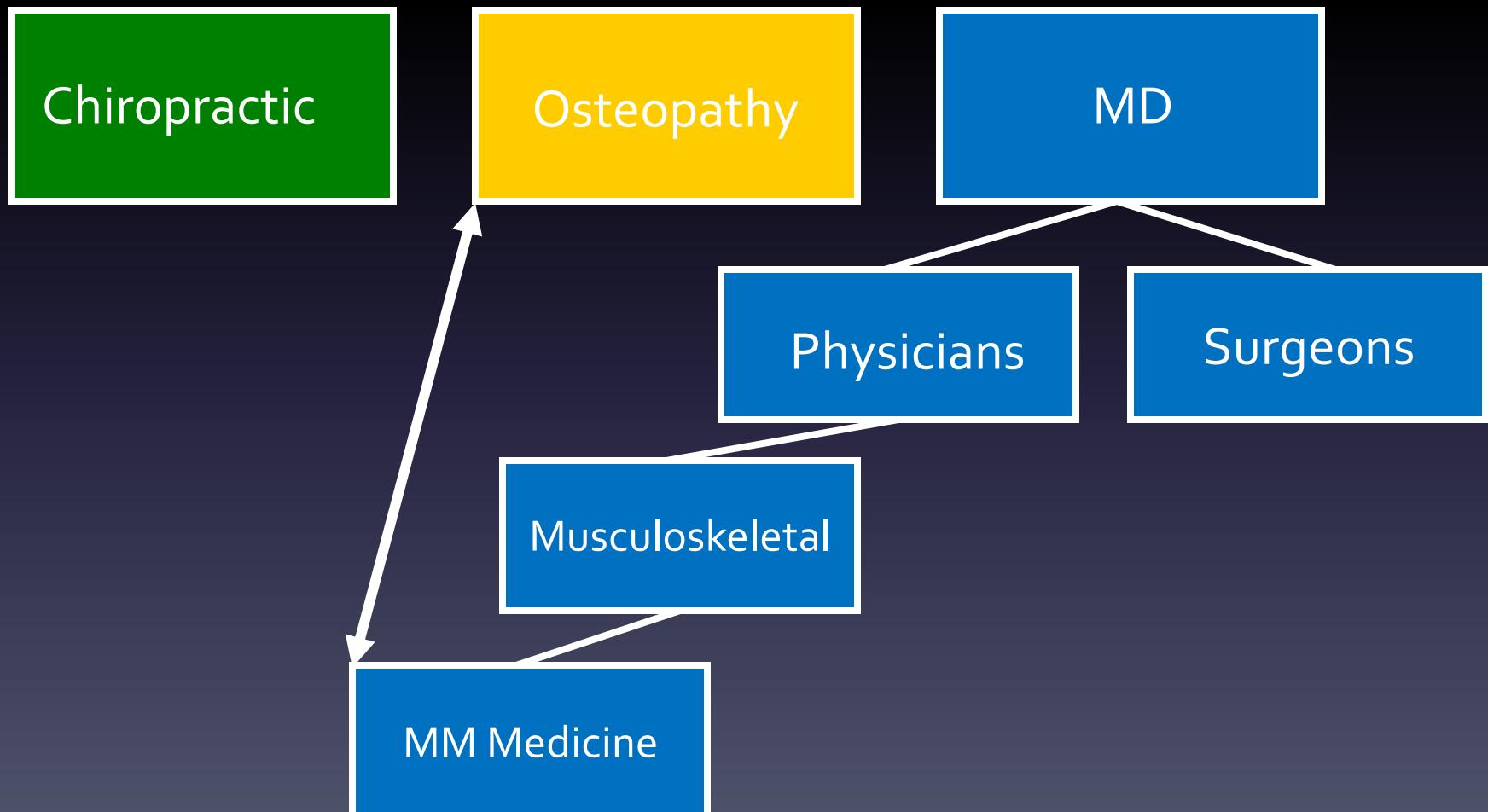
The project failed

WHO Consultation	2009 - 2010	Geneva	EUR	~75'000.00
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- The Consultation process involves extensive dialogue and testimony by WHO committees...
- and invited external representatives, and consultants of the WHO.
- The WHO consultants come from multiple countries to participate in the presentations.

The project failed

WHO Professions



The task of the UEMS team in 2007

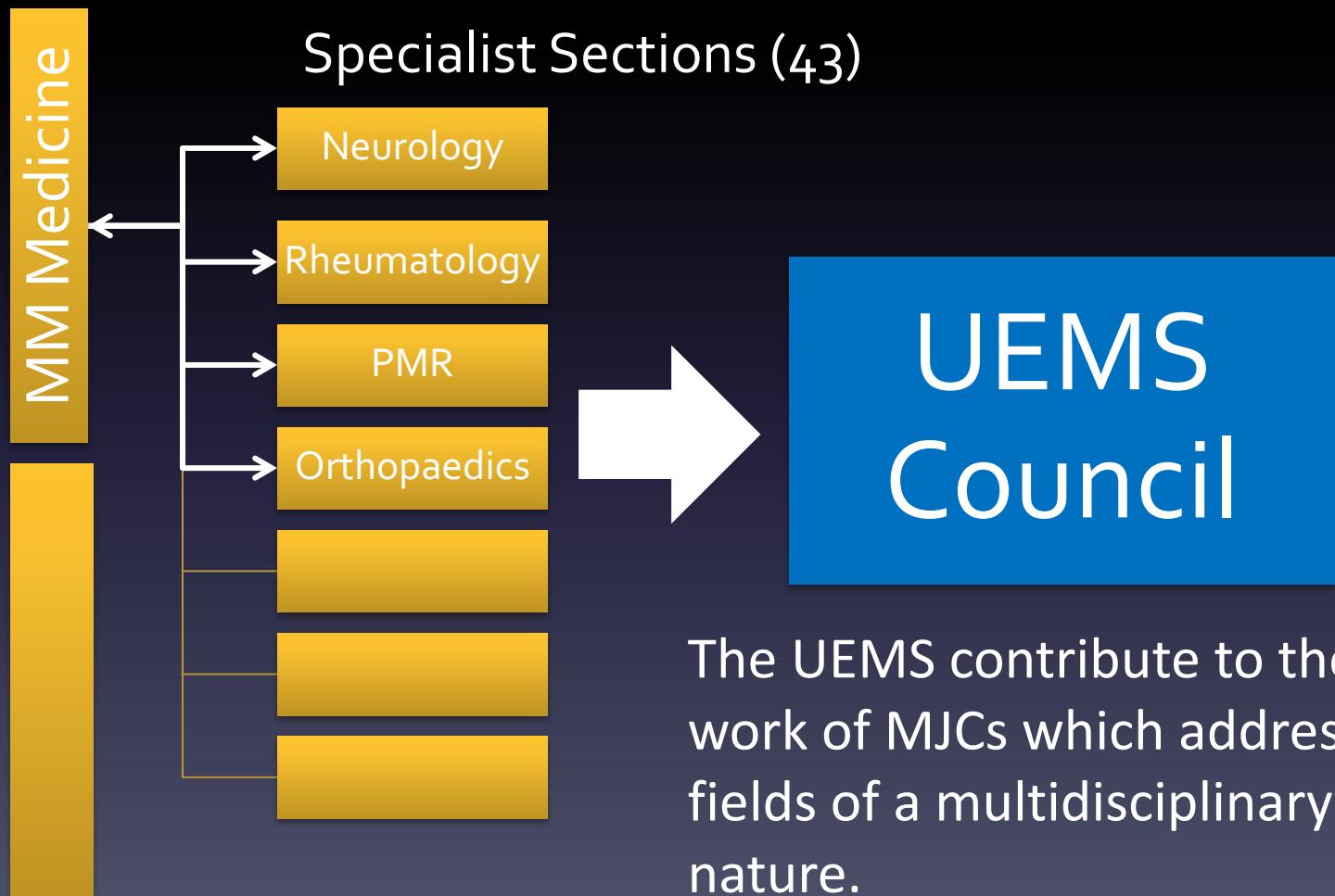
- To initiate the positioning of MM Medicine in Europe as a distinct specialization.

The task of the UEMS team in 2007



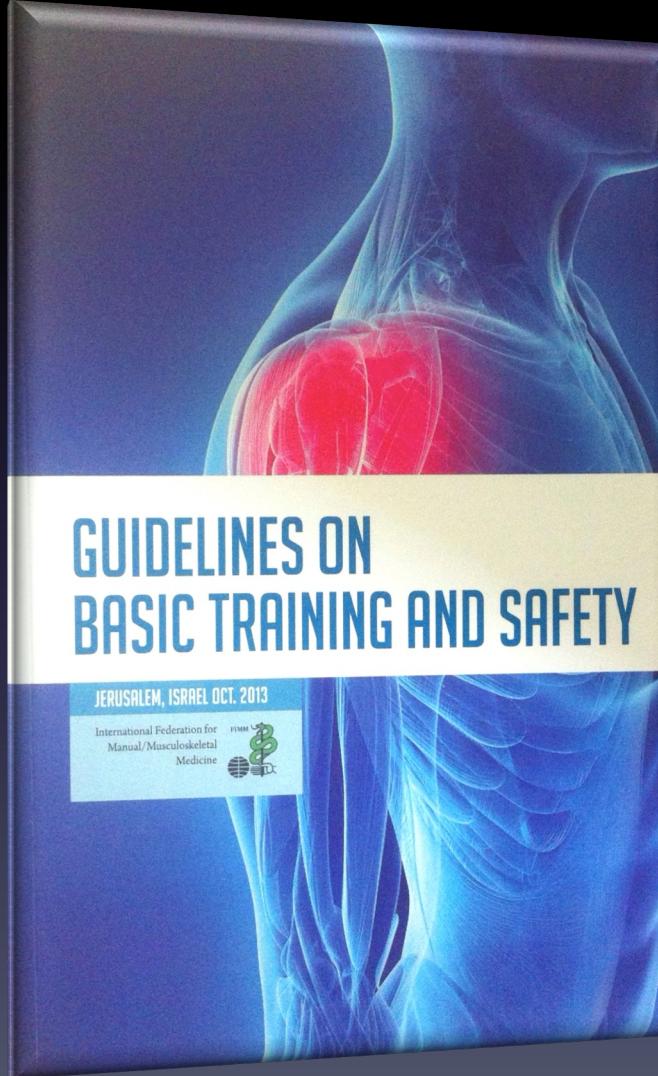
Realisation in 2012

MJC (16) (Multidisciplinary Joint Committees)



FIMM Guidelines 2013 v3.1

Tel Aviv



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What is the purpose of the FIMM Guidelines ?

FIMM Guidelines 2024 v5.0

- To describe and delineate different levels in the requirements for MM medicine education.
- To serve as a reference for national and professional authorities in establishing an examination and licensing system for the qualified practice of MM medicine.
- To review contraindications in order to minimize the risk of accidents.
- To promote the safe practice of MM medicine.

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Many editorial changes were achieved.

Guidelines on basic training and safety

adopted by the FIMM General Assembly on October 15th, 2013
official content version 3.0



GUIDELINES ON TRAINING, SAFETY, EVIDENCE AND QUALITY

SECOND EDITION
adopted by the FIMM General Assembly on September 21st, 2024
version 5.1
English edition

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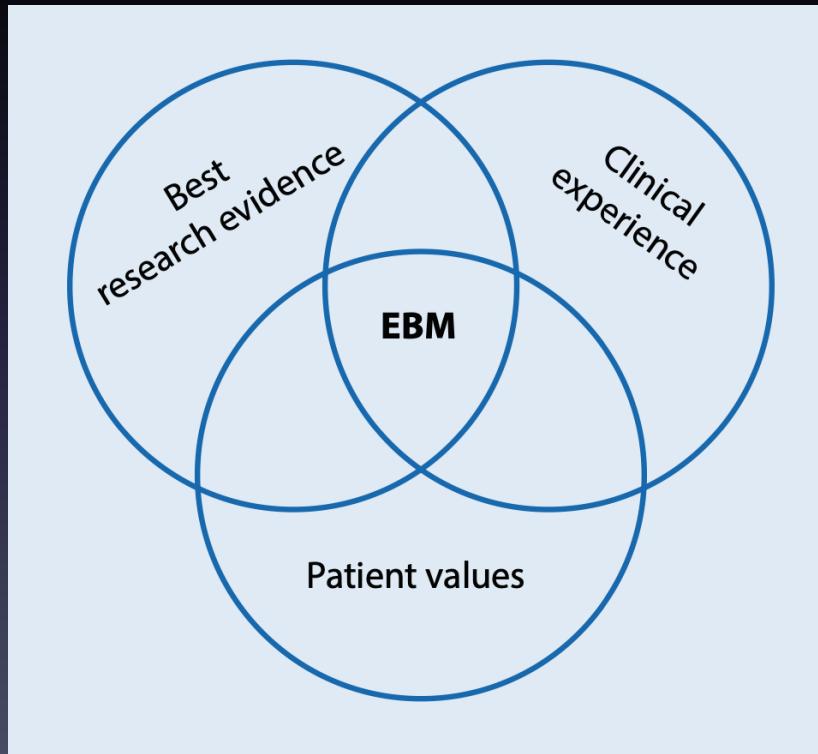
New Sections:

SECTION V: EVIDENCE IN MM MEDICINE

**SECTION VI: QUALITY IN EDUCATION AND TRAINING
IN MM MEDICINE**

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SECTION V: EVIDENCE IN MM MEDICINE



Haneline 2007

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SECTION V: EVIDENCE IN MM MEDICINE

- Spinal manipulation, and mobilization, (acupuncture, and massage treatments) were significantly more efficacious for neck or low-back pain than no treatment, placebo, physical therapy, or usual care in reducing pain.
- Spinal high velocity low amplitude procedures have a statistically significant association with improvements in function and pain improvement in patients with acute low back pain.

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SECTION V: EVIDENCE IN MM MEDICINE

- Musculoskeletal manipulations are effective for the treatment of temporomandibular joint disorders and there is a greater effect for musculoskeletal manual approaches compared to other conservative treatments for temporomandibular joint disorders.
- There is preliminary evidence that sub-group specific manual therapy may produce a greater reduction in pain and increase in activity in people with low back pain when compared with other treatments.
- Other evidence is discussed and presented.

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SECTION VI: QUALITY IN EDUCATION AND TRAINING IN MM MEDICINE

- Countries commit to achieving *health for all*.
- It is therefore imperative to carefully consider the quality of care and health services.
- Quality health care can be defined in many ways.
- Quality health services should be:

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SECTION VI: QUALITY IN EDUCATION AND TRAINING IN MM MEDICINE

- **Effective**
providing evidence-based healthcare services to those who need them,
- **Safe**
avoiding harm to people for whom the care is intended, and
- **People-centred**
providing care that responds to individual preferences, needs and values.

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SECTION VI: QUALITY IN EDUCATION AND TRAINING IN MM MEDICINE

- MM medicine has developed from empiric medical experience.
- This might explain why MM Medicine is quite variable all over the world.
- This was the reasons why in 2013 FIMM published the first edition of *the FIMM Guidelines*.
- The aim will not be to strive for a complete *unité de doctrine* (doctrinal unity).

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SECTION VI: QUALITY IN EDUCATION AND TRAINING IN MM MEDICINE

- The need for some kind of standardisation also on quality in MM medicine remains evident.
- ESSOMM addressed this issue in 2015 in its submission to UEMS entitled *Training Requirements for the Additional Competence “Manual Medicine” for European Medical Specialists*.

SECTION VI: QUALITY IN EDUCATION AND TRAINING IN MM MEDICINE

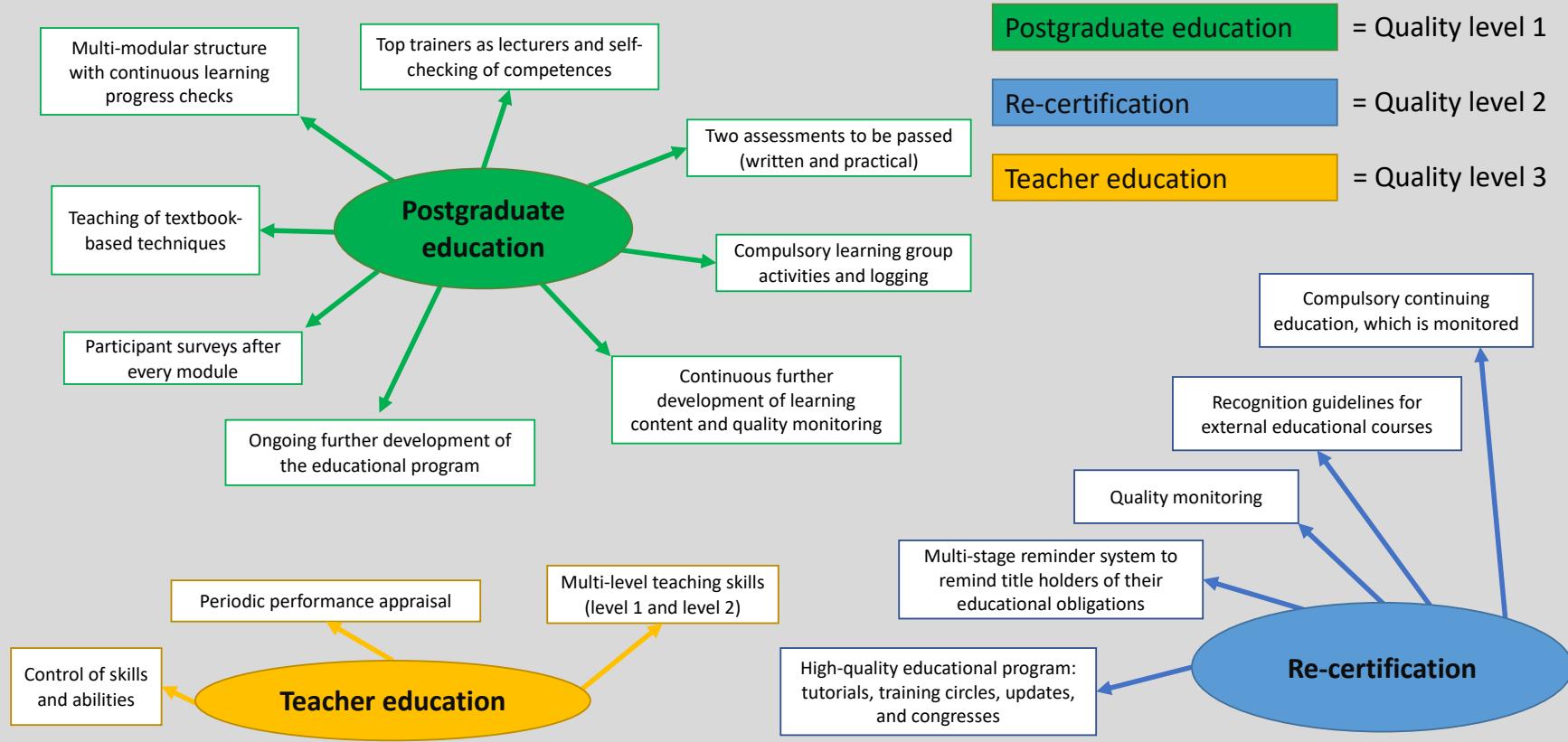
Different aspects of quality

- Requested qualification of a trainer
- Core competencies for trainers
- Quality management for trainers
- Quality of the organisation or institution providing the education
- Quality tools in MM medicine

SECTION VI: QUALITY IN EDUCATION AND TRAINING IN MM MEDICINE

Quality tools in MM education

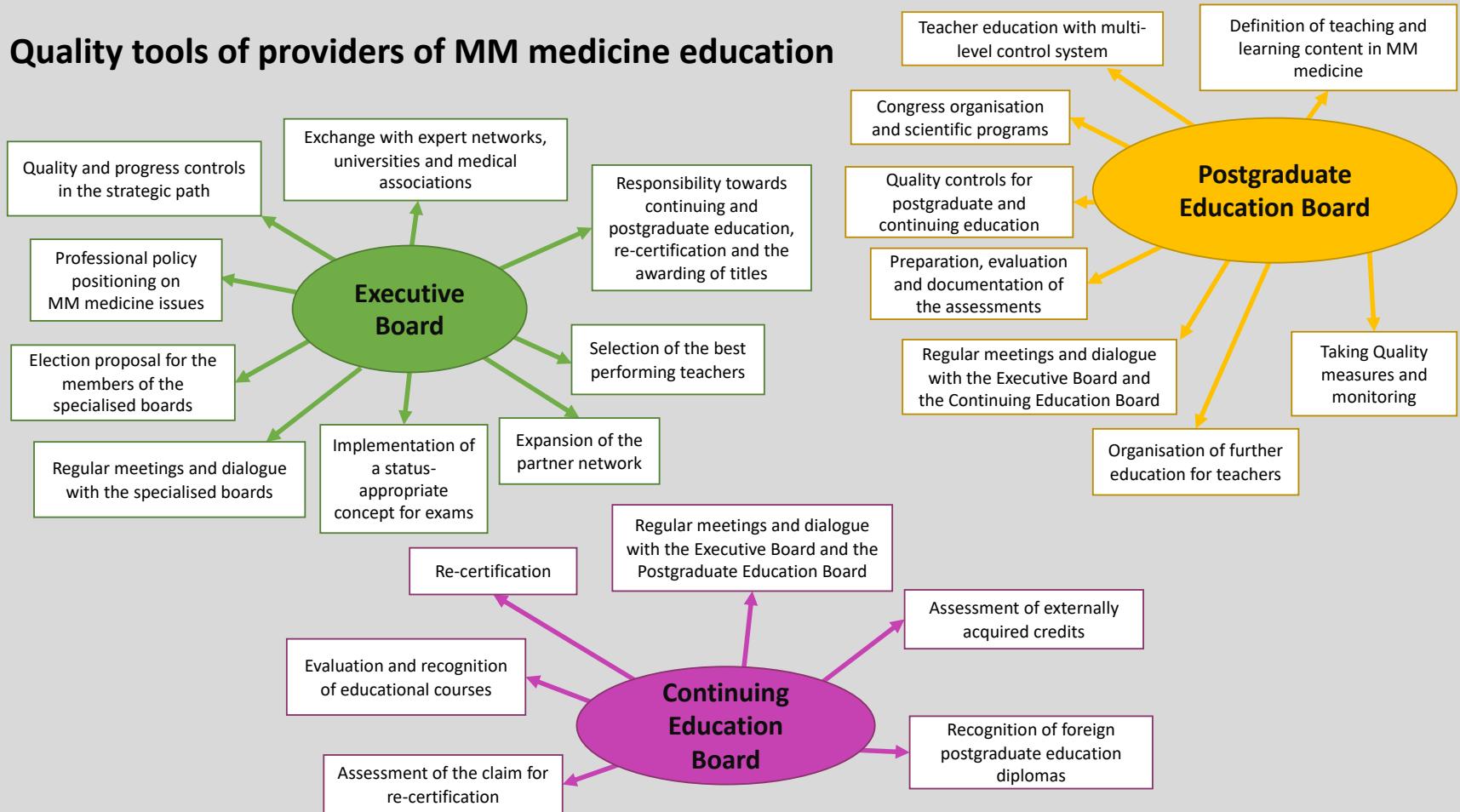
Quality tools in MM medicine education



SECTION VI: QUALITY IN EDUCATION AND TRAINING IN MM MEDICINE

Quality tools of providers

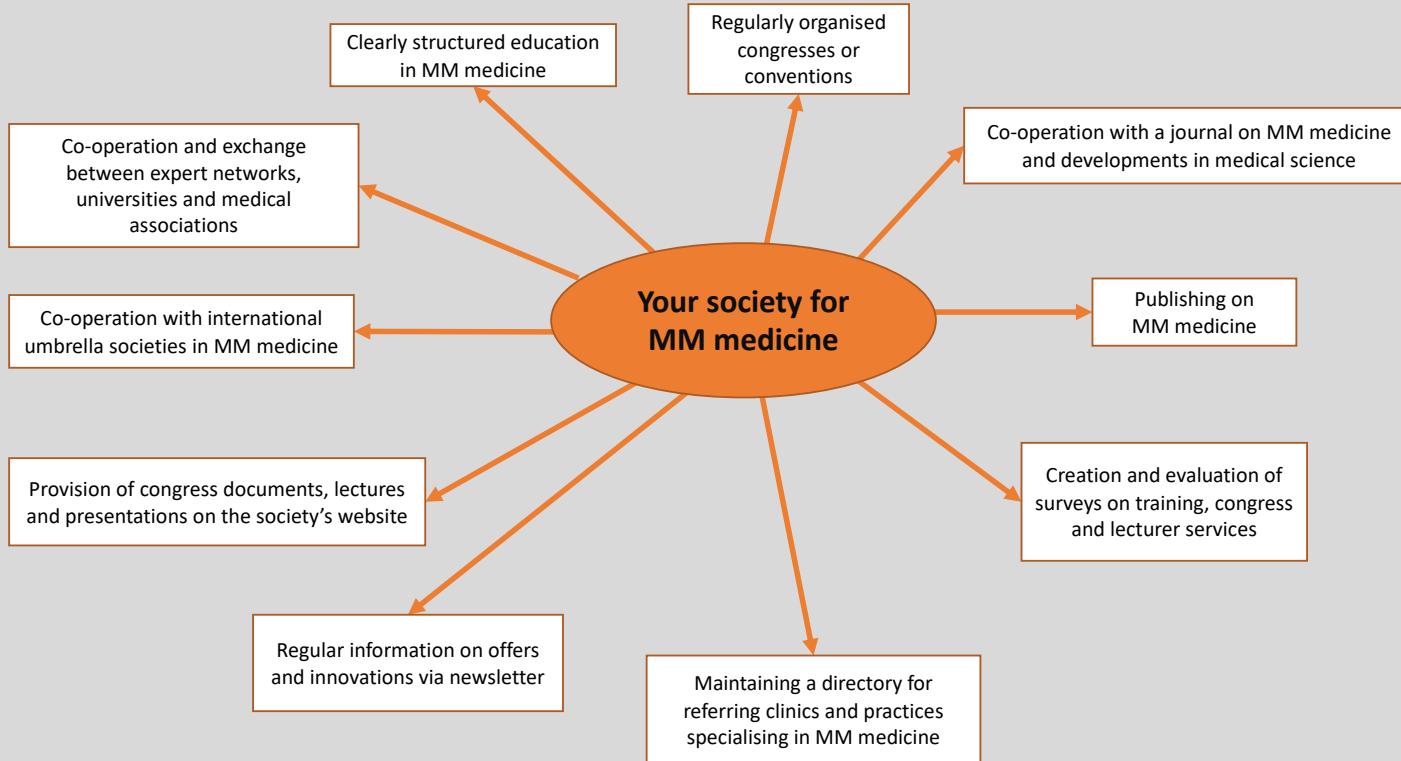
Quality tools of providers of MM medicine education



SECTION VI: QUALITY IN EDUCATION AND TRAINING IN MM MEDICINE

Further quality tools

Further quality tools in MM medicine



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SECTION II: TRAINING IN MM MEDICINE

- For graduates of training in MM medicine, their level of training or skills and abilities can be checked and tested using various methods.
- The methods can complement each other, but not necessarily.
- Depending on the customs or rules of the different health care systems, elements of this or that method have become established in medical education in different countries.

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SECTION II: TRAINING IN MM MEDICINE

- *Structure- and process-based* and the *competency-based* variants are presented.
- In one method, the focus is on the assessment of time spent and the credits awarded for this (for example 300 hours and 30 credits).
- In the other, the focus is on the assessment of professional competences and how the trainee deals with them (for example the assessment of knowledge, skills and attitude).

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Variables	Educational Program	
	Structure- and process-based	Competency-based
Driving force for curriculum	Content – knowledge aquisition	Outcome – knowledge application
Driving force for process	Teacher	Learner
Path of learning	Hierarchical	Non-hierarchical
Responsibility for content	Teacher	Student and teacher
Goal of educational encounter	Knowledge acquisition	Knowledge application
Typical assessment tool	Single subjective measure	Multiple objective measures (evaluation portfolio)
Assessment tool	Proxy	Authentic (mimics real tasks of profession)
Setting of evaluation	Removed	In the trenches (direct obser-vation)
Evaluation	Norm-referenced	Criterion-referenced
Timing of assessment	Emphasis on summative	Emphasis on formative
Program	Fixed time	Variable time

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SECTION II: TRAINING IN MM MEDICINE

3.5.1. Competence-based definition

The skill set includes profound clinical expertise relating to axial and appendicular structures and the associated soft tissues. This consists of clinical reasoning and thorough knowledge of the disorders and treatment techniques, incorporating a complete set of manual techniques related to the physician's or surgeon's specialty.

3.5.2. Structure and process-based definition

This level corresponds to a specialty related competency for MM medicine used in the broad base of clinical conditions related to that physician's or surgeon's specialty practice. This corresponds within the Bologna concept to a DAS^{27,28} (Diploma of Advanced Studies), which allocates 30 ECTS.

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SECTION II: TRAINING IN MM MEDICINE

1	Level 1	Medical school level or predoctoral level
2	Level 2	MM-recognition level or facility level
3	Level 3	MM-specialist level or specialty level
4	Level 4	Master level or doctorate level

Tab. 2: Levels of education in MM medicine.

SECTION I: GENERAL CONSIDERATIONS

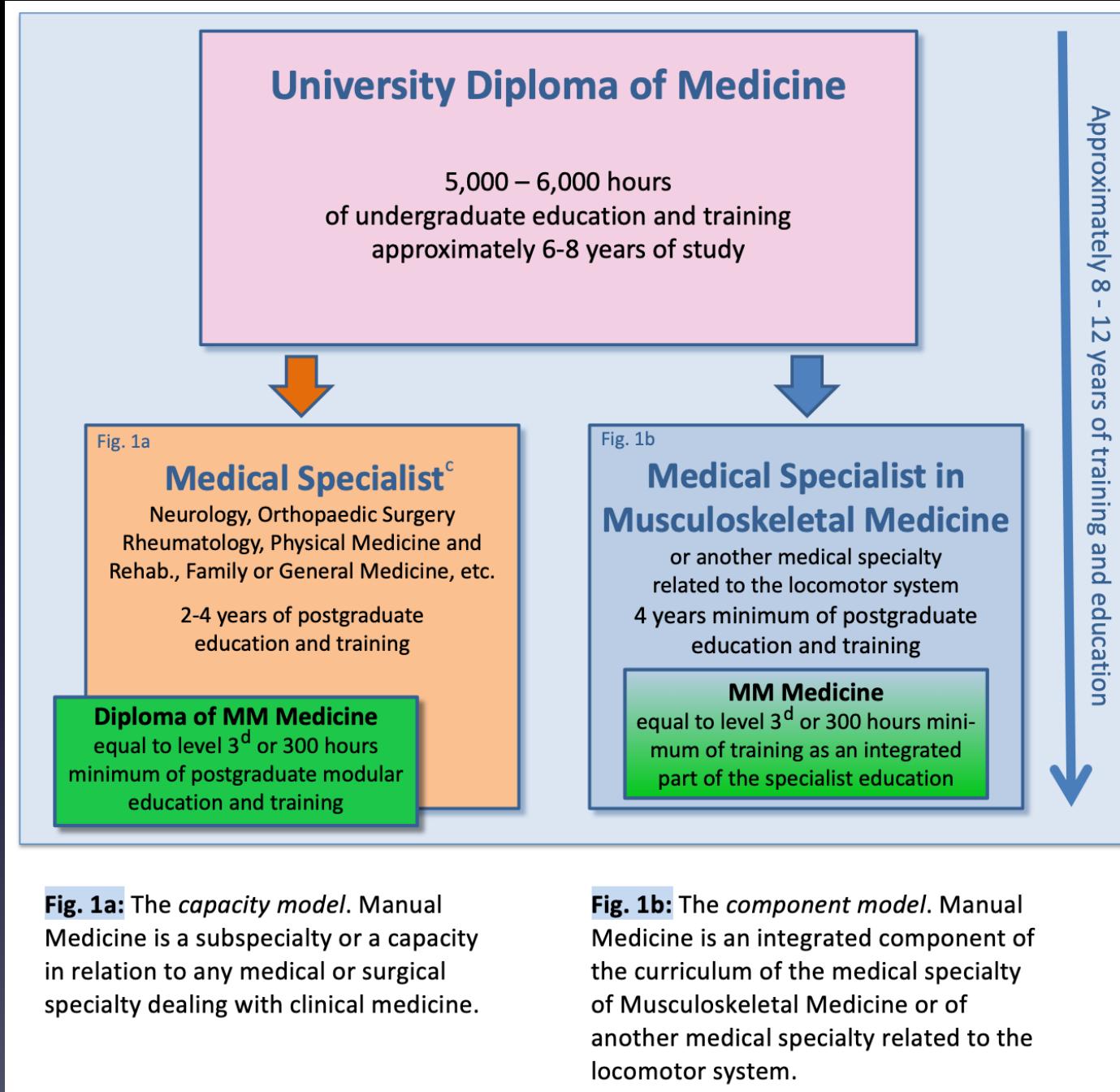


Fig. 1a: The *capacity model*. Manual Medicine is a subspecialty or a capacity in relation to any medical or surgical specialty dealing with clinical medicine.

Fig. 1b: The *component model*. Manual Medicine is an integrated component of the curriculum of the medical specialty of Musculoskeletal Medicine or of another medical specialty related to the locomotor system.

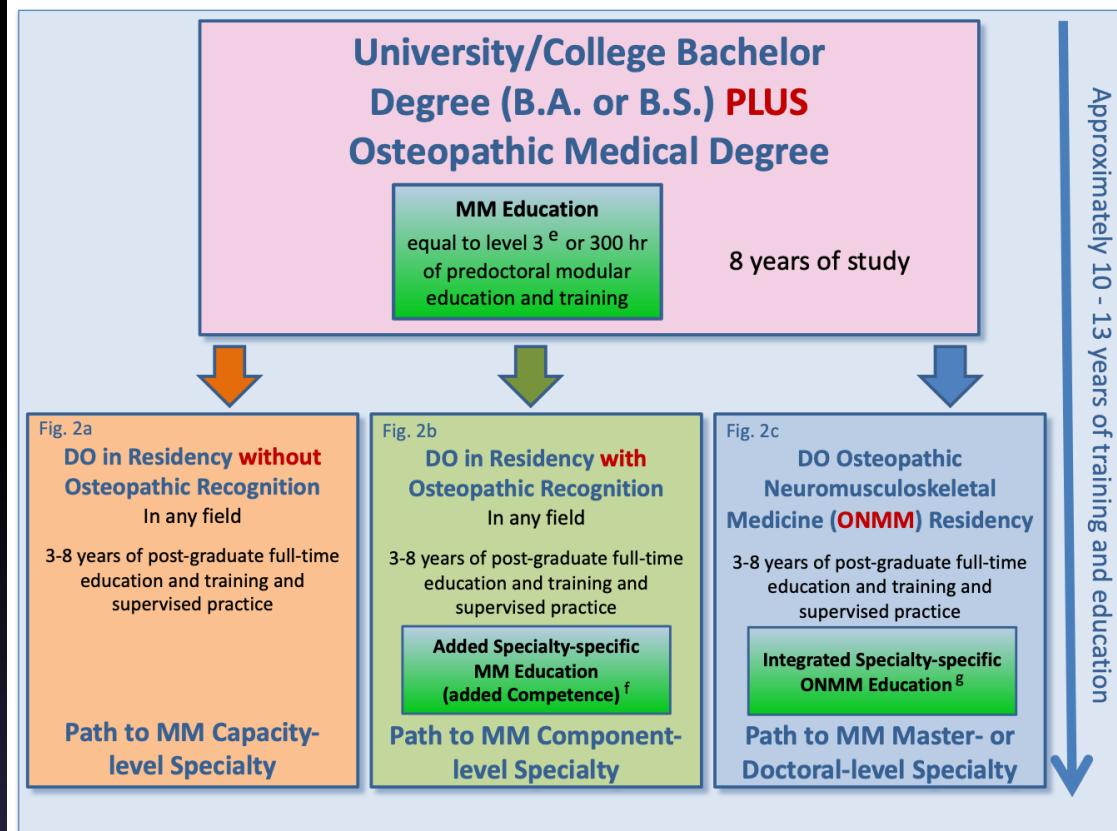


Fig. 2a: A capacity model.
Osteopathic Manipulative Medicine and Osteopathic Manipulative Treatments are integrated components of the predoctoral curriculum of all US-graduated DO physicians. Such DOs in the USA qualify as MM Capacity-level specialists in any medical or surgical discipline.

Fig. 2b: A component model.
An allopathic graduate (MD) or US-graduated DO who completes a residency with an “osteopathic recognition” curriculum within a given specialty field may qualify as MM Capacity- or MM Component-level specialists depending on the discipline. (For example, capacity-level Family Practice with OMT specialists).

Fig. 2c: Master- or Doctoral-level model. An allopathic graduate (MD) or US-graduated DO who completes an Osteopathic Neuromusculoskeletal Medicine (ONMM) residency or completes qualifications including a thesis defense to obtain an FAAO (Fellow of the American Academy of Osteopathy) award may qualify as a MM Master- or Doctoral-level specialist.

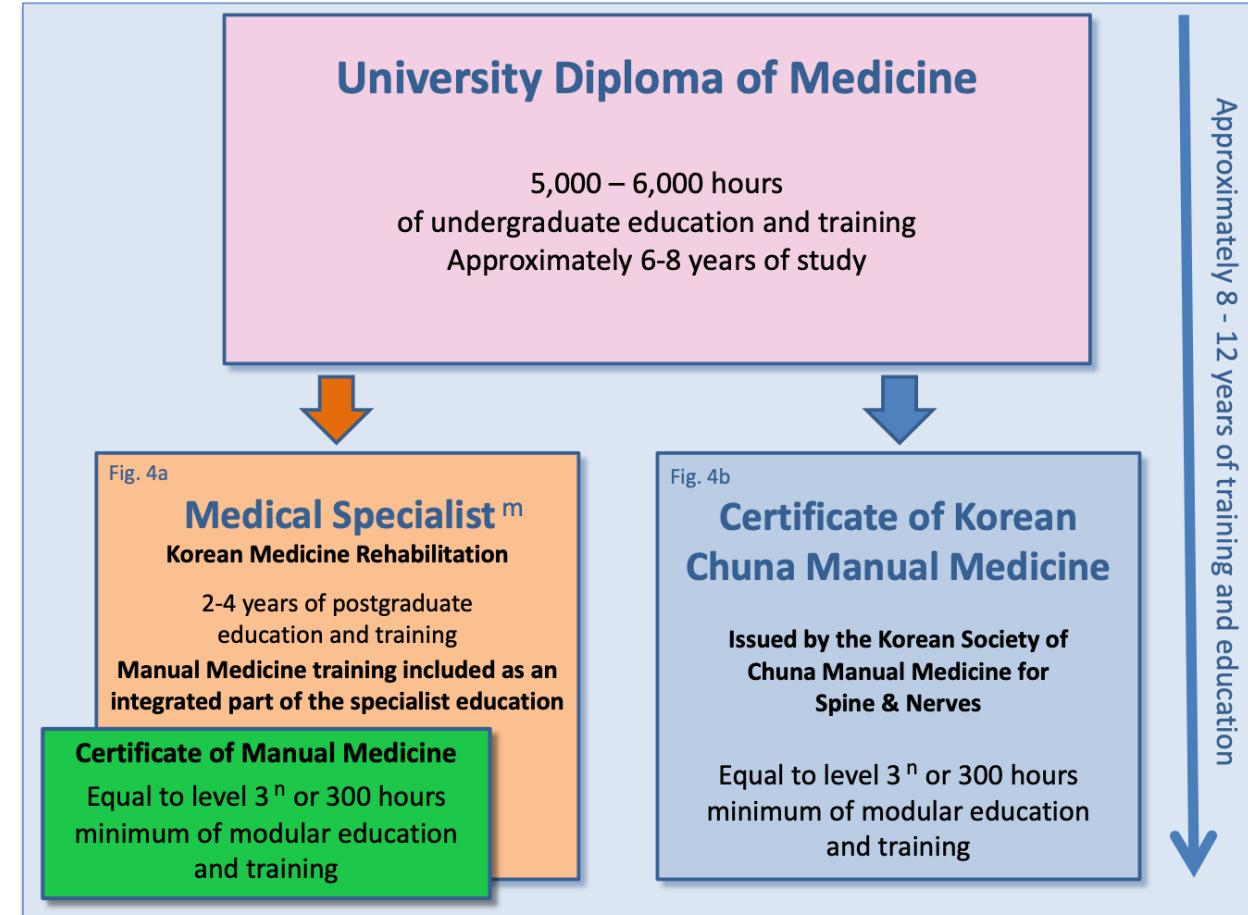


Fig. 4a: Korean capacity model. Specialists in Korean Medical Rehabilitation receive basic training in Manual Medicine. They can complete this with a Certificate on level 3ⁿ or a 300 hour Certificate of Manual Medicine.

Fig. 4b: Holders of the Certificate of Korean Chuna Manual Medicine receive training at level 3ⁿ or at least 300 hours of training in Manual Chuna Medicine.

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integrated part of the specialist education

Certificate of Manual Medicine

Equal to level 3ⁿ or 300 hours
minimum of modular education
and training

Spine & Nerves

Equal to level 3ⁿ or 300 hours
minimum of modular education
and training

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<p>2</p> <p>...</p> <p>2.1 Ordinary Members:</p> <p>2.1 Organisations of Manual Medicine Physicians are entitled to become ordinary members of the Federation.</p> <p>2.2 The General Assembly will decide upon ordinary membership with a simple majority.</p> <p>2.3 After 2025 Ordinary members are obliged to implement an educational curriculum which fulfills the 300 hours of training in Manual/Musculoskeletal Medicine criteria of the valid version of the FIMM Guidelines for Education and Safety.</p> <p>...</p>	<p>...</p> <p>2.1 Ordinary Members:</p> <p>2.1 Organisations of Manual or Manual/Musculoskeletal Medicine Physicians are entitled to become Ordinary members of the Federation.</p> <p>2.2 The General Assembly will decide upon Ordinary membership with a simple majority.</p> <p>2.3 After 2025, Ordinary Members are obliged to implement an Educational Curriculum of their own based on excerpts from the valid FIMM Guidelines for Training, Safety, Evidence and Quality. Such Curricula are free to include additional content and detail.</p> <p>...</p>
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Some goodies...

6. Risks of prolotherapy

Some societies of manual or musculoskeletal medicine promote prolotherapy. Prolotherapy is an injection-based medical therapy for chronic musculoskeletal pain¹²⁹. It has been used for many years, however, its modern applications can be traced to the 1950s when the prolotherapy injection protocols were formalized by George Hackett¹³⁰, a general surgeon in the U.S.A. While prolotherapy techniques and injected solutions vary by condition, clinical severity, and practitioner preferences, a core principle is that a relatively small volume of an irritant or sclerosing solution is injected at sites on painful ligament and tendon insertions, and in adjacent joint space over the course of several treatment sessions. While anecdotal clinical success guides the use of prolotherapy for many conditions, clinical trial literature supporting evidence-based decision-making for the use of prolotherapy exists for low back pain¹³¹, several tendinopathies¹³² and osteoarthritis¹³³.

The main risk of prolotherapy is pain and mild bleeding as a result of needle trauma. Patients frequently report pain, a sense of fullness and occasional numbness at the injection site at the time of injections. These side effects are typically self-limited. A post-injection pain flare during the first 72 hours after the injections is common clinically but its incidence has not been well documented. An ongoing study of prolotherapy for knee OA pain has noted that 10–20% of subjects experience such flares¹³⁴.

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Some goodies...

5. Risks of dry needling

Dry needling stands as an effective and relatively safe technique when administered by adequately trained clinicians to address myofascial trigger points. The majority of associated adverse effects are minor, typically manifesting as local pain and hematoma, with vasovagal reactions being rare. However, the primary serious complication remains pneumothorax.

A study conducted within the Israel Defense Forces offers valuable insights, covering over 47,000 dry needling treatments administered to the chest area by physiotherapists between 2011 and 2017. Remarkably, only two instances of pneumothorax resulting from dry needling treatment were documented, illustrating a minimal risk of 1 in 23,500 sessions (0.004%)¹²⁷. See also a study conducted by Padel et al. ¹²⁸.

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Some goodies...

6.1. Historical information

Physicians have used MM medicine techniques of diagnosis and therapy over thousands of years. The *Edwin-Smith-Papyrus* (3000 to 2500 B.C.E.) notes besides surgical diagnosis also some painful conditions of the neck, where the diagnostic manual procedure is quite similar to that used today. Physicians in India like the surgeon Susruta (1500 B.C.E.), believed to be the founder of *Ayurveda Medicine*, used manual techniques. Apart from *Ayurveda Medicine*, the roots of East Asian manual medicine can be traced back to *Huangdi's Internal Classic* (黃帝內經), a book written by Chinese medicine doctors in the Warring States Period (475 to appr. 221 B.C.E.). Although spinal manipulation in the West dates back to Hippocrates (460 to 375 B.C.E.) and the ancient Greek physicians²² as well as to Galen (130 to 200 C.E.), the evolution of MM medicine is difficult to follow in the Middle Ages. During this period however the philosopher and physician Abu Ibn Sinna from Buchara called Avicenna (980 to 1037 C.E.) published within his *Canonis Medicinae* manual techniques that were taught for some hundred years at all European universities. In East Asia, the first records containing the term Chuna (推拿) were such pediatric medicine classics of the Ming Dynasty (1368 to 1644 C.E.) as *Encyclopedia of pediatric Chuna, formulas, pulse and rescuing* (小兒推拿方脈活秘旨全書) and *Secret tips in pediatric Chuna* (小兒推拿秘訣). In 1599, the Spaniard Luis de Mercado (1525-1611) published instructions in his book *Institutiones para el aprovechamiento y examen de los Algebristas* on the proper use of manual treatments, especially for algebristas who were not doctors²³. The Spanish kings Philip II and Philip III also benefited from such treatments. In the middle of the 19th century the American physician Andrew Taylor Still (1828-1917)

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- SECTION I : General considerations
- SECTION II : Training programs
- SECTION III : Contraindications, complications
- SECTION IV : Safety
- SECTION V : Evidence
- SECTION VI : Quality
- SECTION VII : Glossary

HPB Members 2022 (approved 2020, adopted later)

(according to a decision of the FIMM General Assembly 2020)

Prof. Olavi Airaksinen, Finland Olavi.Airaksinen@kuh.fi

Dr. Henk Bultmann, The Netherlands hbultman@forcemed.info

Prof. Boyd Buser, DO FACOFP, USA bbuser@pc.edu

Dr. Nadine Fouques-Weiss, France DrFouquesW@aol.com

Dr Karen Goss, Denmark* goss_7@hotmail.com

Prof. Hermann Locher, Germany derlocher@gmx.de

Dr. M. Victoria Sotos Borràs, Spain victoria.sotos.borras@gmail.com

Dr. Bernard Terrier, Switzerland, (Chairman) b.terrier@bluewin.ch

Dr. Me-riong Kim, K.M.D, M.S., Republic of Korea thermrk@gmail.com

FIMM Executive Board

* replaces Prof. Berit Schiøtz-Christensen, Denmark

Advisors: Prof. Boyd Buser | Prof. Michael L. Kuchera

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This is not the end !

We need your genius and help.

Please report to your observations:

b.terrier@bluewin.ch

Get a word format.