Fédération Internationale de Médecine Manuelle
International Federation for Manual/Musculoskeletal Medicine
Internationale Gesellschaft für Manuelle Medizin
Международная Федерация Мануальной Медицины

The Secretary-General
Dr. Ron Palmer
AU-4514 Woodford QLD • 1025 Cove Road • Commissioner's Flat • AUSTRALIA
Phone: +61 7 5494 9873 • Fax: +61 7 5494 9573 • email: billabongdowns@bigpond.com

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Content

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Viewpoint on the definition of «Manual Medicine»[1]

Elaborated by the German Society for Manual Medicine (DGMM)

Decision of the Executive Committee of DGMM on March 4, 2006

Original text in German. Translations by www.translator-est.com.

Point de vue sur la définition de la «Médecine Manuelle»[1]

Élaboré par la Société Allemande de Médecine Manuelle (DGMM)

Décision du Comité de Direction de la DGMM du 4 mars 2006

Le texte original est en allemand. Traductions par www.translator-est.com.

Standpunkt zur Definition «Manuelle Medizin»[1]

Erarbeitet durch das Präsidium der Deutschen Gesellschaft für Manuelle Medizin (DGMM)

Präsidiumsbeschluss vom 4. März 2006

Originaltext auf Deutsch. Übersetzungen durch www.translator-est.com.

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[1] Der hier wiedergegebene Standpunkt zur Definition der «Manuellen Medizin» ist jener der Deutschen Gesellschaft für Manuelle Medizin (DGMM) und ist nicht jener der FIMM.

Manual Medicine (MM) is a medical discipline that performs the medical diagnosis of the locomotor system – including all structures in interaction with the locomotor organ in a neuro-reflectory and/or humeral way – as well as treats its dysfunctions manually with a preventive, curative and rehabilitative goal using basic theories, knowledges and procedures of all medical areas. Diagnosis and therapy are based on biomechanical and neuro-physiological principles. (according to the definition of the course book of the Bundesärztekammer (BAK) [German Federal Chamber of Physicians]).

Within the scope of a multi-modal therapy concept, MM includes the interdisciplinary application of its diagnostic and treatment techniques for the identification and treatment of dysfunctions of the locomotor system and the resulting medical conditions. It also adequately takes into account linkages between the locomotor system and vertebro-visceral, viscero-vertebral and viscero-cutaneous as well as psychosomatic influences.

It is indispensable for practicing MM to have approbation as physician.

MM requires theoretical knowledge and practical abilities that are conveyed in structured courses by qualified teachers.

MM integrates all techniques that can be carried out manually, which aim at a validated diagnosis as well as a proven effectiveness of the therapy.

One distinctive feature of MM lays in the fact that phenomena can be detected manually, which otherwise could not have been detected with other diagnostic methods.

The assessment of the diagnostic findings from the functional examination result in:

- independent local findings,
- findings as part of the continuation of the connective tissue of the human organism,
- findings affecting reflex operations or findings in their relevance in regulation and control chains.

This does not only concern the locomotor apparatus but the locomotor system as a whole including the entire organism.

The treatment techniques of MM describe themselves the procedures and/or the mechanisms of action.

Treatment techniques in MM intervene in known reflex mechanisms based on neurophysiological principals aiming at correcting dysfunctions of the locomotor system, eliminating vegetative malfunctions and activating system components with pain inhibition.

MM is characterized by interdisciplinary and multidisciplinary properties.

Besides its independent application – which in some cases is appropriate and sufficient – MM is applied more and more as integral part of multi-dimensional treatment strategies. Today, these strategies are imperative for the treatment of chronic pain patterns.

It is part of MM to advise and instruct the patient with regard to balancing its own way of living, performing suitable sportive activities, and the possibilities of prevention.

Manual therapy is the part of MM carried out by physiotherapists. (stated from the appendix of the agreement according to §125 SGB V [German Code of Social Law V] on the provision of physiotherapeutic services). Manual therapy is carried out by the physiotherapists with a specific training in manual therapy under direction and/or prescription of the physician and includes findings of the physiotherapist and treatment techniques. Physicians can also carry out this part.

La Médecine manuelle (MM) est la discipline médicale qui réalise à l'aide de l'ensemble des bases théoriques, des connaissances et des procédés de tous les domaines médicaux le diagnostic du système moteur - terme qui regroupe l'ensemble des structures en interaction neuroreflectoire et humorale avec le membre moteur - ainsi que le traitement manuel de ses défaillances fonctionnelles dans un but préventif, curatif et réhabilitant. Le diagnostic et la thérapie reposent sur des principes biomécaniques et neurophysiologiques. (selon la définition figurant dans le manuel de la Bundesärztekammer (BAK) [la Chambre fédérale allemande des médecins])

La MM comprend dans le cadre d'un concept de thérapie multimodale l'application interdisciplinaire de ses techniques de diagnostic et de thérapie destinées à la détection et au traitement de fonctions défaillantes du système moteur et des douleurs qui en découlent. Dans ce contexte, les défaillances fonctionnelles interconnectées au sein des systèmes moteur, vertebroviscéral, viscérovertébral et viscérocutané ainsi que les influences psychosomatiques sont souvent prises en compte de façon adaptée.

L'obtention d'une approbation en tant que médecin est indispensable à l'exercice de la MM. La MM exige des connaissances théoriques et des facultés physiques qui sont dispensées dans le cadre de formations structurées par des formateurs qualifiés.

La MM intègre toutes les techniques réalisables manuellement, qui ont pour but un diagnostic validé ainsi qu'une efficacité prouvée de la thérapie.

Une des particularités de la MM est le fait qu'il est possible de détecter manuellement des phénomènes qui restent inaccessibles aux autres procédés de diagnostic.

Le résultat de l'évaluation des diagnostics des analyses des fonctions est constitué par

- *des résultats locaux indépendants,*
- *des résultats en tant qu'éléments de la continuité des tissus conjonctifs de l'organisme humain,*
- *des résultats ayant des effets via des processus réflectoires ou grâce à leur importance au sein des enchaînements de régulation et de commande.*

Dans ce contexte, il ne s'agit pas de l'appareil moteur mais du système moteur / organisme global.

Les techniques de traitement de la MM décrivent le processus ou le mécanisme efficace. Les techniciens de la MM thérapeutique agissent sur des mécanismes réflectoires connus à bases neurophysiologiques dans le but d'éliminer les défaillances fonctionnelles du système moteur et les dysfonctionnements végétatifs ainsi que d'activer les éléments inhibiteurs de douleur du système.

La MM est interdisciplinaire et pluridisciplinaire grâce à sa nature.

La MM s'entend en dehors de son application seule - qui est utile et suffisante dans certains cas - de plus en plus souvent comme élément de stratégies thérapeutiques pluridimensionnelles. Celles-ci sont de nos jours indispensables dans le traitement des douleurs à tendance chronique.

Le conseil et l'instruction du patient concernant la régulation de son propre mode de vie, les activités sportives adaptées et les possibilités de prévention font aujourd'hui partie intégrante de la MM.

***La Thérapie manuelle** constitue la partie de la MM qui est effectuée par le physiothérapeute. (de l'annexe au contrat selon l'Art. 125 SGB V concernant la fourniture de prestations physiothérapeutiques.). La thérapie manuelle est réalisée à la demande ou selon l'ordonnance du médecin par un physiothérapeute disposant d'une formation spécifique en Thérapie manuelle. Elle comprend les techniques d'investigation du physiothérapeute et de traitement. Cette partie peut également être réalisée par un médecin.*

Die Manuelle Medizin (MM) ist die medizinische Disziplin, in der unter Nutzung der theoretischen Grundlagen, Kenntnisse und Verfahren aller medizinischer Gebiete die Befundaufnahme am Bewegungssystem - dazu gehören alle Strukturen, die in neuroreflektorisch-humoraler Wechselwirkung zum Bewegungsorgan stehen - sowie die Behandlung ihrer Funktionsstörungen mit der Hand unter präventiver, kurativer und rehabilitativer Zielsetzung erfolgt. Diagnostik und Therapie beruhen auf biomechanischen und neurophysiologischen Prinzipien. (nach der Definition aus dem Kursbuch der Bundesärztekammer [BAK]).

Die MM umfasst im Rahmen eines multimodalen Therapiekonzeptes die interdisziplinäre Anwendung ihrer diagnostischen und therapeutischen Techniken zur Erkennung und Behandlung gestörter Funktionen des Bewegungssystems und der davon ausgehenden Beschwerden. Dabei finden auch Verkettungen von Funktionsstörungen innerhalb des Bewegungssystems, vertebroviszeral, viszerovertebral und viszerokutan sowie psychosomatische Einflüsse ihre angemessene Berücksichtigung.

Unverzichtbar zur Ausübung der Manuellen Medizin ist das Vorliegen einer Approbation als Arzt.

Die MM erfordert theoretische Kenntnisse und praktische Fertigkeiten, die in strukturierten Kursen von hierfür qualifizierten Weiterbildern vermittelt werden.

Die MM integriert alle mit der Hand ausführbaren Techniken, die sowohl validierte Diagnostik sowie nachweisbare Wirksamkeit der Therapie zum Ziel haben.

Eine Besonderheit der MM liegt darin, dass Phänomene mit der Hand erfasst werden können, die anderen diagnostischen Verfahren verborgen bleiben.

Im Ergebnis der Wertung der Befunde aus der Funktionsuntersuchung ergeben sich:

- eigenständige lokale Befunde,
- Befunde als Teil in der Kontinuität der Bindegewebe des menschlichen Organismus,
- Befunde mit Auswirkung über reflektorische Vorgänge oder in ihrer Bedeutung in Regelungs- und Steuerungsketten.

Damit wird nicht Bewegungsapparat sondern Bewegungssystem/Gesamtorganismus gedacht.

Die manualmedizinischen Behandlungstechniken beschreiben das Vorgehen bzw. den Wirkungsmechanismus.

Manualmedizinisch-therapeutische Techniken greifen in bekannte, neurophysiologisch begründete, reflektorische Mechanismen ein mit dem Ziel, funktionelle Störungen des Bewegungssystems zu beheben, vegetative Fehlfunktionen zu beseitigen und schmerzinhibitorische Systemkomponenten zu aktivieren.

Die MM versteht sich neben ihrer alleinigen Anwendung - die in bestimmten Fällen zweckmäßig und ausreichend ist - zunehmend als Bestandteil von mehrdimensionalen therapeutischen Strategien. Diese sind heute bei der Behandlung von chronifizierenden Schmerzbildern unabdingbar.

Bestandteil der MM ist die Beratung und Anleitung des Patienten im Hinblick auf die Regulation der eigenen Lebensweise, auf geeignete sportliche Aktivität und auf die Möglichkeiten der Prävention.

Manuelle Therapie ist der von Physiotherapeuten durchgeführte Teil der Manuellen Medizin (aus Anlage zum Vertrag gemäß §125 SGB V über die Versorgung mit physiotherapeutischer Leistungen). Manuelle Therapie wird auf Anordnung bzw. Verordnung des Arztes von den Physiotherapeuten mit einer speziellen Weiterbildung in Manueller Therapie durchgeführt. Sie beinhaltet Befunderhebung und Behandlungstechniken. Dieser Teil kann auch von Ärzten ausgeführt werden.

Viewpoint on the definition of «Osteopathy»[2]

Elaborated by the German Society for Manual Medicine (DGMM)

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Point de vue sur la définition de la «Ostéopathie»[2]

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[2] The viewpoint on the definition of «Osteopathy» presented here is the one taken by the German Society for Manual Medicine (DGMM) and does not reflect the viewpoint of FIMM.

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One of the roots of Manual Medicine as introduced in the second half of the 20th century in Germany, is Osteopathy.

Osteopathy refers the teachings established by A. T. Still in the seventies of the 19th century in the USA based on the premise that different manipulation techniques can influence almost all vital functions of the body. Many of the so-called osteopathic techniques can be applied efficiently and are based on neuro-physiologically comprehensible models. In this way, they were partially included into Manual Medicine.

Other parts of Osteopathy are based on approaches that are – at least for now – not compatible with the subjects of modern scientific research.

The practitioners of Osteopathy are divided into non-uniform groups in the USA and Europe. These groups include:

- physicians in the European sense
- Doctors of Osteopathy (D.O., USA)
- non-medical osteopaths (e.g. in UK)
- alternative practitioners
- physiotherapists
- masseurs
- certified trainers and completely non-medical professional groups

Several differently qualified teaching institutions award the most divers certificates and diplomas.

In several European countries apart from Germany, so-called osteopaths practice medicine who can be compared to the German «Heilpraktiker» (alternative practitioner) with regard to their responsibility concerning diagnosis and therapy.

The German Society for Manual Medicine (DGMM) is strictly against the movement to introduce in Germany a non-medical job description of the osteopath with their own diagnosis and therapy responsibility. The application of treatment techniques based on Manual Medicine requires a medical diagnosis prepared according to all rules of medical art, from which alone the therapy is deduced. The non-medical osteopath is not able to master complications.

The German Code of Social Law (Sozialgesetzbuch) and the Swiss Law on Therapeutic Products (Heilmittelgesetz) regulate sufficiently the application of delegable manual-therapeutic services. Furthermore, the qualified professional groups are sufficiently defined as well.

Une des racines de la Médecine manuelle telle qu'elle s'est répandue en Allemagne durant la seconde moitié du 20ème siècle est l'ostéopathie.

Ce terme décrit la doctrine fondée par A.T. Still dans les années 70 du XIXe siècle aux États Unies, qui influence presque tous les processus vitaux du corps par différentes techniques de manipulations manuelles. Bon nombre des techniques dites d'ostéopathie sont appliquées avec succès et reposent sur des modèles de réflexion neurophysiologiques et compréhensibles. Ils ont donc en partie été implémentés dans la Médecine manuelle.

D'autres éléments de l'ostéopathie reposent sur des explications incompatibles - du moins jusqu'à présent - avec les contenus de la recherche scientifique moderne.

Les ostéopathes constituent des groupes peu cohérents aux États Unies et en Europe. Il s'agit entre autres:

- *de médecins dans le sens européen du terme,*
- *de Doctors of Osteopathy (D. 0., États Unies)*
- *d'ostéopathe non médecins (par exemple au Royaume-Uni)*
- *de guérisseurs*
- *de physiothérapeutes*
- *de masseurs*
- *de professeurs de sport diplômés et de groupes professionnels sans rapport avec la profession médicale.*

Différents instituts de formation à qualifications variables décernent des certificats et diplômes divers.

Dans certains pays européens en dehors de l'Allemagne pratiquent des dits ostéopathes comparables grâce à leurs responsabilités de diagnostic et de thérapie aux guérisseurs allemands.

La Société Allemande de Médecine Manuelle (DGMM) s'oppose fortement et formellement à la tendance à instituer en Allemagne un métier d'ostéopathe non médical disposant de responsabilités de diagnostic et de thérapies propres. L'application de techniques de traitement de médecine manuelle exige l'établissement d'un diagnostic selon toutes les règles de l'art médical sur lequel reposera la thérapie. L'ostéopathe non médical n'est pas en mesure de maîtriser les complications.

Le Code Social en Allemagne (Sozialgesetzbuch) et la loi sur les médicaments suisse (Heilmittelgesetz) règlent suffisamment l'application de prestations de Médecine manuelle délégables. Les groupes professionnels qualifiés à cet effet sont également suffisamment bien définis.

Eine der Wurzeln der Manuellen Medizin, wie sie in der zweiten Hälfte des 20. Jahrhunderts in Deutschland eingeführt wurde, ist die Osteopathie.

Man versteht darunter die von A. T. Still in den USA in den 70er Jahren des 19. Jahrhunderts begründete Lehre, die mit Handgrifftechniken verschiedenster Art auf fast alle Lebensvorgänge des Körpers Einfluss nimmt. Viele der so genannten osteopathischen Techniken sind wirksam anzuwenden und stehen auf neurophysiologisch nachvollziehbaren Denkmodellen. So sind sie zum Teil in die Manuelle Medizin eingeflossen.

Andere Teile der Osteopathie fußen auf Erklärungsansätzen, die - wenigstens bisher - mit den Inhalten moderner naturwissenschaftlicher Forschung nicht zur Deckung zu bringen sind.

Die Ausübenden der Osteopathie bilden in USA und Europa uneinheitliche Gruppen. Darunter finden sich:

- Ärzte im europäischen Sinne
- Doctors of Osteopathy (D. O., USA)
- nichtärztliche Osteopathen (z. B. Großbritannien)
- Heilpraktiker
- Physiotherapeuten
- Masseure
- Diplomsportlehrer und gänzlich nichtmedizinische Berufsgruppen,

Verschiedene unterschiedlich qualifizierte Lehrinstitutionen verleihen verschiedenste Zertifikate und Diplome.

In verschiedenen europäischen Ländern außerhalb Deutschlands praktizieren so genannte Osteopathen, die in ihrer Verantwortlichkeit bezüglich Diagnose und Therapie mit dem deutschen Heilpraktiker vergleichbar sind.

Den Strömungen, ein nichtärztliches Berufsbild des Osteopathen mit eigener Diagnose- und Therapieverantwortung in Deutschland einzuführen, steht die DGMM vehement entgegen. Die Anwendung manualmedizinischer Behandlungstechniken erfordert eine nach allen Regeln der ärztlichen Kunst erstellte medizinische Diagnose, aus der sich allein die Therapie ableitet. Der nichtärztliche Osteopath ist nicht in der Lage Komplikationen zu beherrschen.

Das Sozialgesetzbuch (Deutschland) und das Heilmittelgesetz (Schweiz) regulieren ausreichend die Anwendung delegierbarer manualtherapeutischer Leistungen. Auch die hierfür qualifizierten Berufsgruppen sind ausreichend definiert.

Basic research meets Manual Medicine

Results of the Conference of physicians for Manual Medicine of German mother tongue in Bad Horn (Switzerland), Lake of Constance, July 22 – 24, 2005

Presented by Dr. Wolfgang von Heymann[Ψ], Dr. Ulrich Böhni[Σ] and Dr. Hermann Locher[Ξ]

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On the initiative of H. Locher (MWE, Germany) and U. Böhni (SAMM, Switzerland) a conference has taken place in Bad Horn at the Lake of Constance from July 22 – 24, 2005, to which in addition to 20 active physicians for Manual Medicine of German mother tongue the subsequent individuals were invited as referees:

Prof. W. Magerl, Institute for physiology and pathophysiology, University of Mainz

Prof. S. Mense, Institute for anatomy and cell biology, University of Heidelberg

Prof. W. Neuhuber, Institute for anatomy, University of Erlangen

Prof. H. Radanov, Institute of psychiatry, University of Zurich

Prof. J. Sandkühler, Division of neurophysiology, Centre for brain research, University of Vienna

Prof. W. Zieglgänsberger, Max-Planck Institute of psychiatry, Division of clinical neuropharmacology, Munich

On the one hand, on the first day of the conference the physicians for Manual Medicine presented their current view on diagnosis and therapy in Manual Medicine. On the other hand, on the second day the basic researchers exhibited their updated state of the art. On the third day an intensive consensus discussion between both groups, which otherwise obviously do not practice enough mutual exchange, took place.

In the present contribution the results of this consensus discussion – against which there was no contradiction among those taking part – are exhibited. In addition some contributions of the researchers are published. In this issue it is the lecture by Neuhuber on the function of the longissimus muscle as a transmitter of information between occiput and pelvis. The contribution is to be seen in the context of this report.

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Neurophysiology and segmental dysfunction

In discussions on Manual Medicine there arises always the question about the definition of the term «blockage» or «segmental dysfunction», respectively about the meaning

[Ψ] Treasurer of the Dr. Karl-Sell-Seminar Isny-Neutrauchburg MWE
[Σ] President of the Swiss Medical Society for Manual Medicine SAMM
[Ξ] Director of the Dr. Karl-Sell-Seminar Isny-Neutrauchburg MWE

of the reversible functional disorder accessible to treatment.

The following is a very short description of the segmental dysfunction: «It is a contraction of the short, autochthonous, deep muscles caused by nociceptive and/or other afferents, which induce this segmental or metameric effect via alpha- and gamma motoneurons, whereby the efferents are fed by the nociafferents via the corresponding WDR neuron.»

The idea that has been maintained for decades, namely that a blockage designates an exclusively articular movement problem

with one joint segment fixed in one direction and the other one in the opposite direction[27], has proven to be a misconception. Rather it designates a complex nocireactive pathological reflex process, in which one or several segments including all participating structures and in particular the muscular system, are involved.

Hitherto it was not possible to directly derive and thus confirm the effects of the nociceptive afferents on the short, deep paravertebral muscles. Based on the presumption that a painful muscle is not hypertonic, but rather hypotonic[28, 29, 30], many phenomena of back pain were contradictory and unclear. In particular the phenomenon of the segmental point of irritation could not be explained. After intensive discussion, however, Mense confirmed that a muscle that does not itself function as nocigenerator would naturally react with a hypertonus to a pain stimulus occurring in conjunction with a segmental reflex process.

In a needle electromyography the nociceptive stimulus caused by the needle in the muscle examined is usually so strong that motion-induced changes in the deep autochthonous muscles could so far not be identified[35]. In order to support the above hypothesis, a possibility of derivation of muscle potentials from the autochthonous muscles has further to be searched for. To-date, however, there is no theoretical or practical argument against the opinion that via the mechanism of motoric system activation[21] on the segmental level, the deep autochthonous muscles proportional to the stimulus intensity fall into conditions of increasing tension. According to a unanimous opinion, this is the physical substrate of what is palpated as nocireactive hypertonus of the segmental point of irritation[42] in the deep paravertebral layer of the erector spinae muscle.

In addition to the abovementioned nociafferent other afferents to the WDR neuron can be involved in the induction of a motoric system activaton, i.e. a blockage, or also in an activation of the sympathetic system[3, 18, 33]. According to W. Zieglgänsberger the converging afferents including the nociafferents originate from one or also from neighbouring segments. As soon as the sum of the afferents of any kind exceeds the threshold, this leads to the described activation reaction of the WDR neuron via the axon collaterals. There is no doubt that non-nociceptive afferents, too, can cause the summation effect via the multifunctional fibre convergence of the WDR neuron so that the blockage becomes manifest[17]. This explains e.g. why patients with whiplash trauma of the cervical spine can react in quite different ways: besides more centrally located mechanisms, the pain radiation via the WDR neuron is influenced in different ways by other, non-nociceptive afferents, which explains why one patient recovers quickly, while another one suffers for a long time.

Not only the «blockage» as segmental reaction is a consequence of the overflow of the WDR neuron. Over the spinothalamic tract central reflections of the summation afferents are created as well. Since the central pain perception is exclusively based on the activation of the WDR neuron, due to the convergence function of the WDR a precise local differentiation of the afferents is not possible. Independent of the (noci-) afferent source, «pain» is localized by the thalamus or the cerebral cortex anywhere in the segment/metamere (respectively in the neigh-

bouring metameres). This can be called a «central perceptive illusion». To the category of central perceptive illusion pertain the pseudoradicular pain[7], the referred pain as described by Simons/Travell[43], the projection pain, and also the radiated pain. A scientifically relevant differentiation of these pain perceptions, which have been given different names by different groups, cannot currently be identified. With high probability we are dealing with the same phenomenon of central perceptive failure. In any case, this does not affect the statement that the segmental receptor afferent represents only one of several possible causes of an information pathway through the second neuron – the WDR neuron. Of course, other phenomena such as primary and secondary hyperalgesia equally induce central perceptive disorders with confusing pain projections in the beginning.

Also phenomena from the region of the upper cervical spine, which are otherwise difficult to understand, are to be seen in the context of the abovementioned reactions to a overflow of the WDR neuron. There is a marked trigeminospinal convergence in the region C1-C3 – probably the most distinct convergence investigated so far – with information spreading ipsilaterally and over the cervical central nucleus also contralaterally, encompassing in addition the vestibular, cochlear, occulomotor and hypoglossal nuclei[34]. Consequences of these convergences in the craniocervical transition are the hitherto controversially discussed perceptive disorders like vertigo, hearing disorders (tinnitus), dysphagia and phonatory disorders, cervical headache and interactions with craniomandibular dysfunction.

Whether only articular or other deep somatic afferents lead to the abovementioned pain reactions, or whether the neurosecretion of the substance P on the WDR neuron is induced by other processes in a different way, could not be clarified so far.

The structural basis of the segmental dysfunction is provided by the nociceptive afferents predominantly over the C fibres and A-delta fibres, the WDR neuron, the axon collaterals into the lateral and anterior horns of the spinal cord, and by the motoric efferents to the short deep autochthonous muscles with their endplates and muscle spindles.

Functionally the nociafferent generates a stimulation of the WDR neuron via substance P and glutamate, which is not only conducted in the central direction over the spinothalamic tract, but via the axon collaterals leads to a motoric and/or sympathic systemic activation, whereby also inhibitory interneurons appear. Due to the plurifunctional convergence of the WDR neuron, consequences in addition to the local muscular reaction are also central perceptive disorders with pain projections.

The neurophysiological reactions consist in the first place in the directed receptor pain, in the second place in alterations of the first or second neuron corresponding to a primary or secondary hyperalgesia, followed by further alterations in the sense of a conditioning of inhibitory systems which orientate by the inhibitory neurotransmitters GABA, serotonin, endorphins or endocannabinoids. Finally the total condition of the central nervous system for the downregulation predominantly from the periaqueductal grey and the raphe nuclei as well as over the serotoninergic descending paths directly to the WDR neuron is also considered.

The directed receptor pain

The reversible segmental dysfunction is in the first place caused by a receptor pain, which is announced to the WDR neuron via C- and A-delta fibres. At the same time glutamate and substance P are released, which stimulate the second neuron. On the one hand, the information is transmitted in central direction over the spinothalamic tract, and on the other hand to the motoric cells of the anterior horn via the axon collaterals. For pain defence, the alpha- and gamma motoneurons stimulate the agonistic muscles, in particular the extremity muscles from the supply area of the ventral branch of the

spinal nerves. The respective antagonists are inhibited by the RENSHAW interneuron. The agonists also include the short deep rotator muscles of the spinal column, the mono- or oligosegmental autochthonous muscles innervated from the dorsal branch of the spinal nerves. This is the basis of the segmental irritation point in the 3-step diagnosis. It is typical of the receptor pain to produce different reactions with regard to the perceived pain and the muscle tonus depending on the movement direction. Different positioning of the joint causes more or less pain – there is always at least one nearly pain-free or tone-free direction. Here the nomencla

tures of the different organisations of Manual Medicine in the German-speaking area describe either

- a restricted, painful direction, a sensitivity (MWE); or
- an increase in resistance or tension, tension phenomena (ÄMM); or
- an unilateral restriction, an evaluation of the «end feeling» (FAC, SAMM).

These terms obviously describe reactions to a functional test. This description of function is the right consequence of the turning away from the static model of blockage as a positioning change of the articular surfaces, and even more from the former model of articular dislocation or -luxation. On careful analysis there is a large semantic congruence of the three nomenclatures.

Positional diagnosis	**Fuctional diagnosis**
Examination • palpation of the proc. transversus of a vertebra • comparison of position in sagittal plane in flexion/extension	**Examination** • flexion/extension • lateral flexion and rotation • three-dimensional combination
Evaluation • change between symmetry or asymmetry • in flexion or extension: prominence of the proc. transversus	**Evaluation** • «Pathologic direction»/end feeling - *sensitivity* (MWE) - *resistance-/tension increase* (ÄMM) - *restricted direction* (FAC/SAMM) - *pain increase* (all) - *zone of irritation* (SAMM)
Segment evaluation «vertebra is in»: A) extension/left/lateral flexion/rotation ERS left B) Flexion/right/lateral flexion/rotation FRS left	**Type of segmental dysfunction** «Dysfunction in direction of»: A) flexion and lateral flexion right in direction of divergence zone of irritation = point of irritation left B) extension and lateral flexion left in direction of convergence zone of irritation left

Table 1: Comparison of diagnostic systems. Attempt of analysis of different terminologies for an identical phenomenon (Böhni). Pain in segmental dysfunction always appears in the initial phase of receptor pain as pain in motion and not as pain occurring in resting meta-position.

At first glance, the osteopathic terminology seems to be diametrically opposed. This, however, decides on the final position of the respective movement, which automatically results in opposed naming. Eventually, the same phenomenon is described, but rather from a static than from a functional point of view.

Primary hyperalgesia

In contrast to the receptor pain, primary hyperalgesia consists in an equal motion-evoked pain in all directions. Primary hyperalgesia can either be caused by a strong chronified reversible function disorder or by a structural damage. The latter can e.g. cause an articular hyperalgesia in connection with an arthrogenic inflammation.

The clinical picture of primary hyperalgesia is defined as a motion-evoked pain in all possible directions of articular mobility. As discussed before, it occurs in conjunction with a hyperalgesication or hyperactivation of the nocireceptors. In any case the rule «More than three restricted movement directions can no longer be regarded as directed movement pain» is true. An intensified nocireaction in all directions can of course have different causes: hyperalgesia or structural damages (e.g. spondylarthritis, tumour metastasis, spondylodiscitis, etc). If an articular nocireaction cannot be reduced in any direction, a primary hyperalgesia has to be considered – provided that there are no other symptoms corresponding to a secondary hyperalgesia or to a structural damage.

As a new meta-level the notion of primary hyperalgesia clinically designates a chronified dysfunction in the sense of a chronic afferent surplus from the first neuron as well as an activated structural disorder leading to a comparable accumulation of nociceptive afferents, as is demonstrated by the following practical example:

An acute dysfunction C3/4 on the right radiates in the shoulder region on palpation of the irritation point and on provocation in the restricted area: *projection pain*.

A facet «arthritis» C3/4 (primary hyperalgesia) leads to a radiation in the shoulder region already on light movement provocation in practically all directions, maybe even to a spontaneous rest pain in the cervical spine and the shoulder: *primary hyperalgesia in local inflammation; projection pain in the shoulder region.*

Even though conclusive scientific evidence is still missing, there is unanimous agreement nowadays that a pain on motion of a joint occurring in all directions has to be evaluated as a primary hyperalgesia caused by activity of the nocireceptors of the respective joint – considering the differential diagnosis of structural pathologies like primary inflammations, tumour metastases, osteoporosis fractures, etc. Therefore, if every movement of a joint hurts, a primary hyperalgesia on the articular level or caused by comparable deep somatic afferents has to be considered. The common final stage of various articular damages is represented by the change of the receptor (here: C fibre) in the sense of a primary hyperalgesia.

In this connection referral can be made to the various populations of articular receptors, which through a chronic stimulus can change from high- or low-threshold mechanoreceptors into permanent low-threshold nociceptors[3, 47].

A change has also occurred in the models for explanation of the spinal inhibition insofar as the «old» model of gate control has been replaced by the new model of synaptic long-term inhibition[19, 38]. Only this model on the changing direction of chloride transport between the synaptic gap and the nerve cell is able to explain the functional change of receptor populations observed in practice.

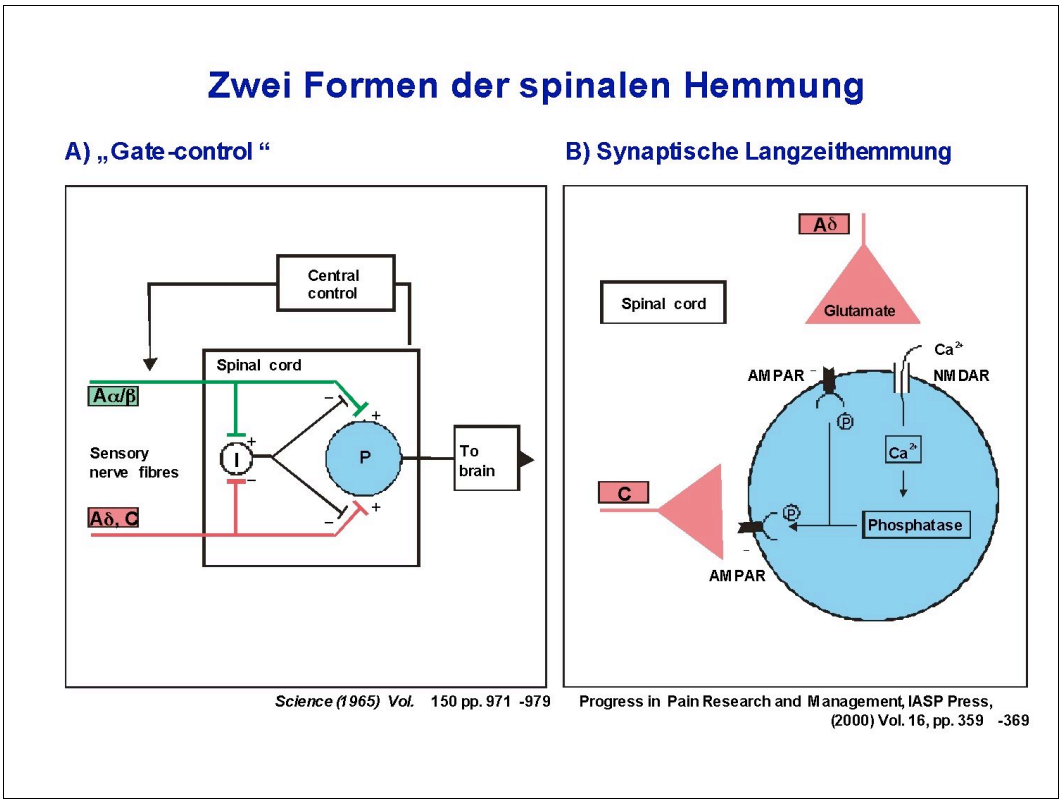

***Fig. 1**:* Comparison of the old model of gate control and the current model of synaptic long-term degression according to Sandkühler.
Two models of spinal inhibition: A) Gate control; B) Synaptic long-term inhibition.

J. Sandkühler[39, 14] has described the mechanism of this functional change of receptive nerve cells. In the extracellular space between the afferent fibre and the WDR neuron GABA opens neuron a potassium-chloride channel. Chloride flows inwards and the negative charge, i.e. the electro-chemical gradient decreases. This leads to a reduced irritability.

In order to maintain the chloride gradient, the chloride has to be pumped back by means of a potassium-chloride co-transporter-2 (KCC-2) serving as a «pump».

In case of a disorder caused by overstrain of the nervous fibre the outward transportation of the chloride is disturbed and thus causes an inversion of the gradient. GABA is further released, though, binds the GABA receptor and the chloride channel opens again. However, the gradient is inversed and the inhibitory transmitter breaks the inhibitory wall. The chloride ions flow from the inside to the outside and thus the negative charge of the cell increases, i.e. the cell becomes more irritable. This means that:

An inhibitory neurotransmitter is transformed into an irritating neurotransmitter.

Sandkühler concludes: In the presence of a reduced inhibition in the spinal cord, all barriers break down. All borders of somatotopy and modality are then abolished in order to enable the spread of irritation – a «worst case scenario» of pain perception.

This contribution on the chloride shift and the relative intra- and extracellular chloride concentrations provides the explanation for the completely unexpected behaviour of nerve cells and nerve cell associations, which according to different environment/milieu phases show entirely different reactions. Thus also phenomena of hyperalgesia can be explained, which on the basis of the mechanisms known so far could not be explained.

Prof. Zieglgänsberger confirms this phenomenon from his research and comments that according to his findings under given circumstances every cell of the body is able

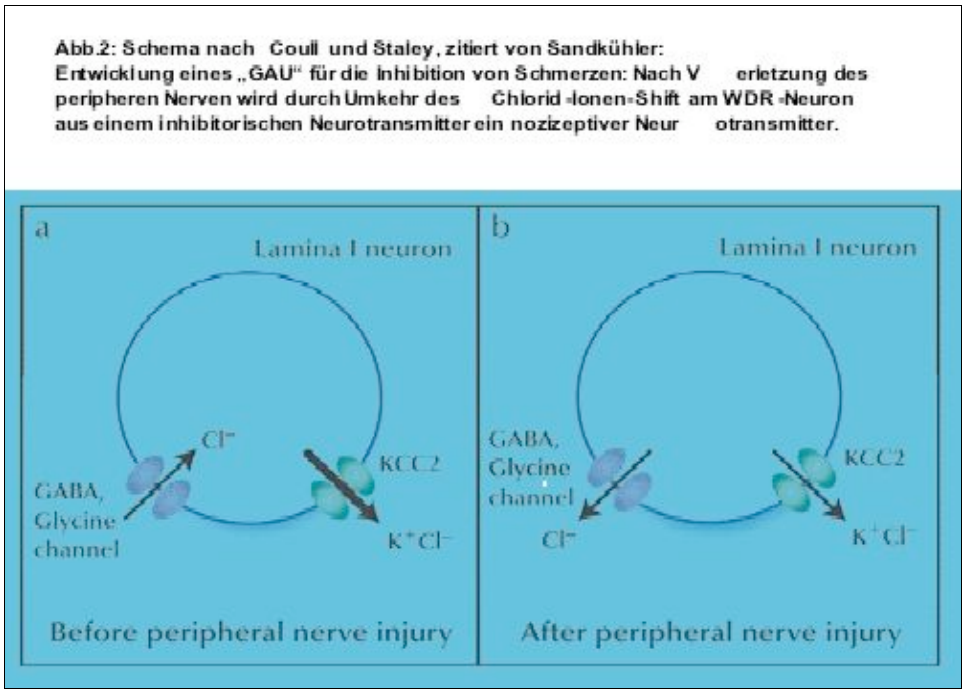

Fig. 2: Scheme of the Lamina I neuron before (a) and after (b) nerve injury (according to[9, 41]. Scheme according to Coull and Staley, quoted by Sandkühler: Development of a «worst case scenario»§ for pain inhibition: After peripheral nerve injury an inhibitory neurotransmitter is transformed into a nociceptive transmitter by inversion of the chloride-ion shift on the WDR neuron.

to produce and secrete the substance P. Thus dramatic changes in the behaviour of entire nerve cell populations can be explained.

Secondary hyperalgesia

The term nowadays designates a number of proceedings subsumed under the notion of chronification mechanisms, which considerably change the reaction behaviour of the WDR neuron. According to the current state of knowledge the central production of prostaglandin E-2 is essentially involved in this process. To describe the development of this chronic pain, the literature uses terms like «wind-up»[48], formation of «ephapses»[5], formation of «sensitive neuron ion channels»[8, 11] and «acid-sensitive ion channels»[22], stimulation of neurokinin-I receptors by the nerve growth factor NGF[46] as well as the abovementioned synthesis of prostaglandin E-2.

The clinical picture of these neurophysiological changes is represented as secondary hyperalgesia. Along with the neuropathic pains goes the allodynia, i.e. a tenderness to touch of the intact, non-inflamed skin. Further symptoms pertaining to secondary hyperalgesia are rest pain and of course all symptoms of primary hyperalgesia, in particular pain on motion in more than three directions.

Also typical is the absence of any kind of local tissue changes, signs of inflammation or other alterations at the topographical projection of pain by the patient – who would not know these «difficult» patients from daily practice?

As cause of secondary hyperalgesia it is nowadays assumed that the chronic induction of nociafferents and also of other afferents leads to a neuroplastic alteration of the 2nd

neuron, the WDR neuron[39, 40, 17]. The WDR neuron starts a permanent spontaneous activity in the sense of a nociafferent path over the spinothalamic tract and can continue this activity in the long run without any further peripheral input. Endocannabinoids are currently discussed as protection of the CNS against this massive stimulus inflow towards centrally[25,26].

The abovementioned terms are all elements of this permanent change of the 2nd neuron, and unfortunately these changes are hardly reversible. Once the stage of secondary hyperalgesia corresponding to a chronic neuropathic pain has been reached, there are only few ways to stop this development[14]. In nervous lesions it appears also necessary to prevent a continuous progression of the neuropathic pain. Rostrally (cranially) from a spinal lesion more and more neuroplastically deformed WDR neurons are generated, leading to the threat of a central chronic pain[48].

A certain effect can be obtained with the tricyclic antidepressant Amitriptylin, the membrane stabilizing anticonvulsant (and Na-channel blocker) Carbamezepin, and Gabapentin acting on neuronal calcium channels[4]. For hitherto unknown reasons opioids are not at all appropriate for the treatment of chronic neuropathic pains[36, 37].

In any case, though, there is no doubt that the pain patient has to be driven into activity, since inactivity favours the chronification.

For the diagnostic classification, however, the following is important:

- The radiated pain must not be confounded with a secondary hyperalgesia.
- A secondary hyperalgesia is not necessarily a radiated pain.

Even if the pain in the absence of obvious local causes often seems to be identical, the threshold position of the system is decisive for the understanding of both phenomena. Thus a permanent «overflow reaction» of the WDR neuron can either occur when the stimulus threshold of the WDR is considerably reduced and every inhibition is missing, i.e. in secondary neuroplastic hyperalgesia. Or the «overflow» can occur if in the normal WDR neuron the inflow of nociceptive or in addition of non-nociceptive afferents has exceeded the threshold, hence in the «simple» radiated pain.

Additional anatomical consideration

When analysing clinical symptoms and combining them to a diagnosis one should always bear in mind – regardless of the phenomena described so far – that in the region of the first neuron the differentiation between the region of the ventral branch and the dorsal branch of the spinal nerve has to be considered.

The most common example to illustrate this possible distinction of different reactions to a peripheral lesion is the spectrum of reactions to a decompression of the nervous structures in intervertebral disk surgery or the surgical treatment of a spinal stenosis.

Either the pains in the leg or the back pains or both or neither disappear after a technically «successful» surgery, which means that either the respective component of the spinal nerve or both or neither was under pressure (since the multipotent convergence concerns the dorsal as well as the ventral root).

Also when considering the generation of inhibitory afferents from the periphery and the motoric system activation in the periphery and on the extremity joints, the idea of the ventral and the dorsal branch should not be ignored.

Hypotheses on the efficiency of muscle-related therapy methods

Based on his own research results and on discussions with A. Mannion on the basis of the scientifically confirmed observations of the latter[23, 24], according to which an increase in rough strength does not correlate with pain

or reduced pain and that a decrease of pain does not correlate with a change of the muscle cross section and an increase in strength, Prof. Mense states that the mechanisms leading to pains within the muscles must be of different nature. He describes free nerve ends running across the muscular or fibre network in the muscular system. According to Mense the adequate stimulus for these nociceptors consists of shearing forces occurring within the muscle.

The muscles cannot be considered as «loose meat in a plastic bag» or as «salami-shaped structure» that is able to produce contractions by means of the anterior and posterior tendon, but rather as a highly complex three-dimensional system that is tightly embedded in the fascia. Hence it becomes evident that based on the above consideration with crosswise interwoven nociceptors already very minor differences of the contractile force or of the length of neighbouring fibre systems can lead to pain caused by shearing of the nociceptors. For the muscle spindle already a change of <100 µm[16] is sufficient. In this light well-known therapeutic methods such as the longitudinal stretching and in comparison the surprisingly even significantly more efficient transversal stretching of the muscles gain a new dimension in the understanding of their therapeutic efficiency. It is assumed that the actual therapeutic agent consists not in the effective change of the muscle length, but in the re-balancing of the various fibre systems in the muscles generated by the described methods

Also in favour of this viewpoint is the fact that various muscle-energy techniques can be explained to a lesser extent by the motoric interneuron formations and the agonist/antagonist effect, but that the majority of these techniques produce intramuscular synchronisations or balancings leading to a depression of the respective nociceptor fibres. These observations explain why in the so-called myofascial release techniques, which in a general sense mean transversal and longitudinal stretching of the muscles induced by pressure, the main therapeutic agent consists not in the release of the anatomically controversial contractile structures in the fascia, but rather in a harmonisation of the intramuscular contraction systems by means of rolling with the thumb ball (thenar). Also from own experience with manual handling of these techniques this seems much more plausible than speculations on the behaviour of fascial structures, which eventually cannot be verified according to ultrastructural and microfunctional criteria.

Seen from this angle, therapies like myofacial release technique, muscle energy techniques, longitudinal and transversal stretching, certain parts of counterstrain, certain forms of connective tissue massage and depending on the circumstances also some of the lymphatic drainage therapy methods can be classified according to their effect, at least insofar as the muscles themselves are concerned. The neurophysiological basis for the effect of all these techniques is the gamma system of the various types of spindle receptors. Muscle energy techniques (MET) can therefore not be distinguished from postisometric relaxation (PIR, NMT I), respectively from the two other neuromuscular techniques (NMT).

Abb. 3:
Endomysium als Verbindungsfäden der Myofibrillen
Aus: Myers TV: Anatomy Trains. Churchill -Livingstone 2001

Fig. 3: Endomysium as communicating fibres of the myofibrils. From: Myers TV: Anatomy Trains. Churchill-Livingstone 2001.

Neuromuscular techniques	
NMT I:	postisometric relaxation
NMT II:	reciprocal inhibition over isometric activation • of the antagonist: static tension • of the antagonist at end of movement
NMT III:	reciprocal inhibition over dynamic activation • of the antagonist: at end of movement minor forward movements into the locomotion (concentric) • slow backward movements (excentric)

Table 2

In any case it has to be considered that the inhibitory proprioceptive afferents are stimulated and that of course central nervous processes above C0/C1 are addressed, which have various complex effects. «Each manual therapy is an interaction with the brain, whereby the anticipation of the reaction by the empathy of the therapist is extremely important» (Zieglgänsberger). Basically each manual action performed on a patient in addition to segmental and local effects has a significant central nervous effect on the brain, where – as it is confirmed – all proprioceptive influences are also pain relieving and pain memory extinctive influences by means of serotonin, endorphins or endocannabinoids[1, 2, 26]. The amygdala plays an important part[2, 25]. The descending pathways run from the periaqueductal grey over the raphe nuclei to the posterior lateral funiculi of the spinal cord[31]. This is consciously formulated as higher hierarchical level as compared to the predominantly GABAergic inhibitory interneurons.

Apart from the above described effect of therapeutic techniques on the muscles there is unanimous consensus that also subliminal mechanical stimuli of a joint at a frequency around 1 Hz corresponding to the already confirmed effect of electric stimulation of 1 Hertz can lead to a long-term depression (LTD), i.e. a longer lasting inhibition of the wide-dynamic-range neuron, whereas high frequency stimulation clearly leads to a long-

term potentiation (LTP), i.e. a permanent stimulus intensification[14, 19, 38].

Zieglgänsberger reports that he was able to deduct inhibitory impulses from the interneuron scene in conjunction with other experiments on anesthetized cats[50] in small movements performed in flectional end position of the knee joints already 30 years ago.

As it became evident from a decade of experience, the repetitive (15-20 times), soft rhythmic elastic mobilisation in a frequency around 1 Hz in the painless relative end position results indeed in a positive therapeutic effect in addition to the mechanic effects on the articular surface, the muscles and the capsules.

«A blockage eventually designates an area, from which a lacking or uncoordinated inflow of afferents reaches the postcentral gyrus and only there can induce an uninhibited surplus of pain active systems which is finally due to a proprioceptive lack of afferents» is a maybe provoking, but nonetheless probably true hypothesis by Zieglgänsberger.

In conclusion manual therapy would consist of any kind of induction of proprioceptive afferents in the entire metamere. The last mentioned theses are so far predominantly confirmed by functional magnetic resonance tomography and are empirically well based on clinical experience with amputation pains, phantom pains etc.

Unfortunately the question how it is possible to efficiently stimulate GABAergic interneurons with manual methods and thus to ultimately explain the effects of various manual therapies remains unanswered. It is stated with certainty that so far there exist no results on in vivo experiments, which derive wide dynamic range neurons or inhibitory GABAergic interneurons in humans. However, our practical experience, according to which the stimulation of proprioceptive afferents activates GABAergic interneurons, is confirmed by animal experiments[51]: The friction in the neighbourhood of a pain stimulus activates the inhibitory interneurons. This phenomenon is also called «inhibitory receptive field».

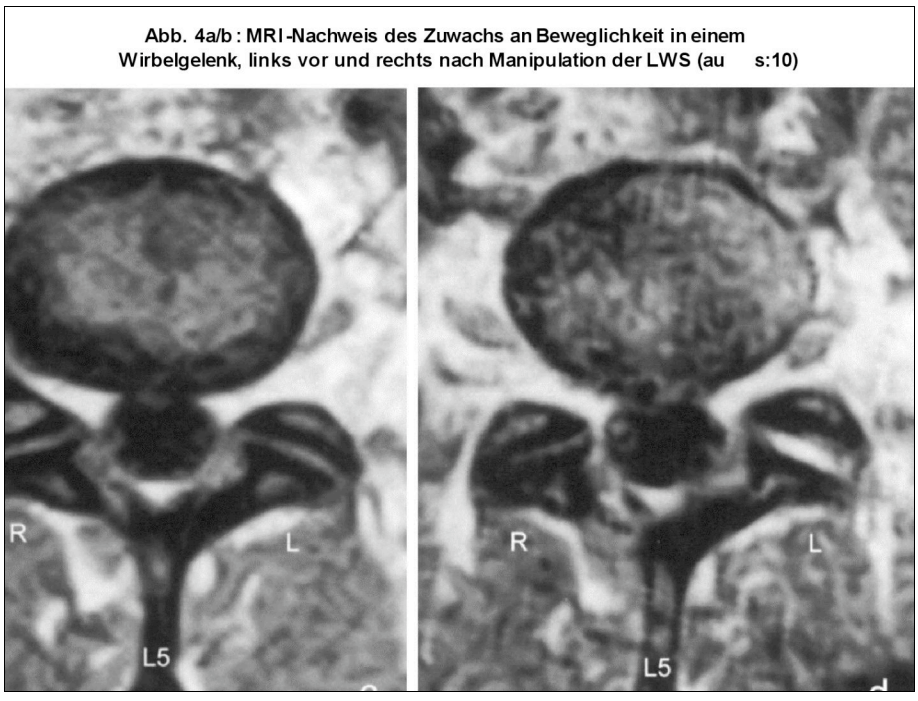

Fig. 4a/bc: MRI-based evidence of increased mobility of a vertebral joint, left prior and right following manipulation of the lumbar spine[10].

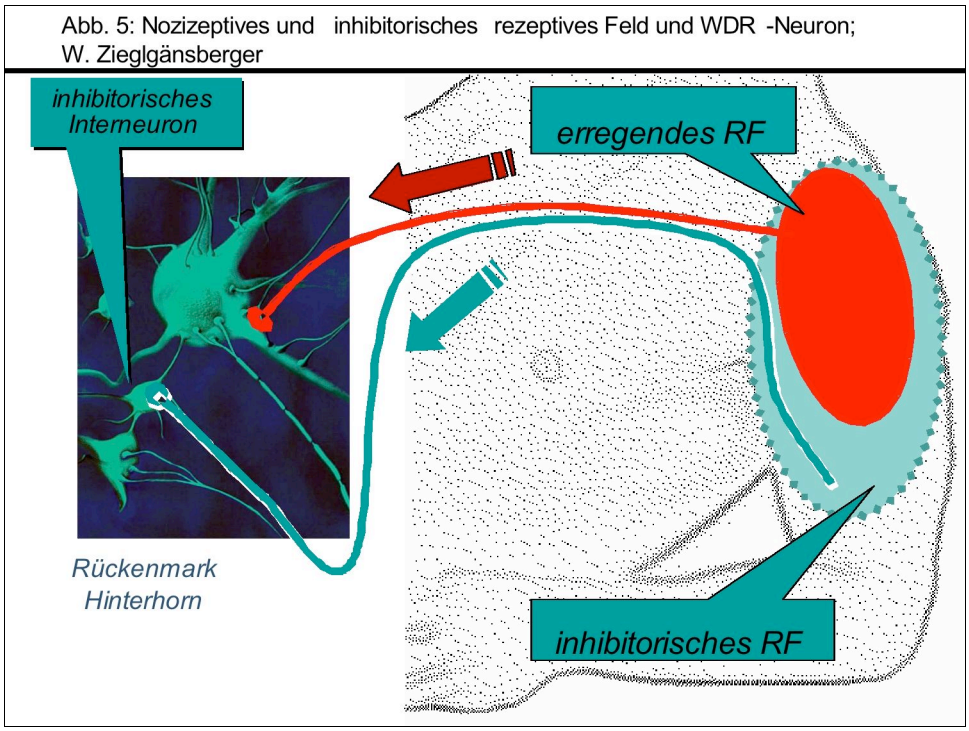

Fig. 5: Nociceptive and inhibitory receptive field and WDR neuron; W. Zieglgänsberger Inhibitory interneuron, excitatory receptive field (RF), posterior horn of spinal cord, inhibitory receptive field (RF).

Inhibitory receptive fields

In the stimulation of proprioceptive afferents in the neighbourhood of a painful body region, the pain reaction can be mitigated or annihilated by stimulation of inhibitory segmental interneurons. The totality of inhibitory potentials is called inhibitory receptive fields.

Inhibitory receptive fields are opposed to the nociceptive fields, which can change due to neuroplastic processes (see central and peripheral sensibilisations/hyperalgesia) with regard to their extension and connecting properties. Generally it can be assumed that secondary hyperalgesic processes lead to an extension of nociceptive receptive fields. The extension of nociceptive receptive fields takes mostly place on account of the extension of inhibitory receptive fields. This means that the development of hyperalgesia can also cause shrinkage of inhibitory potential and even an inversion. Neuroplastic processes can transform inhibitory effective activities into excitative respectively nociceptive receptive fields – inhibitory neurotransmitters transform into pain intensifiers!

From these postulates it can be concluded that in enlarged nociceptive fields the therapeutic strategy must envisage a reduction of these, which goes along with a regression of inhibitory potentials. The mitigation of a secondary hyperalgesia through the administration of centrally effective cyclooxygenase-II inhibitors can result in a dramatic reconstitution of inhibitory potential. Only by adequate pre-treatment with pharmacological COX-II inhibitors a patient can be made accessible to manual therapy methods.

The main argument for the extended indication for manual therapy techniques consists in the idea that chronification mechanisms on the WDR neuron (wind-up etc.) can be interrupted by repetitive proprioceptive inhibitory stimuli and that processes of chronification that have already taken place may regress according to circumstances. This knowledge also justifies the prescription of serial manual therapies of up to 10 administrations in intervals of 1, 2 or 3 days or also longer intervals according to necessity. As a quintessence it is nowadays undisputed that manual therapy methods (in conjunction with other therapies) can also be successfully

administered in chronic pain patients in order to achieve a regression of the chronified neuropathic pain.

In the end: the manipulation

The effect of manipulation (corresponding to osteopathic HVLA technique) is attributed to the fact that the very short and quick/fast impulse can generate special afferent characteristics and in particular frequencies with action potential[6, 13]. This results in a highly effective A-β inhibition of the WDR, which, however, according to Sandkühler and Zieglgänsberger barely exceed the duration of effect of the respective impulses on the WDR. Hypothetically it is required that due to the breakdown of the WDR tension also a reduction of the motoric system activation should take place, which would need some time until it is reconstituted. This would explain the permanent myotonolytic effect of professionally performed manipulations on joint structures, which, however, has not been confirmed by experts.

The current state of the art regarding the better efficacy of manipulative methods as compared to mobilizing and so-called osteopathic techniques without HVLA is amply documented in the literature[10, 12, 15, 20, 44, 46]. At this stage, however, the experts are unable to present a plausible or scientifically confirmed explanation for this observation.

Conclusion for the practice

From the conference between some basic researchers from the fields of anatomy, physiology, pain and neuron research and physicians for Manual Medicine familiar with the therapy of pain of the musculoskeletal system, several useful approaches for the better understanding of pain phenomena hitherto difficult to understand, have resulted. In the first place, it is important to differentiate by means of patient history and the clinical, imaging and if necessary electrophysiological diagnosis between the three following types of pain encountered by the physician for Manual Medicine:

- Directed receptor pain as expression of an acute, reversible dysfunction, with at least one pain free direction of mobility and segmental projection pain.
- Primary hyperalgesia as expression of either a chronified dysfunction or a structural lesion, with no pain free direction of mobility, but with projection pain, which can also be accompanied by a segmental dysfunction due to afferent overflow of the first neuron.
- Secondary hyperalgesia as expression of a neuroplastic transformation of the second neuron, presenting all symptoms of primary hyperalgesia and additional allodynia, with rest pain and absence of any local tissue changes at the topographical pain perception («central perceptive failure»).

The distinction between these three pain phenomena is of utmost importance for any kind of therapy planning. While in the presence of directed receptor pain with «simple blockage» adequate manual therapy methods like manipulation or mobilisation are sufficient, this may not be the case for primary hyperalgesia without the administration of peripherally effective drugs such as analgesics or non-steroidal antirheumatic agents. Eventually, when the effect of the latter is not sufficient in secondary hyperalgesia, centrally effective drugs such as tricyclic antidepressants or anticonvulsants with membrane stabilizing effect (Na-channel blockers) or with effect on the neuronal calcium channels are required, to a limited extent also opioids. However, the truly ideal pharmacotherapy for secondary hyperalgesia does not exist as yet.

Important for the physician of Manual Medicine in practice is the currently confirmed finding that a low frequent mechanic stimulation in the pain-free area ranging around 1 Hz has a considerable therapeutic effect on the chronic pain over a certain period of time (1 – 10 min) due to its long-lasting inhibitory effect (LTD), while a high frequent stimula-

tion has a guaranteed long-lasting pain intensifying effect (LTP). This explains the efficiency of the long-trained «soft rhythmic elastic repetitive» mobilisation and secures its importance for Manual Medicine.

Furthermore we have to take into account that in case of a breakdown of the nocifensive inhibitory systems of the body there is not much time left to prevent the occurrence of a chronification. Neuron researchers find unequivocal neuroplastic changes in vitro in particular of the WDR neuron already after 8 to 48 hours, which can cause serious therapeutic problems. Although from a pragmatic clinical viewpoint we speak of a chronification after 6 weeks only, neuroplastic changes can be detected much earlier.

Summary

Painful disorders of the human postural and locomotor apparatus frequently present considerable diagnostic and therapeutic problems.

When analysing clinical symptoms and all other diagnostic information from the point of view of a physician for Manual Medicine, it is important to differentiate between the three following neurophysiological phenomena:

- Directed receptor pain as expression of a reversible segmental dysfunction, also called «blockage».
- Primary hyperalgesia as neuronal change of the first neuron due to a chronified dysfunction or a local structural lesion.
- Secondary hyperalgesia expressing a neuroplastic change of the second neuron, with rest pain and absence of local lesions or tissue changes at the topographical projection of pain.

For the diagnosis it is helpful to know that muscles that are not themselves acting as nocigenerators can indeed contract indicating a segmental pathological reflex dysfunction, while muscles acting as nocigenerators cannot contract at all. Hence the phenomenon of the segmental point of irritation as expression of the reactive hypertonus of the segmentally organized deep autochthonous back muscles as perfect diagnostic tool of segmental dysfunction can be explained.

The development of the chronification of neuropathic pains starting with the discharge of glutamate and substance P over the expression of new ion channels and lowering of the stimulus threshold in the wide dynamic range (WDR) neuron up to the failure of inhibitory systems and the transformation of inhibitory neurotransmitters into pain intensifying neurotransmitters were discussed according to the current state of the art. The inhibitory effects of the neuroransmitters GABA, glycin, serotonin, endorphins and endocannabinoids on the one hand and the mechanic therapeutic possibilities for the improvement of these systems by Manual Medicine on the other hand were widely discussed. From this discussion it has to be pointed out in particular that a low frequent mechanic stimulation around 1 Hz over a certain period of time helps against neuroplastic pain in the sense of a long-term depression (LTD). This confirms the high importance of pain-free repetitive mobilisations «on the barrier» of Manual Medicine.

Regarding therapy it was confirmed that the effect of the majority of methods used in Manual Medicine is obtained in and by the muscles. It is there where the complex three-dimensional structure of the muscle, embedded in the fascia and the tendons, by means of free nerve ends and muscle spindles through change of the contraction force and – direction by shear generates pains which can be successfully treated by adequate methods like neuromuscular techniques as well as the majority of osteopathic techniques up to massage. Besides their local effect on the muscle, all these techniques give a strong proprioceptive afference to the brain and thus prevent the sprouting of the nociceptive neurons in the postcentral gyrus.

Although the better effect of manipulation compared to mobilisation in the treatment of segmental dysfunction is generally undisputed, there is so far no evidence of this observation provided by basic research.

Abstract

The problems dealing with diagnosis and therapy of painful disorders of the human locomotor system are well known and not yet solved at all.

In a conference of basic researchers and physicians for Manual Medicine in July 2005 there was an intensive exchange between both groups. In this and in the following issues of this journal some lectures and the results of the discussion are going to be presented.

Analysing clinical symptoms and all other diagnostic information we have to consider the following three neurophysiologic phenomena:

- Directed pain of receptor, indicating a reversible segmental dysfunction, also called blockage, with almost one pain free direction of mobility.
- Primary hyperalgesia, indicating neural changes of the first neuron by chronic segmental dysfunction or lesions of anatomic structures and no pain free mobility.
- Secondary hyperalgesia, indicating neuroplastic transformation of the second neuron, with rest pain and absence of local lesion or tissue changes at the topographical projection of pain.

In terms of modern diagnostic it is important to differentiate that muscles not acting as a generator of pain can very well contract indicating a pathological segmental dysfunction, while muscles acting as such a pain-generator cannot contract at all. This explains the phenomena of the segmental point of irritation. Therefore the irritation-point gives evidence about the reactive hypertonus of the deep, segmental organized (autochthonous) muscles of the spine. This is the perfect diagnostic information-system about any segmental dysfunction.

The development of chronic neuropathic/neuroplastic pain starting with the discharge of glutamate and substance P continuing with expression of ion channels and loss of inhibition in the wide dynamic range neuron of the dorsal horn of the spinal cord up to complete failure of inhibitory systems and transformation of neurotransmitters from inhibition to increased nociception was widely discussed. The inhibitory effects of the neurotransmitters GABA, glycin, serotonin, endorphin and endocannabinoids were presented. There was a broad discussion about mechanic possibilities for improvement of inhibitory systems especially by Manual Medicine. From this can be pointed out that mechanical stimulation without pain in low frequency around 1 Hz for a certain period leads to «long-term-depression» and helps against neuropathic pain. This confirms the importance of repetitive pain free mobilisation techniques in Manual Medicine.

Concerning the therapy it was confirmed that almost all techniques used today in Manual Medicine have their effects in and by the muscles. The pain is generated in the complex 3-dimensional structure of the muscle, which is imbedded in the fascia and the tendons and filled with free nerve ends and muscle spindles that react on force and direction of contraction by shear. This can be treated by manual techniques, such as the neuromuscular or osteopathic techniques up to forms of massage. Beside their local reaction all these manual techniques give a strong proprioceptive afference to the brain and therefore also avoid the sprouting of nociceptive neurons in the somatic-sensory cortex.

Better results of manipulation (HVLA) in comparison with mobilisation for the manual treatment of segmental dysfunction are widely known in empirical studies. Hitherto there cannot be given a basic researcher's explanation or approval for this observation.

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First FIMM Academy Conference

Reliability and Efficacy in Musculoskeletal Disorders

June 10, 2006 Leipzig (Germany)

2nd Announcement

This 1st FIMM Academy Conference is planned to deal with Reliability and Efficacy in Musculoskeletal Medicine, as these two aspects represent the essence of our speciality. Reliable tests are necessary to make reliable diagnoses – essential for teaching in the profession. Effective treatment modalities are of course essential when planning how to treat the patients and also how to educate the newcomers to the speciality. However, we do want to emphasize that it is our hope that the contributions to the Conference cover all aspects, such as:

1. protocols
2. preliminary results
3. final results of trials
4. implementation in teaching
5. teaching in reliability and efficacy
6. reviews,

and that we wish to have an open debate among the attendees. There will be oral presentations, of maximum 20 minutes each to include discussion, and posters if necessary.

For registration, hotel room reservation and call of papers go to www.fimm-online.com.

☐ I wish to present a paper

Title of paper to be presented:

_____
_____
_____
_____
_____
_____
_____

☐ Abstract will be forwarded to the conference secretariat

Guidelines:
Title (Arial 16 bold), Author(s) and Institution (Arial 14) and ordinary text (Arial 12), divided in Purpose, Material & Methods, Results, Discussion and Conclusion (Arial 12 bold). Line spacing 1½. Maximum 2000 characters.

Deadline for abstract 30.04.06

Organising committee:
Lars Remvig, DrMedSc,
lars.remvig@rh.hosp.dk,
Prof Dr, Lothar Beyer,
LoBeyer@t-online.de,
Jan Vacek, Prof Dr
vacek@fnkv.cz

Scientific committee:
Jacob Patijn, PhD
Jpat@sane.azm.nl,
Berit Schiøttz-Christensen, PhD
berit@inet.uni2.dk
Michael Yelland, PhD
myelland@bigpond.net.au

For information: www.leipzig.de

Transportation:
For cheapest possible transportation please contact:

FIS Travelservice
Blocherstrasse 2
CH-3653 Oberhofen
Switzerland
Tel: 0041.33.244 1444
Fax: 0041.33.244 1440
e-mail: ris@fisski.ch
Name: Mrs Caroline RIS

Venue:
Fortbildungszentrum ÄMM
Lessingstr. 1
04109 Leipzig
Germany

1st FIMM Academy Conference June 10, 2006

2nd Announcement & Preliminary programme

Reliability and Efficacy in Musculoskeletal Disorders

Leipzig Germany

FIMM 40 YEARS

Dear Colleague,

This 1st FIMM Academy Conference is planned to deal with Reliability and Efficacy in Musculoskeletal Medicine, as these two aspects represent the essence of our speciality.

We cordially invite you to participate in the Conference and to present a paper. We do want to emphasize that it is our hope that the contributions to the Conference cover all aspects, such as

- protocols
- preliminary results
- final results of trials
- implementation in teaching
- teaching in reliability and efficacy
- reviews,

and that we wish to have an open debate among the attendees.

There will be oral presentations, of maximum 15 minutes each to include discussion, and posters if necessary.

The programme is still open for contributions so don't hesitate to forward your abstract and to register for this exciting event.

We are looking forward to seeing you in Leipzig.

Jacob Patijn Lothar Beyer Lars Remvig

Preliminary programme

09.00-09.15	Opening of the 1st FIMM International Academy Conference. *Scientific Director, FIMM Int. Academy, Prof. PhD, J. Patijn.*
09.15-09.30	The Place of Science in the FIMM International Academy. *Chairman, FIMM Int. Academy, Dr. M. Hutson*
09.30-09.45	Reproducibility of Beighton's tests and of the Brighton Criteria for Benign Joint Hypermobility Syndrome. *B. Juul-Kristensen, H. Røgind, DV Jensen, L. Remvig.*
09.45-10.00	Hautant test for cervicogenic dizziness in normal subjects: a reproducibility study. *J. Patijn, I. Huijnen*
10.00-10.15	Foot dysfunction and EMG findings. *K. Lewit, M. Lepsikova*
10.15-10.45	**Coffee/Tea break**
10.45-11.00	Cervical motion pattern in normal subjects: preliminary results. *J. Patijn, I. Huijnen*
11.00-11.15	Free Active and Passive Cervical range of motion in 80 age matched normal subjects. Preliminary results. *J. Patijn, I. Huijnen, C. van Gronsveld.*
11.15-11.30	Lumbar preferential mobility in relation to lateralisation tests: quantitative measurements in 20 normal subjects. *S. Rutte*
11.30-11.45	The evaluation of the Sommerfeld Assessment System. *K. Niemier*
11.45-12.00	From "Black Box" to classification-based care; our paradigm shift. *R. Donelson*
12.00-14.00	**Lunch break**
14.00-14.15	The Treatment of Chronic Coccydynia with Intrarectal Manipulation: a Randomized Controlled Study. *J-Y. Maigne, G. Chatellier, M. Le Faou, M. Archambeau*
14.15-14.30	To be announced *Stefan Blomberg*
14.30-14.45	To be announced *Sergei Nikonov*
14.45-15.0	To be announced *M. Patterson*
15.00-15.15	Free
15.15-15.45	**Coffee/Tea break**
15.45-16.00	Free
16.00-16.15	Free
16.15-16.30	Free
16.30-16.45	Evaluation
16.45-17.00	Closing remarks *Scientific Director, FIMM Int. Academy, Prof. PhD, J. Patijn.*

Registration form
(or use www.FIMM-online.com)

1st FIMM Academy Conference

Name

Occupation

Address

Post-code

Phone

Fax

E-mail

Conference fee (coffee & lunch included)

☐ Academy member
50 Euro _____ Euro

☐ Non-Academy member
100 Euro _____ Euro

☐ Payment by bank transfer

Bank für Sozialwirtschaft
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Please remember to notice: FIMM Academy + your name.

For accommodation, please take contact to:

Galerie Hotel Leipziger Hof — 79 Euro single room/night
Hedwigstr. 1-3, 04315 Leipzig
Tel. 0341/6974-0
Fax 0341/6974-150
E-Mail info@leipziger-hof.de

Hotel Vivaldi — 65 Euro single room/night
Wittenberger Str. 87, 04129 Leipzig
Tel. 0341/9036-0
Fax 0341/9036-234
E-Mail info@hotel-vivaldi.de

Conference secretariat:
Fr. Gisela Harder
Frankfurter Allee 263
10317 Berlin
Tel.030/52279440
Fax 030/52279442
E-Mail FIMM-Akademie@aemm-aerzteseminar-berlin.de

15e Congrès international de la FIMM 2007

Zurich (Suisse)
Société médicale Suisse de Médecine Manuelle SAMM
Première annonce

15th Triennial International FIMM Congress 2007

Zurich (Switzerland)
Swiss medical Society for Manual Medicine
First announcement

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15. Internationaler FIMM Kongress 2007

Zürich (Schweiz)
Schweizerische Ärztegesellschaft für Manuelle Medizin SAMM
Erste Ankündigung

Neuromusculoskeletal Medicine: Facts and new evidencess.

For more information go to www.fimm-online.com.

The report of the Secretary-General

Presented to the General Assembly at London Gatwick, September 9, 2005

Dr. Ron Palmer

Dear colleagues

This year has seen a consolidation of activities within FIMM. Society representatives voted for the formation of the Academy at the last General Assembly in Bratislava and this year was the first annual meeting of the Academy in Prague. The development of the Academy has now commenced and it is expected to both increase in membership and importance in the scientific world of medicine in the future. Both Prof. Jacob Patijn and Dr. Michael Hutson have spent considerable time in this early stage to foster a solid basis on which the Academy will continue to exist. It is now the responsibility of the Academy Board to ensure that this occurs. Individual membership for the Academy is now open and appropriate information is on the FIMM web-site.

Indeed, the FIMM web-site has had some minor trouble due to legal wrangling over the use of the web page address. This is due to the change of the page operators from the UK to Switzerland. While this would appear quite silly to most of us, the web page has been forced to change address from “org” to “com” to satisfy all legal requirements. Our President, Bernard Terrier, has carried all of the detailed work involved with this web-site work out. The delay in this modification was a reason why there was a lapse in FIMM NEWS and FIMM Newsletter updates. We apologise for this inconvenience. It is now proposed that a communication segment of the Executive Committee will continue to carry out the web-site function, as well as publication of the FIMM NEWS and Newsletter electronically.

Again there has been some new possible expansion of the FIMM Society membership. Kazakhstan inquired about formally applying for membership of FIMM. They were invited to address this General Assembly, but unfortunately have not contacted the Executive Committee since. Also at this General Assembly, as an observer by invitation, is Dr. Sarveshwar Sood, from India. India has expressed interest in joining FIMM as a member society. We are now seeing an expansion of the influence of FIMM into both Asia and the sub-continent. This argues very well for the future of FIMM becoming a truly international organisation. There are still several large gaps on our global representation, namely South America and Africa and we hope to address this deficit in the future.

Worldwide representation for FIMM is important in gaining ‘Specialist’ recognition for Manual/Musculoskeletal Medicine. This is one political aspect that FIMM should be involved in and indirectly to this aim is the involvement of the FIMM Academy in establishing both scientific recognition and a standard of excellence for teaching a universal basis of Manual/Musculoskeletal Medicine. The pressure for specialist recognition is not directly from the medical fraternity, rather from Government involvement and acceptance of our field of medicine. By definition this implies that we must have some medico/political activity and your Executive Committee has considered this type of

involvement and later today you will hear further about this.

Together with our increasing world expansion, the financial burden on FIMM increases. There needs to be a democratic representation from all member Societies and this means extra expense to FIMM in bringing members from out lying regions to committee meetings. There is no possible exclusion of this expense, so by definition, as FIMM expands globally the financial burden will increase. This burden will be minimised as the Academy becomes more self-supporting. Your Executive Board has also looked extensively at cost cutting procedures. During the course of this General Assembly you will hear more about this.

Each year I make the same plea for member Societies to let me know of changes to their Executive offices and any change in contact addresses and e-mail. Keeping this system up to date is not easy as there are still many lapses by the members. We cannot run efficiently as an organisation if we do not have the ability to contact all membership.

I have received excellent help from my Deputy, Dr. Michel Dedée throughout the year and his possible future role in managing the communication portfolio within the Executive Board will add further to his workload. I thank him for his assistance.

I thank you for your attention and I am available at any time for FIMM business. Feel free to contact me any time during this meeting.

The report of the President 2005

Presented to the General Assembly at London Gatwick, September 9, 2005

Dr. Bernard Terrier

Dear colleagues

When the General Assembly adopted the resolution to establish the FIMM International Academy of Manual/Musculoskeletal Medicine last year in Bratislava, FIMM took the step into the second half of its transition time.

This time is marked by the development starting from the established structures having for Science in Manual/Musculoskeletal Medicine a place in the FIMM Scientific Committee and for Educational matters in the FIMM Education Committee and reaching hopefully structures in which Science in Manual/Musculoskeletal Medicine is given a home in the FIMM International Academy for Manual/Musculoskeletal Medicine and Educational matters the same as in FIMM. For many reasons medico-political issues have become eminent and the General Assembly 2004 ratified the proposal to establish structures that are compatible with these demands.

The process of migrating from FIMM Scientific Committee to FIMM International Academy of Manual/Musculoskeletal Medicine has been perfectly well demonstrated in an article by Prof. Jacob Patijn, which was published in FIMM NEWS Vol. 14 No. 1 of 2005. I am not going to repeat it here.

But I can say, this process has successfully come to an end. The FIMM Academy held its first annual meeting and Assembly in June of this year in Prague. It was from the beginning a successful meeting and Assembly and I would congratulate the FIMM Academy and those responsible for that.

Where do the other two edges of the triangle go? By triangle I mean Science – Education – Medico-political or Health Policies?

It is on its way. However, let me first again clarify some circumstances and facts:

In consequence of the establishment of the FIMM Academy FIMM will need to look at its own role. On the one hand FIMM will take a much more important role in Education and in Health Policy matters. On the other, for educational matters, the FIMM Education Committee will be largely responsible. A structure, yet to be defined, will need to take care of political matters such as recently raised by some of you. I mention as an example Germany and Estonia.

The benchmarks of ***the role of the FIMM Academy*** have been clarified:

- individual membership
- heading for skill and expertise
- dealing with matters of science as the core activity
- no political considerations
- taking a semi-autonomous status by representing the scientific arm of FIMM.

The future benchmarks of ***the role of FIMM*** could be clarified as well. In our opinion they are:

- collective membership (that means national societies or national schools)
- representation by political and educational positions
- dealing with educational and political matters as the core activity

In order to make a step forward and to be in the position to present this General Assembly with substantial propositions for the implementation of these requirements, the Executive Committee held two meetings this year, the last being a two-day meeting yesterday and the day before. These two meetings were successful as the Executive Committee is now in the position to propose solutions. They will be mentioned under agenda item no. 7. Agenda Item no. 7 is part of this report.

Separate sub-reports are prepared and they will be presented. When it comes to Health Policy matters one might wonder why the «European Card» is emphasised so much at this stage. Let me explain that to some extend:

Out of 29 FIMM Members 23 are European. Europe at the moment, as an unintended result of this composition, represents a certain zone of gravity when it comes to some questions and needs raised by some of you. By all means, the Federation is a body based on democratic principles. All members have the same rights. Still, that doesn't mean that sometimes some emphasis can be put on issues important to a majority of members, unless such an emphasis presents not a severe disadvantage to others.

Some European members of FIMM have clearly declared that FIMM (in their view) needs an initiative, which deals with such problems related to the European Union and its institutions in Strasbourg and Brussels. If FIMM does not do it some another European organisation will be established and do it.

You can discuss why European members should be privileged and why FIMM as a worldwide international body should take care of local (that means in this context European) requirements and problems. The answer could be that it is the task of FIMM as an international body to establish relationships worldwide between the different educational systems, one being the European, to the benefit of Manual/Musculoskeletal Medicine. That includes getting involved in regional or local health care systems in order to establish for instance the FIMM syllabus for Manual/Musculoskeletal Medicine at the level of the European Union. If there is none, how will Australia or North America (that means their Governmental and Educational structures) communicate with Europe on educational matters? What is meant is that giving support for instance to Estonia is not only a European affair but is ultimately to the benefit of Manual/Musculoskeletal Medicine worldwide.

Therefore, the FIMM Executive Committee has decided to respond to the invitation of the Estonian Society and to attend the Estonian Health Forum November 24, 2005 organised by The Ministry of Social Affairs in cooperation with the World Health Organisation[3].

To keep you better and faster informed the Executive Committee has accepted an initiative of the Secretary-General, and his Deputy. You will now receive regularly, besides the FIMM NEWS, the FIMM NEWSLETTER, which will be edited in English in a new format.

[3] FIMM finally did not attend this meeting because the Estonian authorities did not schedule Musculoskeletal Medicine although the Estonian Medical Society for Manual Medicine [Esti Manuaalse Meditsiini Selts (EMMS)] was trying very hard to get it on the schedule.

The minutes of the General Assembly 2005

September 9, 2005, 09.00-19.20 hours
Copthorne Hotel, London Gatwick, United Kingdom
Dr. Ron Palmer, Secretary-General

Members present

Executive Committee

President	Dr. B. TERRIER	Medizinisches Zentrum Kurplatz 1 CH-5400 BADEN SWITZERLAND	Phone +41 56 203 95 55 Fax +41 56 221 71 91 b.terrier@bluewin.ch
Vice President	Dr. M. HUTSON	The Park Row Clinic 2, Regent street NOTTINGHAM NG1 5BQ UNITED KINGDOM	Phone +44 1 94 98 17 86 mobile +44 77 68 51 53 72 mahutson@aol.com
Vice President	Prof. M. KUCHERA	4170, City Avenue, Suite 320 PHILADELPHIA, PA 19131 USA	Phone +1 215 871 6168 Fax +1 215 871 6361 michaelkuc@pcom.edu
Secretary-General	Dr. R. PALMER	1025 Cove Road Commissioner's Flat WOODFORD QLD 5414 AUSTRALIA	Phone +61 7 5494 9873 Fax +61 7 5494 9573 billabongdowns@bigpond.com
Deputy Secretary	Dr. M. DEDÉE	Their Saive, 49 B-4608 WARSAGE BELGIUM	Phone +324 376 64 38 Fax +324 376 65 28 michel.dedee@skynet.be
Treasurer	Dr. V. DVORAK	Postfach 53 CH-7005 CHUR SWITZERLAND	Phone +41 81 630 22 30 Fax +41 81 630 22 34 dvd@smile.ch
Assessor (confirmed by the GA 2005)	Dr. W. VON HEYMANN	Auf dem Peterswerder 28 D-28205 BREMEN GERMANY	Phone +49 421 49 00 90 Fax +49 421 49 87 159 heymann@cosit.de
EC Chairman	Dr. G. G. RASMUSSEN	Aalborg Hospital Rheumatology DK-9000 AALBORG DENMARK	Phone +45 99 32 17 69 Fax +45 98 16 69 95 glengorm@aas.nja.dk
Director **FIMM Academy**	Prof. J. PATIJN	University Hospital PO Box 5800 NL-6020 AZ MAASTRICHT NL	Phone +31 43 387 65 43 Fax +31 43 387 54 57 jpat@sane.azm.nl jacob.patijn@hccnet.nl

Representatives

Australia	Dr. R. PALMER	1025 Cove Road Commissioner's Flat WOODFORD QLD 5414 AUSTRALIA	Phone +61 7 5494 9873 Fax +61 7 5494 9573 billabongdowns@bigpond.com
Austria	Dr. R. KERN	Nummer 88 A-3383 HÜRM AUSTRIA	Phon +43 2754 82 00 Fax +43 2754 85 30
Belgium	Prof. J. DE NAYER	Cliniques Univ. St Luc Avenue Hippocarte, 10 B-1200 BRUXELLES BELGIUM	Phone +322 764 16 60 Fax +322 764 89 75 denayer@read.ucl.ac.be
Bulgaria	Prof. T. TODOROV	Boul. Zar Oswoboditel 70 BUL-9002 VARNA BULGARIA	Phone +359 52 24 39 13 Fax +359 52 30 24 13 todoroff@doctor.com
Canada	Dr. C. APPLEYARD	552 Raglan St S Renfrew, ONTARIO K7V1R8 CANADA	Phone +1 613 432 7075 Fax +1 613 432 9 huckle@renfrew.net
Czech Republic	prim. MUDr. V. TOSNEROVÁ	Rehabilitacni Klinika Nezvalova 956 CZ-500 05 HRADEC KRALOVA 5 CZECH REPUBLIC	Phone +42 049 583 72 80 Fax +42 049 583 72 79 tosnerova@fnhk.cz
Denmark	Dr. A. GRAVESEN	Laegernes Hus Norbangen 3 DK-4220 KORSOER DENMARK	Phone +45 4090 0163 Fax +45 5836 0019 allan.gravesen@dadlnet.dk
	Dr. N. JENSEN	Maaloev Hovedgade 69 DK-2760 MAALOEV DENMARK	Phone +45 44 65 54 43 Fax +45 44 65 54 05 niels.jensen@dadlnet.dk
Finland	Prof. Dr. O. AIRAKSINEN	Kuopion Yliopistollinen Sairaala PL 1777 SF-70210 KUOPIO FINLAND	Phone +358 17 17 34 50 Fax +358 17 17 34 66 olavi.airaksinen@kuh.fi
	Dr. K.A. LINDGREN	Invalidisäätiö PL 29 Tenholantie 10 SF-00281 HELSINKI FINLAND	Phone +358 94 748 23 66 karl-august.lindgren@ invalidisaatio.fi
France	Dr. M. J. TEYSSANDIER	Av. Joseph Giordan 56 F-06200 NICE FRANCE	Phone +33 493 21 10 43 Fax +33 493 21 65 47 mjteyssandier@voila.fr

Germany	Dr. W. VON HEYMANN	Auf dem Peterswerder 28 D-28205 BREMEN GERMANY	Phone +49 421 49 00 90 Fax +49 421 49 87 159 heymann@cosit.de
Japan	Dr. K. SUMITA	3-9-7 Minami-ikebukuro Toshima-ku 171-0022 TOKYO JAPAN	Phone +81 48 881 7433 Fax +81 48 881 5330 k-sumita@spn1.speednet.ne.jp m_mochi@lapis.plala.or.jp
New Zealand	Dr. J. WATT	Musculoskeletal & Spine Centre 256 Papanui Rd. CHRISTCHURCH NEW ZEALAND	Phones 64 3 355 0342 64 3 310 0512 Fax 64 3 310 0516 jon.r@xtra.co.nz
Russian Federation	Prof. A. B. SITEL	Vernadsky prosp., 121 RU-117571 MOSCOW RUSSIAN FEDERATION	Phones +7 434 56 94 +7 434 84 01 Fax +7 433 64 66 sitel@cmt-moscow.com
	Prof. S. NIKONOV	Vernadsky prosp., 121 RU-117571 MOSCOW RUSSIAN FEDERATION	Phone +7 434 56 94 Mobile +7 903 593 44 96 Fax +7 433 64 66 snn00@list.ru
Slovak Republic	MUDr. S. BODNAR	Hrnciarska 20 SK-040 01 KOSICE SLOVAK REPUBLIC	bodnaro@isternet.sk
Spain	Dr. Dr. V. SOTOS BORRAS	Apto de correos 31 E-03201 ELCHE Alicante SPAIN	Phone +34 670 06 27 16 Fax +34 966 92 27 06 vsotos@hsanjaime.com
Switzerland	Dr. M.-H. GAUCHAT	Rue Pré Fleuri 9 CH-1950 SION SWITZERLAND	Phone +41 27 322 30 78 Fax +41 27 322 30 82 marc-henri.gauchat@netplus.ch
United Kingdom	Dr. R. MACDONALD	23 British Grove, Chiswick LONDON W4 2 NL UNITED KINGDOM	orthmed@doctors.org.uk
	Dr. U. JANNOUN	1 New England Cottages BALCOMBE W. Sussex UNITED KINGDOM	Phone +44 1444 400 449 orthmed@doctors.org.uk
USA	Prof. M. L. KUCHERA	4170 City Avenue Suite 320 PHILADELPHIA, PA 19131 USA	Phone +1 660 662 25 37 Fax +1 660 626 20 80 michaelkuc@pcom.edu

Apologies

Estonia	e-mail	03.08.2005
Italy	e-mail	26.08.2005
Latvia	e-mail	07.02.2005
Lithuania	e-mail	05.09.2005
Poland	e-mail	19.08.2005
Portugal	e-mail	01.09.2005

Absent

Greece
Hungary
Luxemburg
Netherlands
South Korea

Honorary members present

Dr. L. Burn
Prof. K. Lewit
Dr. J. Paterson

The minutes of the General Assembly

*

The meeting was held under the chairmanship of Dr. B. TERRIER.

*

Agenda

1. Opening by the President
2. Presentation of the British Institute of Musculoskeletal Medicine BIMM
3. Presentation of the representatives of the national societies (limited to 4 minutes per presentation)
4. Matters arising from the minutes of the last General Assembly (Bratislava – Slovak Republic)
5. Report from the President
6. Report from the Secretary General
7. Matters concerning FIMM structure and strategy
8. Report from the FIMM International Academy of Manual/Musculoskeletal Medicine
9. Report from the Chairman of the Education Committee
10. Report from the Chairman of the Policy Committee: FIMM Policy 2010.
11. Report from the Treasurer
12. Report from the Auditors
13. Budget 2006
14. Election of Auditors
15. Elections of officers and members

15a Intermediate elections of Members of the Executive Committee

15b Reappointment of the Chairman of the *FIMM* Academy

15c Elections of Honorary Members

16. Admission of new members
17. Exclusion of members
18. Information on the next International FIMM Congress 2007
19. Date and place for the General Assembly 2006
20. Any other Business
21. Closing of the General Assembly by the President

*

1. Opening by the President, Dr. B. TERRIER

The President thanked the BIMM for organizing the current meeting and also thanked the Slovak Society for holding the last General Assembly and Congress in Bratislava in 2004. He also thanks Prof K. LEWIT, who attends this General Assembly, for his pre-diner presentation this evening. He reminds the delegates that this General Assembly is the 40th FIMM General Assembly.

He mentions several small changes to the printed agenda of the meeting by inclusion of some additional topics. The assembly accepts these.

He chooses the counters of votes: Dr A. GRAVESEN (Denmark) and Prof. K. SUMITA (Japan).

2. Presentation of the British Institute of Musculoskeletal Medicine BIMM

By Dr. R. MACDONALD, President BIMM. (Summarised)

The British Institute of Musculoskeletal Medicine (BIMM) was formed in 1992 by the amalgamation of The In stitute of Orthopaedic Medicine (IOM) with the British Association of Ma-

nipulative Medicine (BAMM). BAMM had been a founding member of FIMM.

To provide a standard of proficiency a Diploma of Musculoskeletal Medicine examination was established in1993. BIMM now has over 300 members. An official 300-hour course has been in place since 2001.

72 members of BIMM have full osteopathic training in addition to their medical qualifications.

He stated that for FIMM to be an effective international body the national societies must try to work together on communication and understanding. International involvement will not solve national schisms.

BIMM welcomed the formation of the Academy. He proposed that FIMM makes an effort to organise web-based videoconferencing for most of its meetings.

3. Presentation of the representatives of the national societies (limited to 4 minutes per presentation)

See the list of participants above. Some general questions were voiced.

4. Matters arising from the minutes of the last General Assembly (Bratislava – Slovak Republic)

The President thanks the Secretary-General for preparing these minutes.
No remarks: the minutes are accepted unanimously.

5. Report from the President, Dr. B. TERRIER

See FIMM NEWS Vol. 15, No. 1.

No remarks.

The Secretary General gives some additional information on the FIMM NEWSLETTER which will be published at least twice a year with information from FIMM to the national members but also include input from the members to FIMM.

No comment from the assembly.

6. Report from the Secretary-General, Dr. R. PALMER

See FIMM NEWS Vol. 15, No. 1.

Some comments.

The report is accepted unanimously.

7. Matters concerning FIMM structure and strategy

The President presents the result of the work of the Executive Committee meeting on the new structures and strategy in the future. If accepted by the assembly, these new structures should need a change of the statutes but the decision about this should be taken at the next General Assembly in 2006. The reason of these propositions is mainly the high costs of the current Executive committee.

He first presents the current structure of the executive committee with 9 voices and 7 votes and compares with the proposed new structure and an Executive Board of 7 voices and 7 votes – version 7/7 – elected by the General Assembly. Attached to this Executive Board (EB), two other boards called «Education Board» (EduB) and «Health Policy Board» (HPB); the members of these last boards would be not elected but ratified by the General Assembly. Two other versions of the Executive Board are also presented with 8 members – version 8/7 or 8/8 – or 9 members – version 9/8 –. These versions are certainly more expensive than the version 7/7. (See the pictures). The version 8/8 looks more democratic.

Following a question, the President confirms that the term of board remains still of four years.

The President reminds that the change of the statutes, if necessary, needs two-third of the votes.

Discussion follows on these different propositions.

Procedures of votes: Two resolutions: (1) shall we start now with new structures and (2) what version shall we

develop in the future.

1) Do we agree to vote on these resolutions: pro: 16, against: 0, abs: 0.

2) Do we agree to start with to work on these new structures and plan to change the statutes: pro: 14, against 0, abs: 0.

3) Version 9/8 against 8/8: pro: 1, against: 15, abs: 0.

4) Version 8/8 against 8/7: pro: 8, against: 7, abs: 0.

5) Version 8/8 against 7/7: pro: 7 against: 11, abs: 0.

Version 7/7 wins.

Strategy plan for Education: See FIMM NEWS Vol. 15, No. 1. Dr. G. G. RASMUSSEN: Power point presentation. Some comments.

Strategy plan for FIMM Global Health Policy: See FIMM NEWS Vol. 15, No. 1. Prof. M. KUCHERA: Power point presentation. Discussion.

The assembly passes the agenda item 7 unanimously.

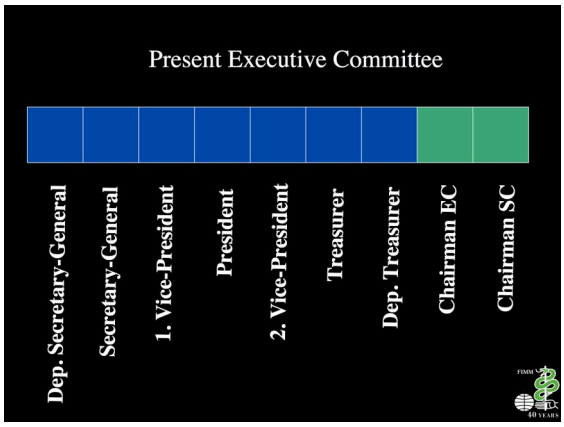

Fig. 6: Present solution.

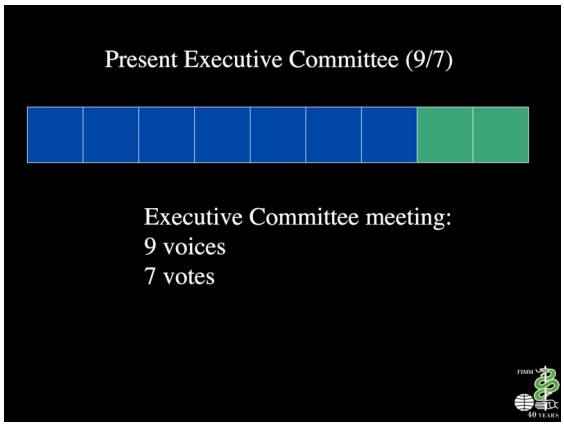

Fig. 7: 9 voices, 7 votes.

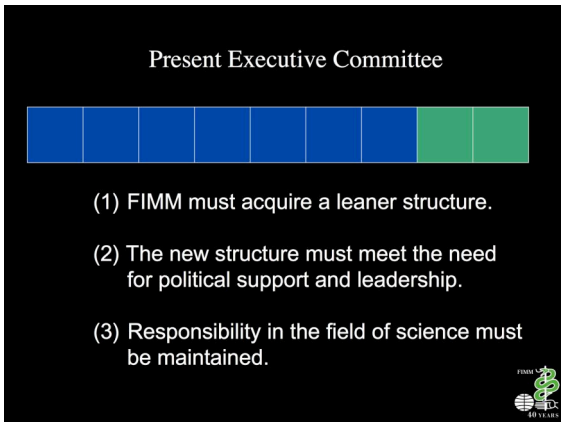

Fig. 8: Preconditions.

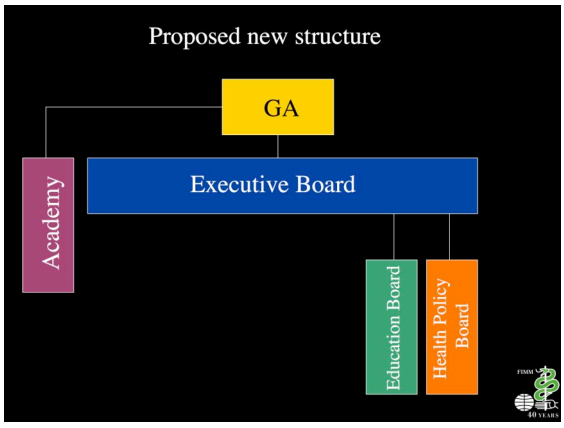

Fig. 9: Proposed new structure.

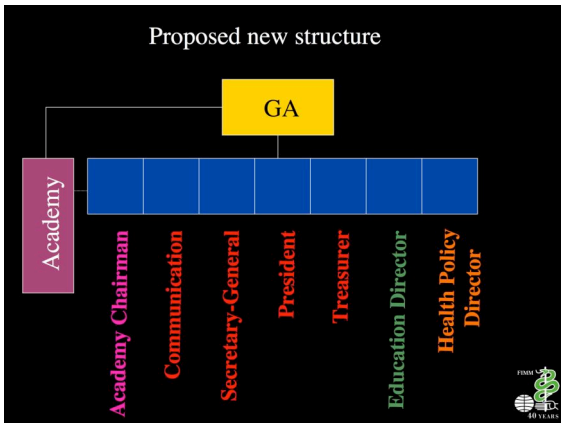

Fig. 10: Office bearers.

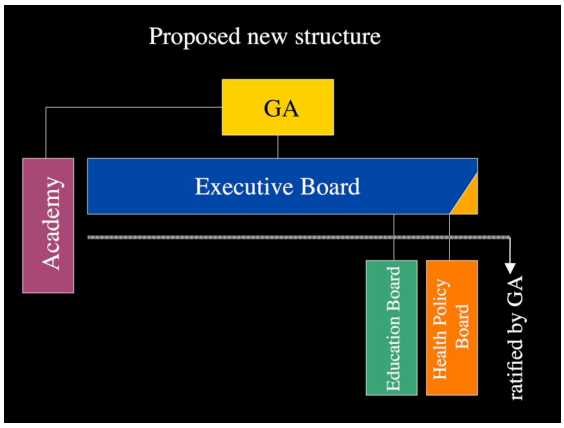

Fig. 13: The Education Board and the Health Policy Board are appointed by their Directors and confirmed by the General Assembly.

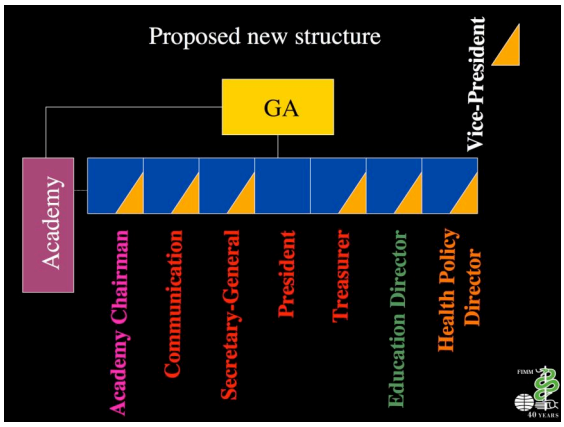

Fig. 11: The Vice President is appointed among the office bearers.

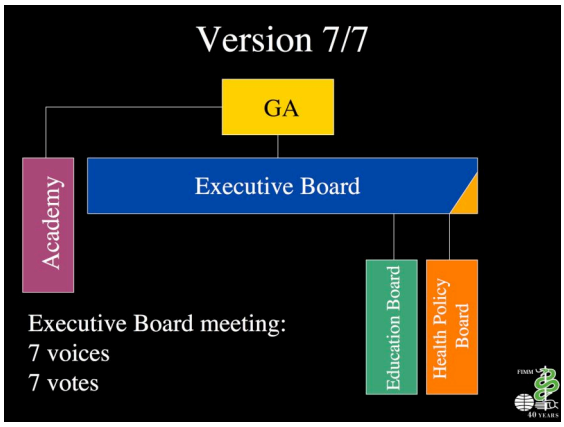

Fig. 14: Version 7/7; 7 voices, 7 votes.

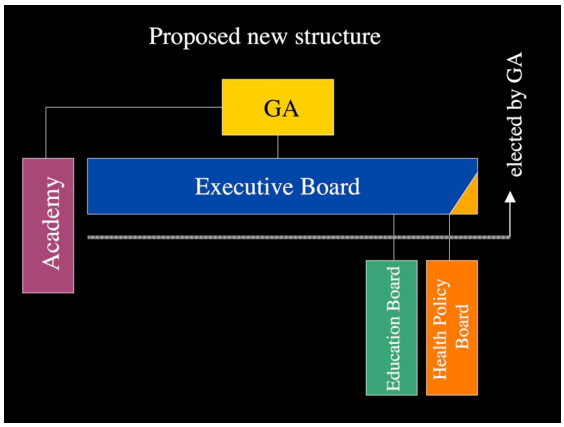

Fig. 12: The Executive Board is elected by the General Assembly.

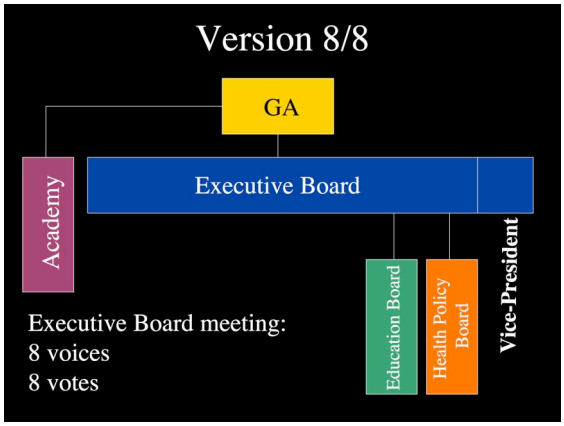

Fig. 15: Version 8/8; 8 voices, 8 votes.

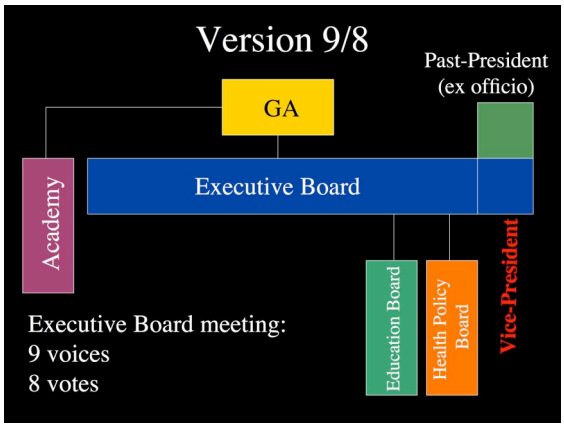

Fig. 16: Version 9/8: 9 voices, 8 votes.

8. Report from the FIMM International Academy of Manual/ Musculoskeletal Medicine

Two reports presented. The first by Dr. M. HUTSON and the second by Prof. J. PATIJN.

1. Academy outline, its role and its organisation. The Academy had its first annual general meeting in Prague in June 2005. The first academy conference will take place in Leipzig on June 10, 2006. Currently, the Academy counts more than 50 members.

2. Shift from Scientific advisory committee to Academy. The story and the advantages. The content does not change, but the format and the membership. Explanation on the current structure and the future directions.

The funding and financial review of the Academy by Dr. V. DVORAK. The finances are under control. The costs were lower than the expected budget.

No remarks.

9. Report from the Chairman of the Education Committee, Dr. G. G. RASMUSSEN

The Education Committee revised the FIMM Core Curriculum for Manual Medicine on its last meeting on Mach 2-3, 2005 in St. Goar, Germany. See FIMM NEWS Vol. 14, No. 3.

The report summarizes the structure, the way of working and the results of this committee, its relation with Academy and of course the future. It is proposed that the EC be reorganized with 9 members representing different schools of M/MM. The EC chairman asks to have the higher number possible of members in the Academy, representing the different schools.

The President asks a vote on the core curriculum.

Version 2.2 is unanimously ratified.

One remark: this curriculum must be broadened. 2d vote on the report: accepted.

10. Report from the Chairman of the Policy Committee: FIMM Policy 2010.

Just on time before the General Assembly 2005 the Policy Paper has reached its final version no. 2.8 d/e/f.

As it is usual in a trilingual paper, compromises were inevitable. It is not possible that everyone shall be satisfied with all of the details of the paper. The Policy Paper has been discussed first by the Executive Committee on the occasion of its two-day meeting in September 7-8, 2005.

See FIMM NEWS Vol. 14, No. 3.

This will be published and sent to the national societies in one of the 3 languages.

This form is accepted by the General Assembly.

11. Report from the Treasurer Dr. V. DVORAK

For different reasons we have an extraordinary and unique expenditure in 2004 with a loss of 40,391.38 CHF. The first reason: only 17 nations paid their fees on time. The 2nd: the number of activities increases the expenditures. The 3rd: we have had a lot of extraordinary and unique expenditures following the Assemblies in Montreux (2003) and Bratislava

(2004). All the last Congresses have lost money. It is a cumulating situation with a bad occasional result.

There are some proposals to improve the results, for example, the suppression of the FIMM diner after the General Assembly.

Some comments on this report.

Vote on:

Figures of report, without the measures needed: pro: 16, against: 0, abs. 0.

12. Report from the Auditors

No remarks from the two Auditors.

The General Assembly accepts the measures taken for the future with: pro 16, against 0, abs: 0.

The assembly also accepts the report of the treasurer with: pro: 16, against: 0, abs: 0.

13. Budget 2006

The Treasurer proposed the figures for 2006 hoping an excess of 15'600 CHF or 9'700 € of income on expenditures.

He proposes to maintain the same fee for the members.

The invoice must be sent to the Treasurer maximum one month after the event and at least before December 15. After this date, the count will be closed.

Some comments.

Voting on the budget: pro: 15, against: 0, abs: 1.

Voting on the annual fee (remains the same): pro: 15, against 0, abs. 1.

14. Election of Auditors

Candidates are Dr. N. JENSEN and Prof T. TODOROF. They have been accepted unanimously.

15. Elections of officers and members

15a Intermediate elections of Members of the Executive Committee

Dr. W. VON HEYMANN is accepted unanimously as an assessor of the Executive Committee.

15b Reappointment of the Chairman of the *FIMM* Academy

Candidate is Dr. M. HUTSON. The FIMM General Assembly 2004 in Bratislava has appointed Dr HUTSON as the first Chairman of the Executive Board of the FIMM Academy. He has now to be reappointed.

Voting for this reappointment: pro: 15, against: 1, abs: 0.

15c Elections of Honorary Members

Proposed are:

DR. LOÏC BURN: A Past President of the British Association of Manipulative Medicine, a former member of the British League against Rheumatism, a former member of the Council of Management of the National Back Pain Association. In 1972 he obtained his Diploma in Physical Medicine and has been active in writing and teaching in this field. His titles are BA, MRCS, LRCP, DPhysMed. He is a Past President of FIMM, was a member of the FIMM Executive Committee and the FIMM Scientific Advisory Committee. And do not forget that he organized a remarkable worldwide FIMM congress in 1989 – in London.

DR. JOHN K. PATERSON: A Past President of the British Association of Manipulative Medicine. As Dr. LOÏC BURN, he was active in teaching M/M medicine for years. His titles are MB, BS, MRCPG. He was a Member of the FIMM Scientific Advisory Committee and the Chairman of the FIMM Terminology Subcommittee, where he contributed a lot. He helped Dr. LOÏC BURN to organize the LONDON FIMM Congress in 1989. His help was significant.

The two were mostly working together. They have run postgraduate courses in M/M Medicine together

between 1983 and 1990. They have published five medical textbooks.

Dr. ALFRED MÖHRLE, Past President of FIMM. Dr. ALFRED MÖHRLE has been a distinguished FIMM officer for more than 15 years. As a member of the FIMM Executive Committee he established in 1992 the trilingual Glossary Subcommittee and followed the project until the first edition of the Glossary in 1998. In 1994 he proposed and outlined the establishment of the FIMM Policy Committee, which was ratified by the FIMM General Assembly in 1995. He was President of FIMM from 1995-1999. Under his leadership FIMM grew to be a true worldwide international organisation having definitely spread to Australasian and North-American continents. Under his presidency the FIMM statutes were revised and adopted. Dr. ALFRED MÖHRLE was later a FIMM Vice-President and Deputy Treasurer until he resigned in 2004. He has given tremendously much to the organisation and the FIMM community.

They are unanimously accepted by applause.

In 1995, at the General Assembly in Vienna, Univ. Prof. H. TILSCHER was elected as honorary member but not nominated because other involvement in FIMM. He today receives his certificate via the hands of Dr. R. KERN.

16. Admission of new members

Proposed candidate is **Kazakhstan,** represented by Dr. N. A. KRASNOYAROVA, President of Association of Manual Therapists of Kazakhstan, The Centre of Manual Therapy, Zheltoksan 111, 480009 Almaty City, Kazakhstan, Tel. 8 3272 755-883, (krasnon@mail.kz).

Unfortunately they failed to attend the meeting. No communication was received as to why.

The Secretary-General will contact them after the meeting by e-mail.

India has announced to take part at the General Assembly as an observer represented by Dr. S. CHANDER SOOD, Orthopaedic Surgeon and Head Department of Physical, Medicine & Rehabilitation, S.B.L.S.Hospital 812/1, Housing Board Colony, Model Town, Jalandhar City, Punjab State, India. (sarveshwar@vsnl.com, http://personal.vsnl.com/sarveshwar, www.health-india.com\personal\drsood.htm).

He apologised for non-attendance due to inability to get leave from his Hospital at short notice.

17. Exclusion of members

According to article 5 of the FIMM Statutes exclusions of some members have to be discussed by the General Assembly.

"… Art. 5: Exclusion from the Association may take place if the member

- substantially disobeys its duties according to Article 4,

- has acted against the aims and interests of the Association or has damaged its authority,

- has failed to pay a membership fee for two consecutive years to the Association.

The General Assembly will decide about exclusion with a majority of two-thirds following a proposal of the Executive Committee. In serious cases, the Executive Committee may immediately suspend the membership until the next General Assembly. The member being aware of exclusion must be invited to the General Assembly to present his defence."

Concerned are: **Greece, Lithuania** and **Portugal**.

Both members have been addressed several times. Portugal has replied by e-mail dated September 1, 2005:

"Following your letter from July 11 regarding annual fees payments from our Society 2003 - 2004, I must inform you of the following: The Portu-

guese Society of Manual Medicine Orthopaedics and Manual Therapeutics - Back School, it is a doctors association which objective/ aim consists in giving formation/Background after graduation. It is a Society without any profits/gains, so all the partners associated do not pay anything towards the Society: Our Portuguese and foreigner colleagues, (Spanish, French, Belgium) who came here to give courses do not receive payment because the Society doesn't have financial conditions. I apologize but we are not able to be present at the General Assembly of FIMM 2005 in England. It's with regret, but we don't have money available. I hope this letter will clarify to you, the reason why the Portuguese Society has not pay annual fees. I will remain at your disposal for any questions you may have. Yours Sincerely, JORGE MANUEL JARDIM FERNANDES, President S.P.M.O. e TM-ED (jjfernandes@hdfaro.min-saude.pt)."

The President points out that the statutes say that: "Exclusion from the Association **may** take place if…".

Some propositions are made by a member to help these small societies to avoid their exclusion but also some are in favour of the exclusion to avoid example for the future. Portugal and Greece never kept in touch with FIMM over the years.

The assembly decides by 15 voices to follow the proposition to send a letter to these Societies to explain the advantages to be in FIMM and postpone the decision to the next General Assembly.

18. Information on the next International FIMM Congress 2007

The General Assembly was informed, that the 15th Triennial International FIMM Congress would take place in Interlaken, Switzerland from November 28 to December 1, 2007 organized by the Swiss Medical Society for Manual Medicine SAMM.

In the meantime FIMM was informed about changes in the organisation of this congress:

The 15th Triennial International FIMM Congress will now take place in Zurich, Switzerland from September 12-15, 2007.

The proposition as for a title of the Congress is:

Neuromusculoskeletal Medicine: Facts, New Approaches and Evidence.

Accepted.

19. Date and place for the General Assembly 2006

Proposed is on May 17-18, 2006, Moscow, by invitation of the Russian League of Professionals of Manual Medicine).

20. Any other Business

Nil.

20. Closing of the General Assembly by the President

At 19.20 hours.

The report of the Treasurer 2004

Presented to the General Assembly at London Gatwick on September 9, 2005

Dr. Viktor Dvořák

Success estimation 01.01.2004 - 31.12.2004

Income	**CHF**
Operating yield	
members annual fee	67’786.50
societies annual fee	4’000.00
diverse yields	0.00
interest yield of bonds	2’017.95
Total operating yield	**73’804.45**

Expenditures	**CHF**
Operating expenditures	
Interest on capital	
interest and expenses	440.60
Total interest on capital	**440.60**
Administration expenditures	
office material and print expenditures news	4’655.75
translations	1’989.40
tel./fax/internet/mail Treasurer	667.50
bookkeeping/revision	700.00
other administration expenditures	2082.10
Total administration expenditures	**10’094.75**
Executive Committee	
President	3’244.13
1. Vice President	371.75
2. Vice President	2’682.09
Secretary-General	6’788.85
Deputy Secretary-General	0.00
Treasurer	1’813.66
Deputy Treasurer	613.81
Total Executive Committee	**15’514.29**

Scientific Committee	
accommodation	1'140.10
travel expenses	6'981.17
workshop 2003 Montreux	2'000.00
diverse expenses	629.55
Total Scientific Committee	**10'750.82**
Education Committee	
accommodation	3'515.20
travel expenses	5'398.29
workshop 2003 Montreux	800.00
diverse expenses	787.55
Total Education Committee	**10'501.04**
Policy Committee	
accommodation	123.07
travel expenses	5'398.29
diverse expenses	787.55
Total Policy Committee	**6'822.04**
General Assembly 2004 an FIMM Congress	
accommodation	9'137.55
travel expenses	874.97
diverse expenditures (venues, facilities)	11'850.00
Total General Assembly 2004	**21'862.52**
Loss of Bonds and assets	
Loss	547.50
Total of Bonds and assets	**547.50**
Total standard operating expenditures	**76'804.45**
Standard operating result	**-2'791.11**
Extraordinary and unique expenditures	
documents SC, EC, GA	9'042.75
AOA meeting expenses	3'567.85
website	12'946.40
PC Montreux 2003	2'782.92
GA Montreux 2003 venue	2'178.00
GA Montreux accommodation	2'934.40
GA Bratislava 2004	4'209.95
Total of extraordinary and unique expenditures	**37'662.27**
TOTAL EXPENDITURES	**114'195.83**

	CHF
Total yield	**73'804.45**
Standard operating result	**-2'791.11**
Extraordinary expenditures	**-37'662.27**
Operating result 2004	**-40'391.38**

Balance per 31.12.2004

Active capital	**CHF**
Checkout (cash)	2'220.00
PC 85-764598-5	2'553.91
UBS 206-310232.01K Foundation	480.05
UBS 0206-P0327142	10'360.72
Bonds value per 31.12.2004	6'036.00
Debtors	6'735.00
Transitory account	1'178.95
Clearing tax	46.05
Excess of assets	**29'610.68**
Operating result 2004	**(loss) 40'391.38**
Total active capital	**70'002.06**

Passive capital	**CHF**
Accounts payable	4'209.95
Transitory liabilities	70.00
Loan SAMM foundation	20'000.00
Account 8000 per 01.01.2004	45'092.11
Total passive capital	**70'022.06**

Fig. 17: Components of the extraordinary and unique expenditures in 2004.

Fig. 18: Financial plan 2002 – 2007.

Fig. 19: Budget 2006, predicted income.

Fig. 20: Budget 2006, predicted expenditures for the Education Committee.

Fig. 21: Budget 2006, predicted expenditures for the FIMM Academy.

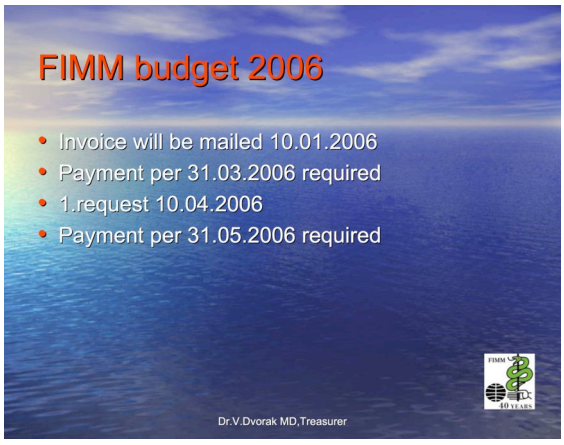

Fig. 22: Budget 2006, requirements asked by the FIMM Treasurer.

The report of the Chairman of the Policy Committee

FIMM policy and mission

Elaborated by the FIMM Policy Committee[4]

Presented to the General Assembly at London Gatwick, September 9, 2005
Dr. Bernard Terrier

Dr. Peter G. Skew[5] has adapted the English version of the FIMM Policy

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Le rapport du président du Policy Committee

La FIMM • de quoi s'agit-il ?

Élaboré par le FIMM Policy Committee[1]

Présenté à l'Assemblée générale de Gatwick Londre, le 9 septembre 2005
Le Dr Bernard Terrier

Der Bericht des Vorsitzenden des Policy Committee

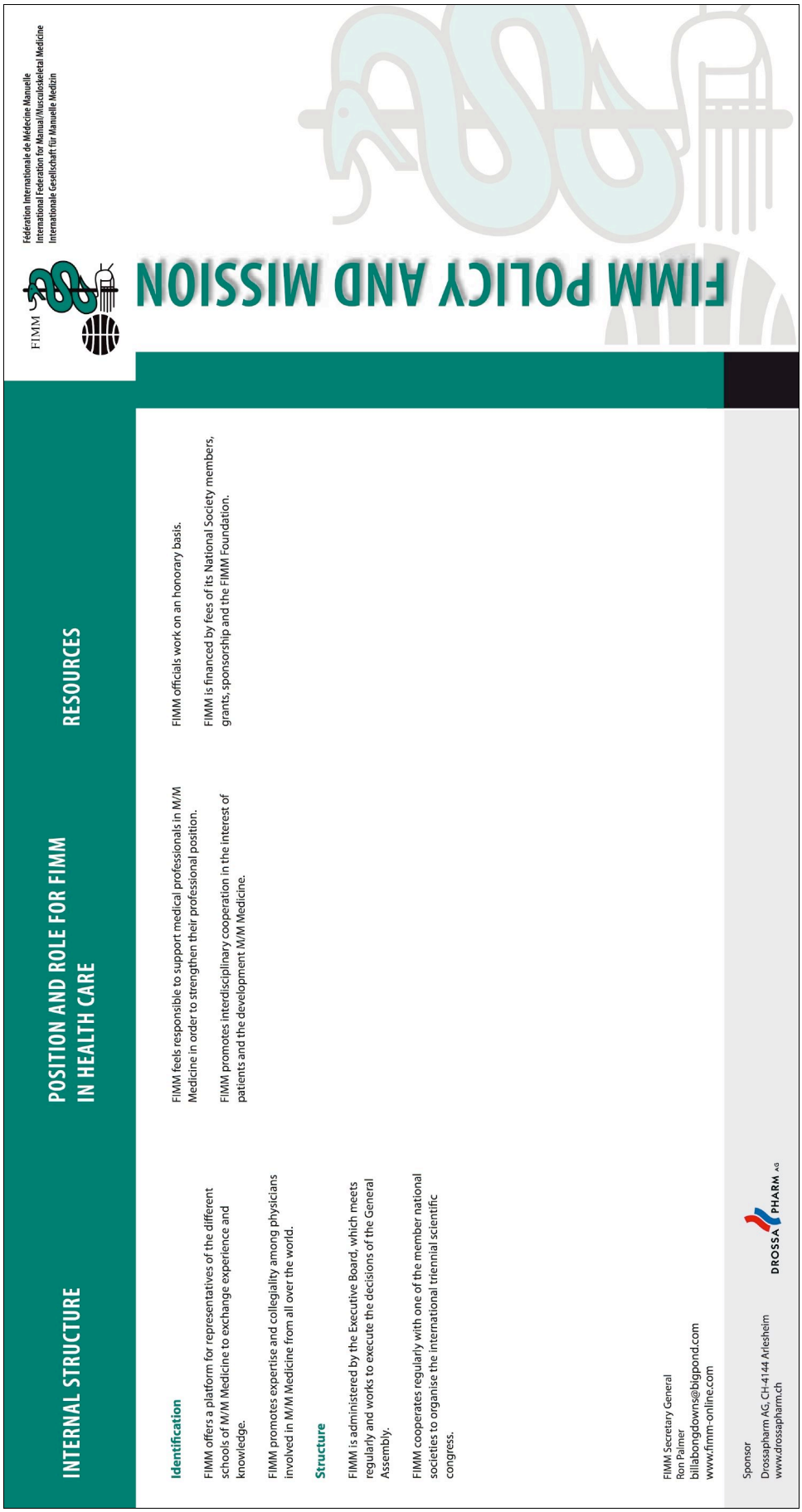
FIMM Leitbild

Erarbeitet durch das FIMM Policy Committee[1]

Präsentiert an der Generalversammlung in London Gatwick am 9. September 2005
Dr. Bernard Terrier

The document comes as foldable leaflet. You can download the print version by going to the FIMM web site www.fimm–online.com or order the leaflet for free by indicating shipping address, number and language: b.terrier@bluewin.ch.

[4] Members: Dr. G. Brugnoni, Dr. T. Rousi, Dr. A. Sadovski, Dr. B. Terrier (Chairman), Dr. M. J. Teyssandier, Univ. Prof. H. Tilscher, Dr. W. von Heymann.
[5] Invited member.



FIMM

Fédération Internationale de Médecine Manuelle
International Federation for Manual/Musculoskeletal Medicine
Internationale Gesellschaft für Manuelle Medizin

FIMM POLICY AND MISSION

INTERNAL STRUCTURE

Identification

FIMM offers a platform for representatives of the different schools of M/M Medicine to exchange experience and knowledge.

FIMM promotes expertise and collegiality among physicians involved in M/M Medicine from all over the world.

Structure

FIMM is administered by the Executive Board, which meets regularly and works to execute the decisions of the General Assembly.

FIMM cooperates regularly with one of the member national societies to organise the international triennial scientific congress.

POSITION AND ROLE FOR FIMM IN HEALTH CARE

FIMM feels responsible to support medical professionals in M/M Medicine in order to strengthen their professional position.

FIMM promotes interdisciplinary cooperation in the interest of patients and the development M/M Medicine.

RESOURCES

FIMM officials work on an honorary basis.

FIMM is financed by fees of its National Society members, grants, sponsorship and the FIMM Foundation.

FIMM Secretary General
Ron Palmer
billabongdowns@bigpond.com
www.fmm-online.com

English version, front page.

INTRODUCTION

The International Federation for Manual/Musculoskeletal Medicine (FIMM) is the federation of national societies, worldwide, of physicians who practice Manual/Musculoskeletal Medicine (M/M Medicine). FIMM is a society according to Belgium law.

M/M Medicine is the true medical discipline of the most common causes of pain and disability, namely the reversible dysfunctions of the locomotor system and especially the spine.

M/M Medicine completes and complements the syllabus of both undergraduate and postgraduate education & training of physicians.

M/M Medicine is a specific help for the individual as well as economical for social expenditure.

FIMM Policy Committee

Guido Brugnoni, Italy
Timo Rousi, Finland
Andrzej Sadowski, Poland
Peter Skew, UK (invited member)
Bernard Terrier, Switzerland (Chairman)
Marie-José Teyssandier, France
Hans Tilscher, Austria
Wolfgang von Heymann, Germany

Accepetd by the FIMM General Assembly 2005.

DEFINITIONS AND GOALS

Manual/Musculoskeletal Medicine

M/M Medicine is the medical discipline of enhanced knowledge and skills in the diagnosis, therapy and prevention of functional reversible disorders of the locomotor system.

Diagnostic skills build on conventional medical techniques with manual assessment of individual tissues and functional assessment of the whole system, based on scientific biomechanical and neurophysiologic principles.

Therapeutic skills add manual/manipulative techniques and advanced interventional techniques to conventional treatments for the reduction of pain or other therapeutic outcome.

Patient involvement in the therapeutic activity, resulting from the detailed diagnosis, helps in the prevention of recurrence.

FIMM

FIMM is *the* Federation of national societies, worldwide, of physicians who practice M/M Medicine.

FIMM acts as an international coordinator for science and education in M/M Medicine.

FIMM aims to be the recognised representative of *all* international activities concerning M/M Medicine.

FIMM International Academy of Manual/ Musculoskeletal Medicine (FIMM Academy)

The FIMM Academy is according to English law semi-autonomous and consisting of individual members.

The FIMM Academy is open to all scientists and educationalists involved in the development and understanding of sciences related to M/M Medicine.

FIMM Foundation

The FIMM Foundation is a foundation registered under the Swiss Commerce Register. The aim of the Foundation is to give financial support to educational and scientific activities in Manual and Musculoskeletal Medicine.

STRATEGIES AND METHODS

Role in science and research

FIMM initiates, promotes and coordinates scientific research concerning M/M Medicine and the neuro-musculoskeletal system.
FIMM selects literature about M/M Medicine and makes it accessible for FIMM members, especially via internet.
FIMM initiates and promotes committee work in terms of reading and valuing the specific literature.

Role in education

FIMM recognises that education in M/M Medicine is based on fully completed medical studies (is undertaken as postgraduate training).
FIMM aims to propose internationally accepted programs for education in M/M Medicine.
FIMM promotes and encourages programs based on science.

Role in quality management

FIMM takes an active role in analysing the scientific reports and communications about incidents, accidents and complications of methods and techniques of M/M Medicine, as it is usual in medicine.

FIMM contributes to quality management systems in many ways including promoting regularly scientific congresses and educational courses as well as promoting and updating educational standards of M/M Medicine.

The report of the Chairman of the Policy Committee
Le rapport du Président du Policy Committee
Der Bericht des Vorsitzenden des Policy Committee

English version,
rear side.

Fédération Internationale de Médecine Manuelle
International Federation for Manual/Musculoskeletal Medicine
Internationale Gesellschaft für Manuelle Medizin

FIMM

LA FIMM • DE QUOI S'AGIT-IL?

ORGANISATION INTERNE

Identification

La FIMM favorise la mise en contact des représentants des différentes écoles de Médecine Manuelle pour échanger expérience et savoir.

La FIMM assure la promotion des connaissances et la collégialité parmi les médecins qui pratiquent la Médecine Manuelle dans le monde entier.

Structure

La FIMM est administrée par le Conseil de Direction qui se réunit régulièrement. Il est chargé de faire exécuter les décisions prises par l'Assemblée Générale.

La FIMM entre en coopération avec une des Sociétés Nationales membre qui est chargée d'organiser le Congres scientifique triennal de la FIMM.

Secrétaire générale de la FIMM
Ron Palmer
billabongdowns@bigpond.com
www.fimm-online.com

Mécène
Drossapharm AG, CH-4144 Arlesheim
www.drossapharm.ch

DROSSA PHARM AG

POSITION ET RÔLE DE LA FIMM DANS LE DOMAINE DE LA SANTÉ

La FIMM est prête à apporter son soutien aux professionnels médicaux actifs en matière de Médecine Manuelle pour valoriser leur exercice professionnel.

La FIMM assure la promotion de la coopération interdisciplinaire dans l'intérêt des patients ainsi que le développement de la Médecine Manuelle.

RESSOURCES

Les responsables de la FIMM travaillent à titre honorifique. Ils ne perçoivent aucun honoraire.

La FIMM est financée par les cotisations des sociétés nationales membres, les subventions, le mécénat et la Fondation de la FIMM.

Version française, avant.

PRÉAMBULE

La Fédération Internationale de la Médecine Manuelle (FIMM) est la fédération mondiale de sociétés nationales de médecins qui pratiquent la Médecine Manuelle. FIMM est une société de droit belge.

La Médecine Manuelle est une authentique discipline médicale des causes les plus fréquentes de douleurs et de handicaps moteurs; c'est-à-dire les dysfonctions réversibles de l'appareil locomoteur et en particulier de la colonne vertébrale.

L'enseignement théorique et pratique de la Médecine Manuelle est prodigué en complément des enseignements universitaire et post-universitaire des médecins.

La Médecine Manuelle présente un intérêt particulier aussi bien dans le domaine médical que dans celui des dépenses en matière médico-sociale.

FIMM Policy Committee

Guido Brugnoni, Italie
Timo Rousi, Finlande
Andrzej Sadowski, Pologne
Peter Skew, Royaume-Uni (membre invité)
Bernard Terrier, Switzerland (Président)
Marie-José Teyssandier, France
Hans Tilscher, Autriche
Wolfgang von Heymann, Allemagne

Accepté par l'Assemblée générale de la FIMM en 2005.

DÉFINITIONS ET OBJECTIFS

La Médecine Manuelle

La Médecine Manuelle est une discipline médicale, qui se donne pour objectifs le diagnostic, le traitement et la prévention des désordres fonctionnels réversibles de l'appareil locomoteur.

L'étape diagnostique inclut, en plus du diagnostic médical conventionnel obligatoire, un examen manuel palpatoire particulier des articulations des membres, du rachis et des tissus mous, basé sur les principes scientifiques (biomécaniques et neurophysiologiques).

L'étape thérapeutique inclut, en plus des traitements conventionnels, des traitements manuels spécifiques destinés à diminuer les douleurs ou obtenir d'autres résultats thérapeutiques.

L'étape diagnostique détaillée intervient dans le choix des actes de prévention des récidives pratiqués activement par le patient.

FIMM

La FIMM est *la* fédération mondiale regroupant des sociétés nationales de médecins qui pratiquent la Médecine Manuelle.

La FIMM intervient en tant que coordinateur international en matière scientifique et d'enseignement de la Médecine Manuelle.

La FIMM vise à être reconnue pour représenter les intérêts de la Médecine Manuelle auprès de *toutes* les instances internationales.

Académie Internationale de la FIMM pour la Médecine Manuelle (Académie de la FIMM)

L'Académie de la FIMM est une Société semi autonome de droit anglais, constituée de membres individuels.

L'Académie de la FIMM est ouverte à tous les scientifiques, chercheurs, enseignants, concernés par le développement et la recherche en matière de la Médecine Manuelle et musculo-squelettique.

Fondation de la FIMM

La Fondation de la FIMM est une fondation régie par le Registre du Commerce suisse. Elle se donne pour objectif le support financier de l'enseignement et des travaux scientifiques en matière de Médecin Manuelle.

STRATEGIES ET METHODES

Rôle dans la science et la recherche

La FIMM joue un rôle dans l'initiative, la promotion et la coordination en matière scientifique et de recherche au niveau de la Médecine Manuelle et le system neuro-musculo-squelettiques.
La FIMM joue un rôle dans la sélection de la littérature traitant de Médecine Manuelle et de son accessibilité pour tous les membres de la FIMM, en particulier par Internet.
La FIMM joue un rôle dans l'installation et dans le fonctionnement de commissions de travail en vue de lire et évaluer les publications scientifiques.

Rôle en matière d'enseignement

La FIMM reconnaît qu'il faut d'avoir terminé le cursus complet des études médicales conventionnelles avant d'entreprendre des études de Médecine Manuelle.
La FIMM se donne pour objectif de proposer des programmes d'enseignement acceptés internationalement.
La FIMM assure la promotion des programmes d'enseignement fondés sur les résultats de recherches scientifiques.

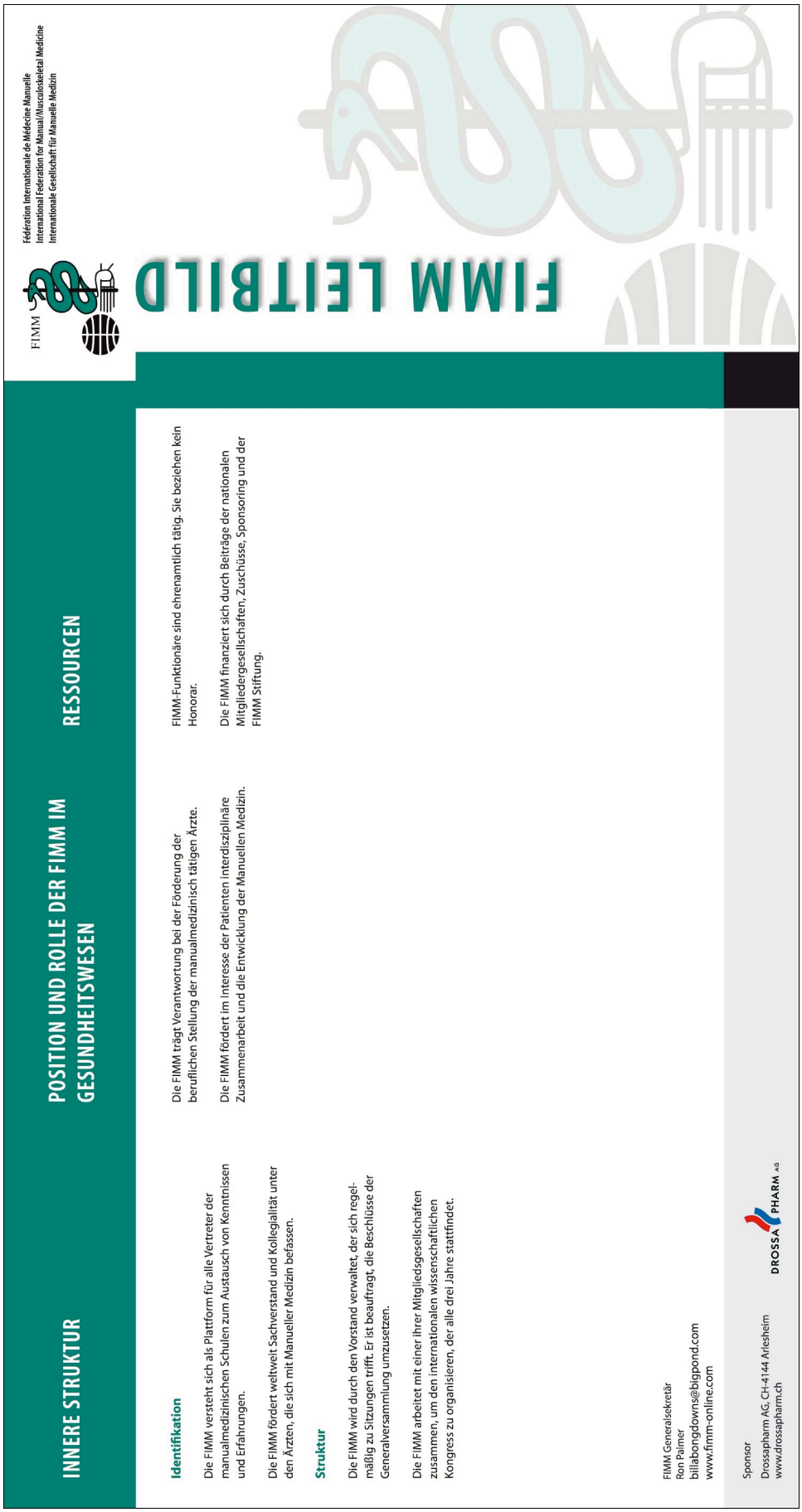
Rôle dans l'assurance-qualité

La FIMM intervient pour analyser les rapports et communications scientifiques en matières d'incidents, accidents et complication des actes de Médecine Manuelle comme il est habituel de le faire pour toute spécialité médicale.

La FIMM contribue aux systèmes d'assurance-qualité de nombreuses manières dont la promotion régulière de congrès scientifiques, séminaires d'enseignement, ainsi que la promotion et la mise à jour des standards d'enseignement en Médecine Manuelle.

The report of the Chairman of the Policy Committee
Le rapport du Président du Policy Committee
Der Bericht des Vorsitzenden des Policy Committee

Version française, dos.



FIMM LEITBILD

Fédération Internationale de Médecine Manuelle
International Federation for Manual/Musculoskeletal Medicine
Internationale Gesellschaft für Manuelle Medizin

FIMM

INNERE STRUKTUR

Identifikation

Die FIMM versteht sich als Plattform für alle Vertreter der manualmedizinischen Schulen zum Austausch von Kenntnissen und Erfahrungen.

Die FIMM fördert weltweit Sachverstand und Kollegialität unter den Ärzten, die sich mit Manueller Medizin befassen.

Struktur

Die FIMM wird durch den Vorstand verwaltet, der sich regelmäßig zu Sitzungen trifft. Er ist beauftragt, die Beschlüsse der Generalversammlung umzusetzen.

Die FIMM arbeitet mit einer ihrer Mitgliedsgesellschaften zusammen, um den internationalen wissenschaftlichen Kongress zu organisieren, der alle drei Jahre stattfindet.

POSITION UND ROLLE DER FIMM IM GESUNDHEITSWESEN

Die FIMM trägt Verantwortung bei der Förderung der beruflichen Stellung der manualmedizinisch tätigen Ärzte.

Die FIMM fördert im Interesse der Patienten interdisziplinäre Zusammenarbeit und die Entwicklung der Manuellen Medizin.

RESSOURCEN

FIMM-Funktionäre sind ehrenamtlich tätig. Sie beziehen kein Honorar.

Die FIMM finanziert sich durch Beiträge der nationalen Mitgliedergesellschaften, Zuschüsse, Sponsoring und der FIMM Stiftung.

FIMM Generalsekretär
Ron Palmer
billabongdowns@bigpond.com
www.fimm-online.com

Deutsche Version, Vorderseite.

PRÄAMBEL

Die Internationale Gesellschaft für Manuelle Medizin (FIMM) ist die internationale Föderation von nationalen Ärztegesellschaften, die sich mit Manueller Medizin befassen. FIMM ist eine Gesellschaft nach Belgischem Recht.

Manuelle Medizin ist die originäre ärztliche Disziplin der häufigsten Ursachen der Schmerzen und der Arbeitsunfähigkeit beim Menschen, namentlich der reversiblen Funktionsstörungen am Bewegungssytem, speziell an der Wirbelsäule.

Manuelle Medizin erweitert und ergänzt in Theorie und Praxis die Aus- und Weiterbildung prä- und postgraduierter Ärzte.

Manuelle Medizin ist eine Hilfe für den Einzelnen wie auch für die Sozialsysteme.

FIMM Policy Committee

Guido Brugnoni, Italien
Timo Rousi, Finnland
Andrzej Sadowski, Polen
Peter Skew, UK (eingeladenes Mitglied)
Bernard Terrier, Switzerland (Vorsitzender)
Marie-José Teyssandier, Frankreich
Hans Tilscher, Österreich
Wolfgang von Heymann, Deutschland

DEFINITIONEN UND ZIELE

Manuelle Medizin

Manuelle Medizin ist die medizinische Disziplin, die sich umfassend mit der Diagnose, der Therapie und der Prävention reversibler Funktionsstörungen des Bewegungssystems befasst.

Die Diagnostik schließt unter Nutzung der theoretischen Grundlagen, Kenntnisse und Verfahren weiterer medizinischer Gebiete auch die Untersuchungstechniken ein, die mit der Hand durchgeführt werden können und die auf wissenschaftlichen, biomechanischen und neurophysiologischen Grundlagen beruhen.

Therapie umfasst neben den üblichen und fachspezifischen Behandlungsverfahren Hangrifftechniken zur Verminderung von Schmerzen oder zur Erzielung anderer therapeutischer Effekte.

Die Prävention setzt den aktiven Einbezug des Patienten durch Information und Übungsanleitung voraus, die auf der exakten Manuellen Diagnostik basieren.

FIMM

Die FIMM ist *die* internationale Föderation von nationalen Ärztegesellschaften, die sich mit Manueller Medizin befassen.

Die FIMM wirkt international als Koordinator der Wissenschaften und der Ausbildung in Manueller Medizin.

Die FIMM strebt danach, der anerkannte Vertreter für *alle* internationalen Aktivitäten im Bereich der Manuellen Medizin zu sein.

Internationale FIMM-Akademie für Manuelle Medizin (FIMM-Akademie)

Die FIMM-Akademie ist semi-autonom und steht unter Englischem Recht. Sie setzt sich aus individuellen Mitgliedern zusammen.

Die FIMM-Akademie steht allen Forschern und Ausbildnern offen, die sich wissenschaftlich mit der Entwicklung und dem Verständnis in Bezug auf die Manuelle und Muskuloskelettale Medizin befassen.

FIMM-Stifung

Die FIMM-Stiftung ist im Schweizerischen Handelsregister eingetragen. Das Ziel der Stiftung ist die finanzielle Unterstützung der Ausbildung und der wissenschaftlichen Tätigkeit in der Manuellen Medizin.

STRATEGIEN UND METHODEN

Die Bedeutung in Wissenschaft und Forschung

Die FIMM initiiert, fördert und koordiniert die wissenschaftliche Forschung in der Manuellen Medizin und dem neuromuskuloskelettalen System.
Die FIMM sichtet die Literatur über Manuelle Medizin und macht sie den FIMM-Mitgliedern zugänglich, speziell über das Internet.
Die FIMM initiiert und fördert die Kommissionsarbeit zur Durchsicht und Auswertung der spezifischen Literatur.

Die Bedeutung in der Ausbildung

Die FIMM fördert die postgraduale Weiterbildung in Manueller Medizin im Anschluss an ein vollständig abgeschlossenes Medizinstudium.
Die FIMM strebt international anerkannte Grundsätze für die Ausbildung in Manueller Medizin an.
Die FIMM fördert Fort- und Weiterbildungsprogramme, die auf wissenschaftlichen Ergebnissen beruhen.

Die Bedeutung des Qualitätsmanagements

Die FIMM übernimmt eine aktive Rolle bei der Analyse der wissenschaftlichen Berichte und Mitteilungen über Ereignisse, Zwischenfälle und Komplikationen im Rahmen der manualmedizinischen Tätigkeit wie in der Medizin üblich.

Die FIMM betreibt vielfältig Qualitätsmanagement, beispielsweise durch Förderung regelmäßiger wissenschaftlicher Veranstaltungen, von Ausbildungskursen sowie der Aktualisierung von Fort- und Weiterbildungsstandards in der Manuellen Medizin.

Angenommen durch die FIMM Generalversammlung 2005.

The report of the Chairman of the Policy Committee
Le rapport du Président du Policy Committee
Der Bericht des Vorsitzenden des Policy Committee

Deutsche Version,
Rückseite.

Tasks of a future FIMM Education Board

Elaborated by the FIMM Executive Committee

Presented to the General Assembly at London Gatwick, September 9, 2005

Dr. Glen Gorm Rasmussen

Fig. 23

Fig. 24

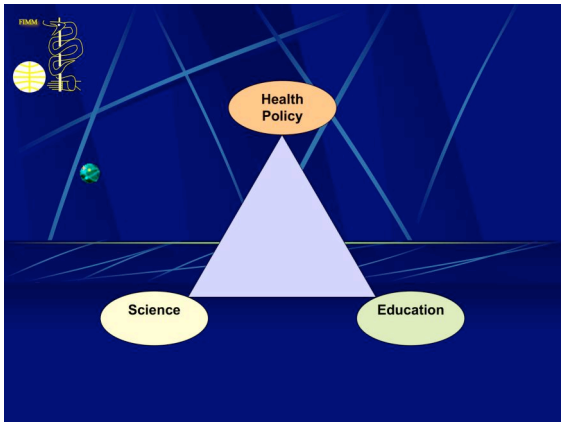


Fig. 25

Fig. 26

Fig. 27

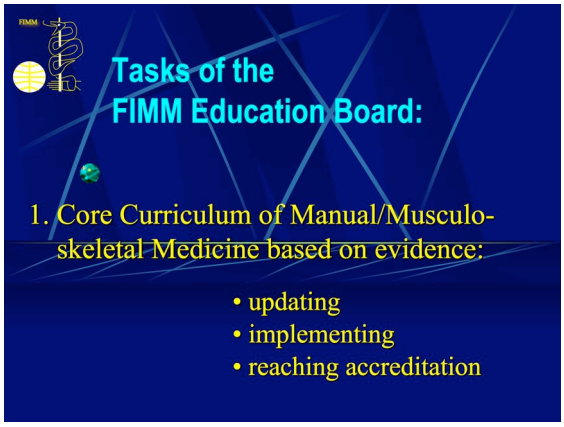


Fig. 28

Fig. 29

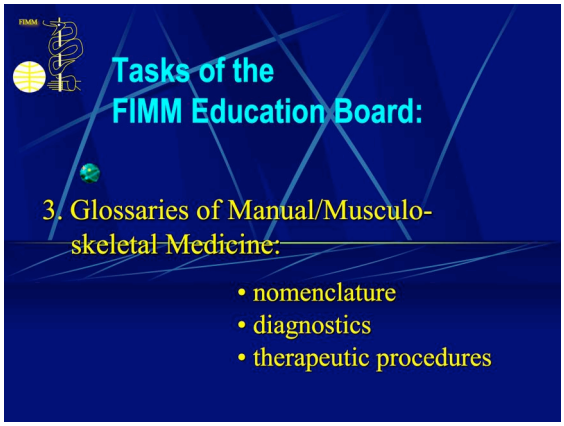


Fig. 30

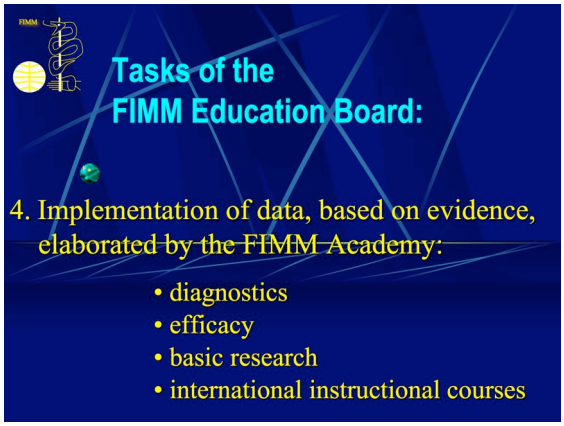


Fig. 31

Fig. 32

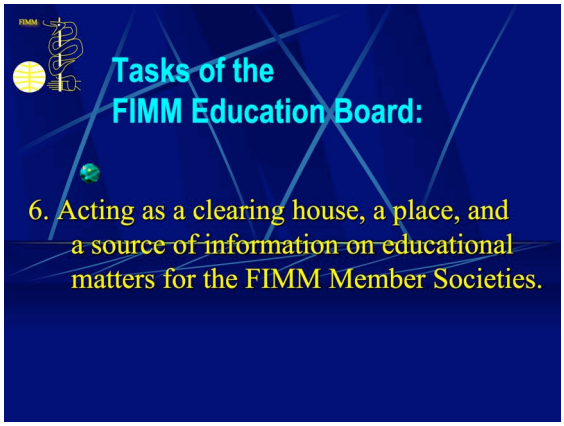


Fig. 33

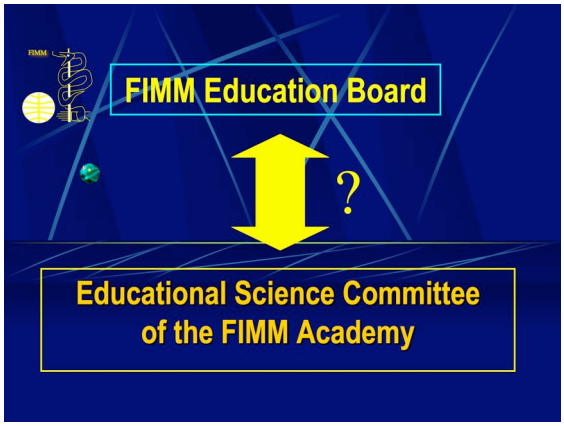


Fig. 34

Tasks of a future FIMM Health Policy Board

Elaborated by the FIMM Executive Committee

Presented to the General Assembly at London Gatwick, September 9, 2005

Prof. Michael Kuchera, D.O., FAAO

Fig. 35

Fig. 38

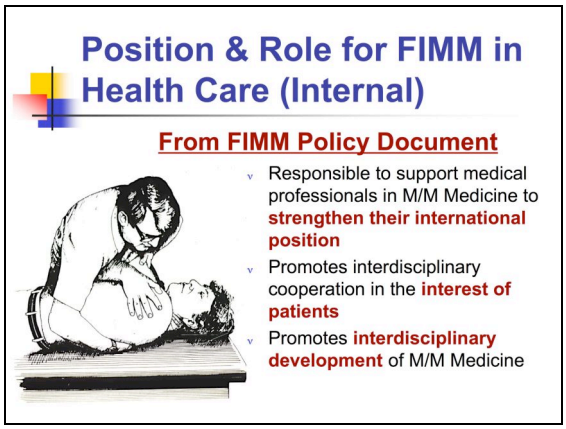


Fig. 36

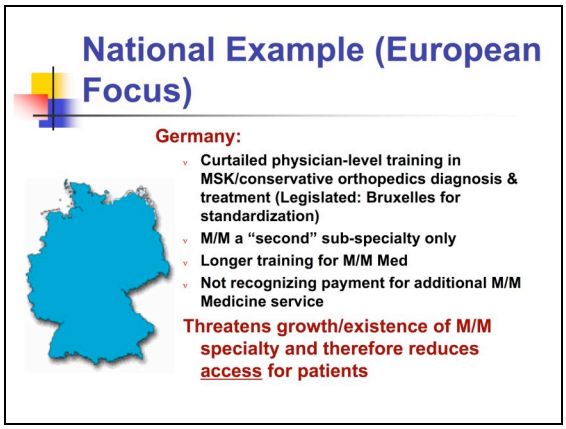


Fig. 39

Fig. 37

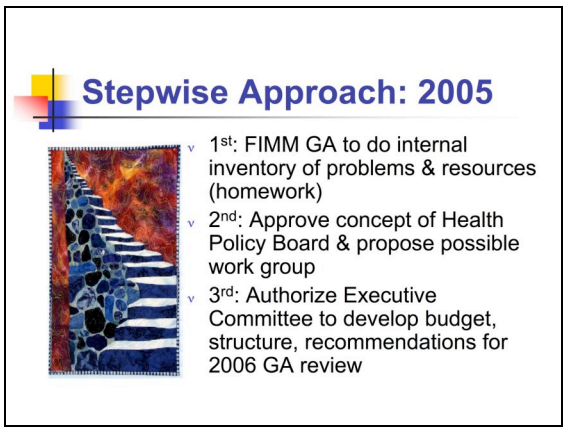


Fig. 40

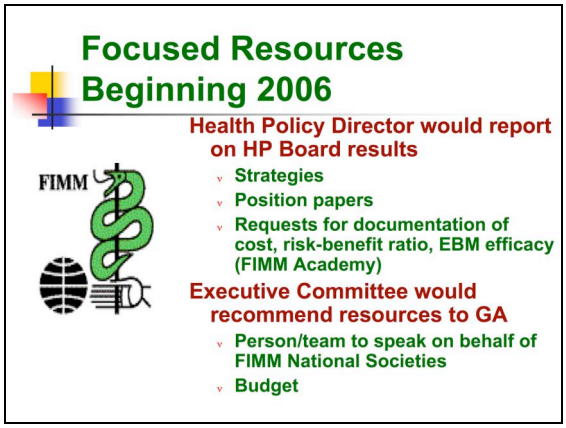

Focused Resources
Beginning 2006
Health Policy Director would report on HP Board results
Strategies
Position papers
Requests for documentation of cost, risk-benefit ratio, EBM efficacy (FIMM Academy)
Executive Committee would recommend resources to GA
Person/team to speak on behalf of FIMM National Societies
Budget
FIMM

Fig. 41

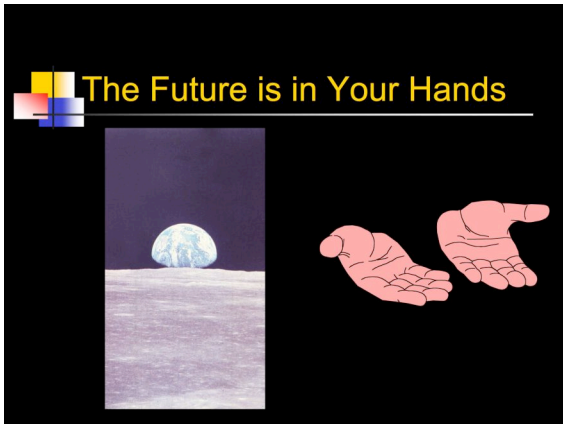

The Future is in Your Hands

Fig. 42

The report of the Chairman of the Education Committee

Presented to the General Assembly at Gatwick London on September 9, 2005

Dr. Glen Gorm Rasmussen

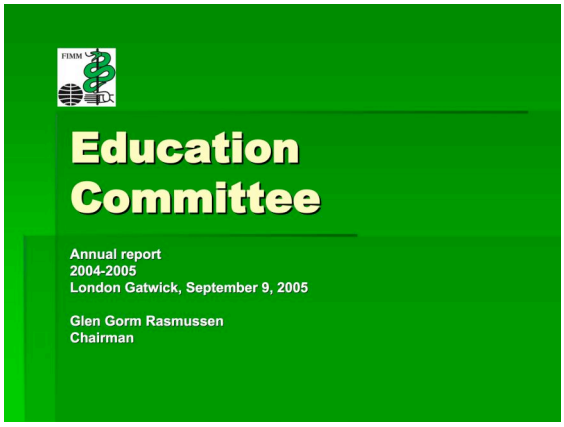


Fig. 43

Fig. 44

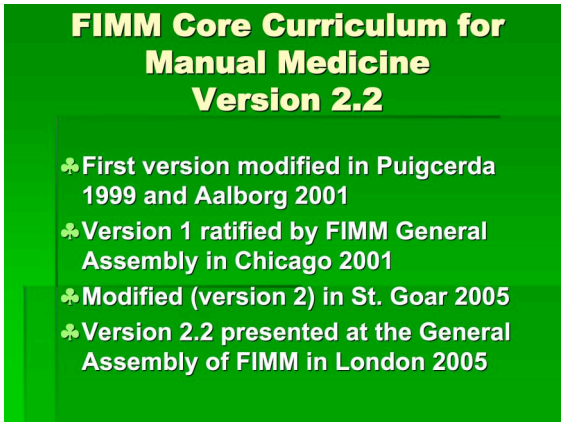


Fig. 45

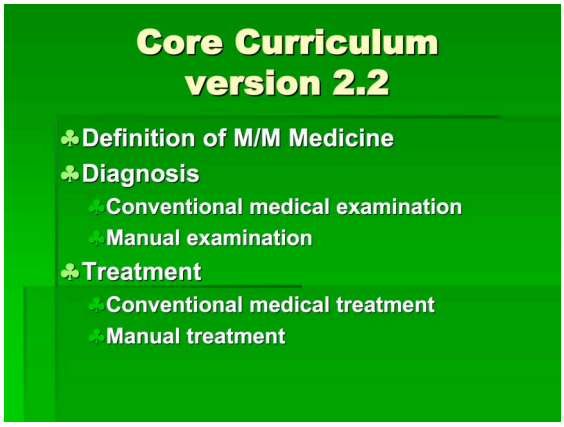


Fig. 46

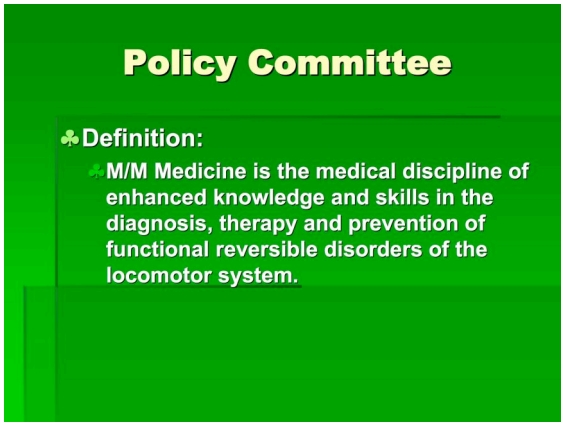


Fig. 47

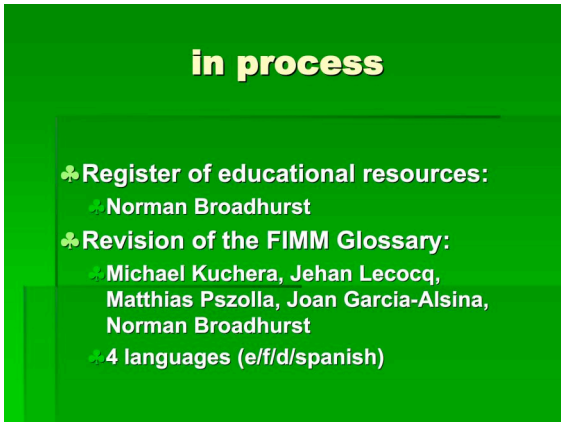


Fig. 48

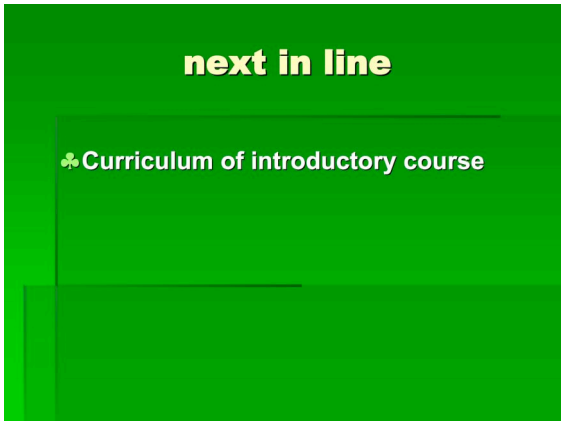


Fig. 49

Fig. 50

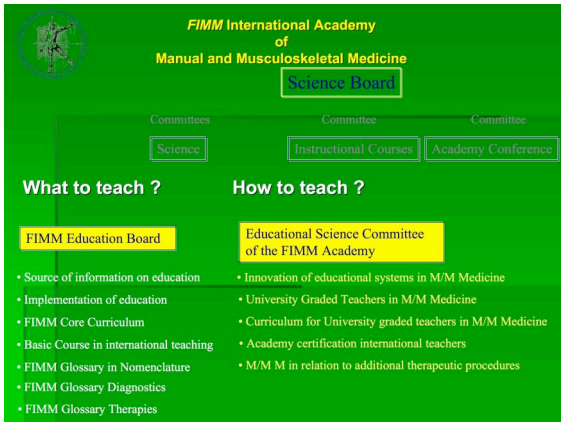


Fig. 51

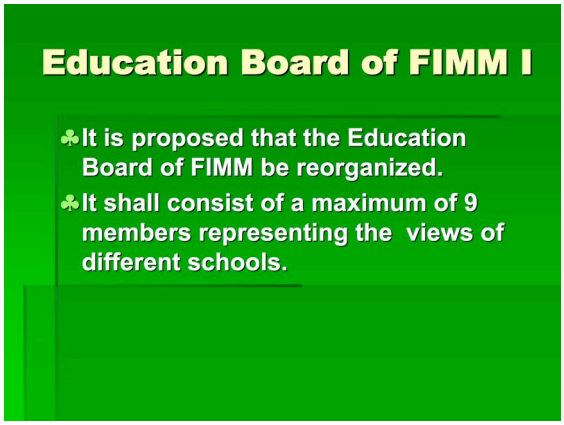


Fig. 52

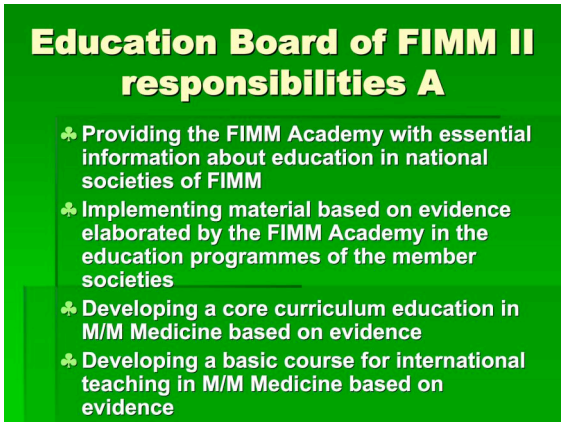


Fig. 53

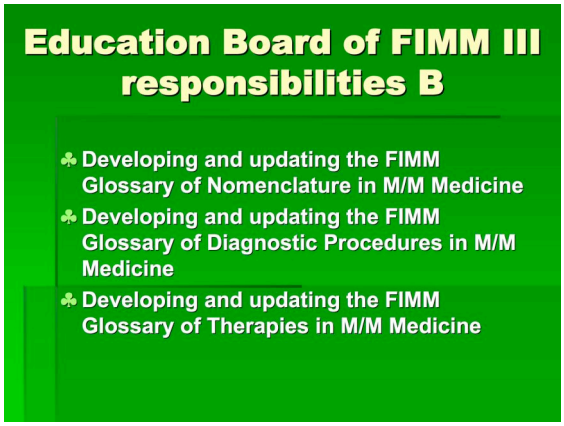


Fig. 54

The report of the Chairman of the FIMM Academy

Presented to the General Assembly at Gatwick London on September 9, 2005

Dr. Michael Hutson

(FIMM International Academy of Manual/Musculoskeletal Medicine)

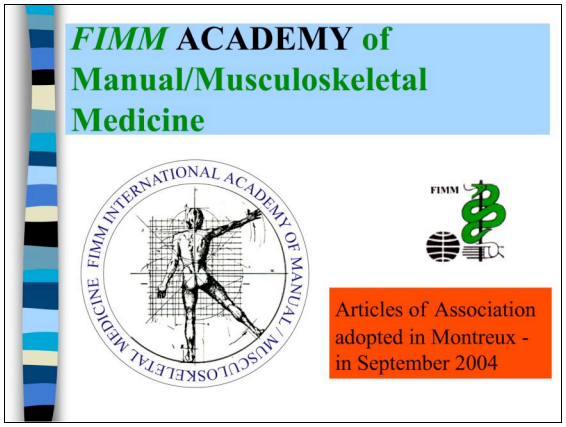
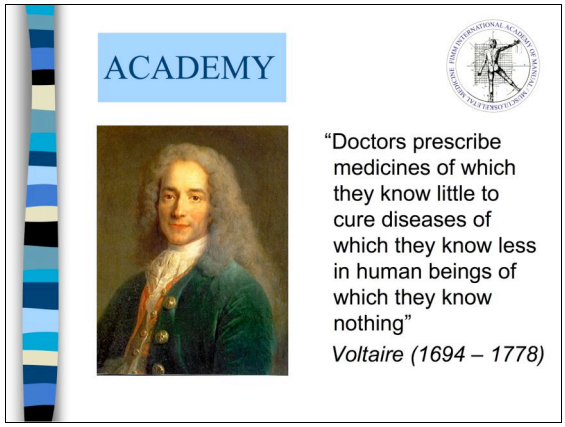


Fig. 55



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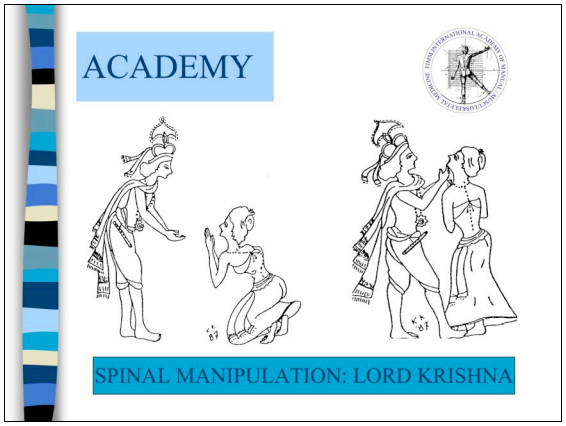

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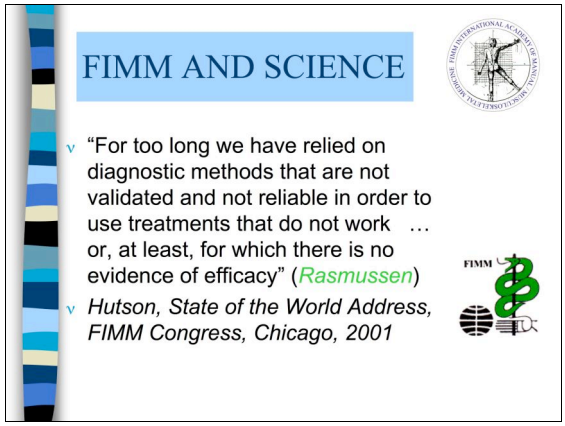

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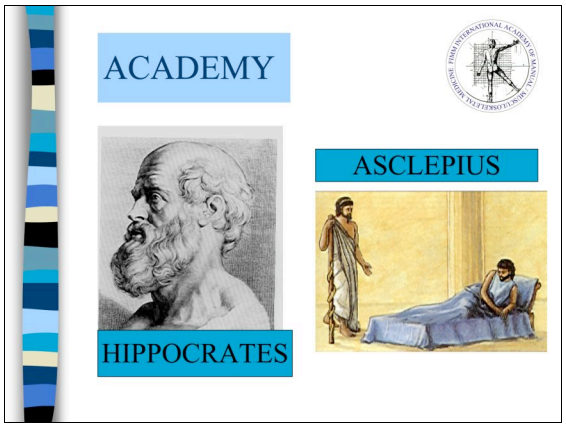

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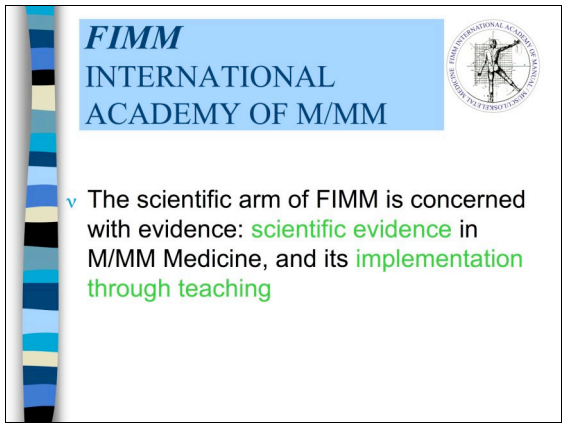

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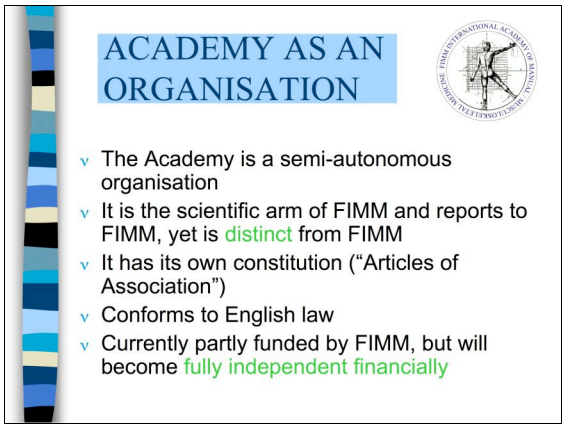

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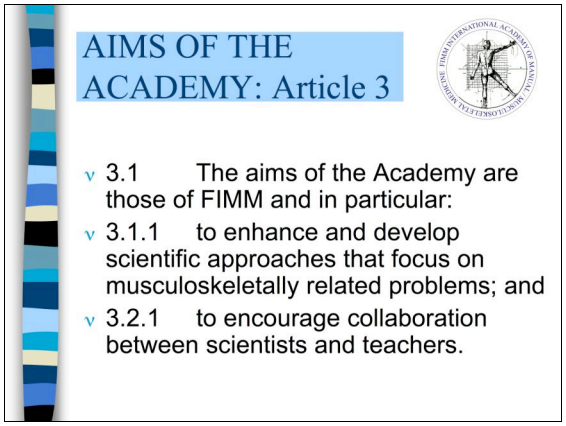

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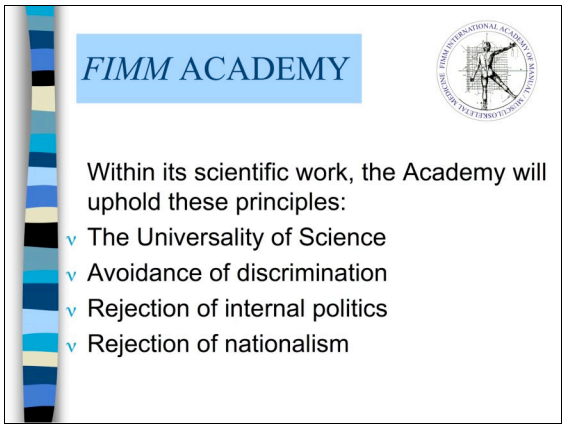

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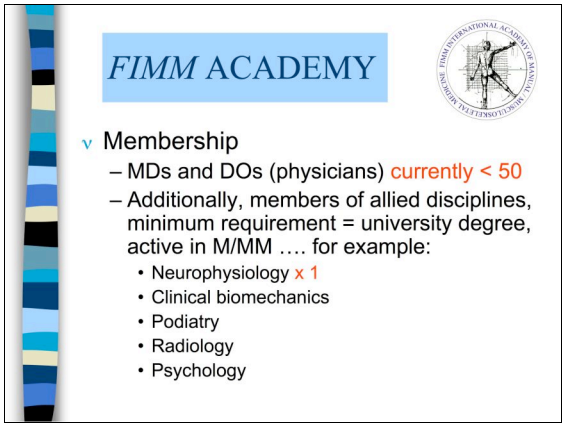

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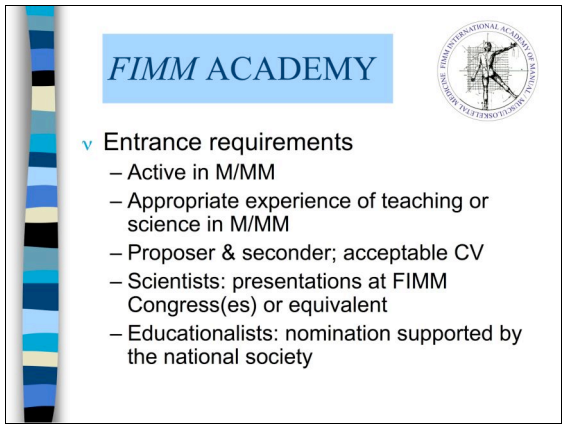

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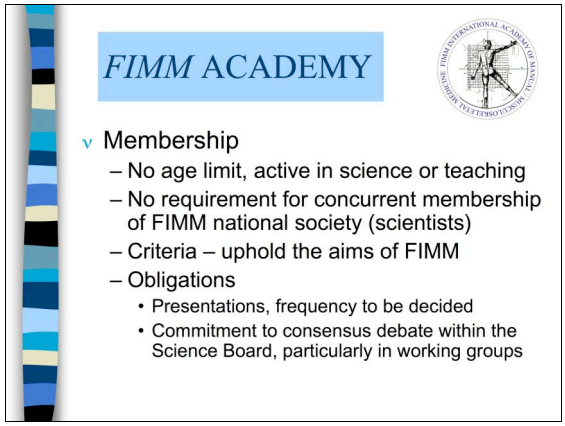

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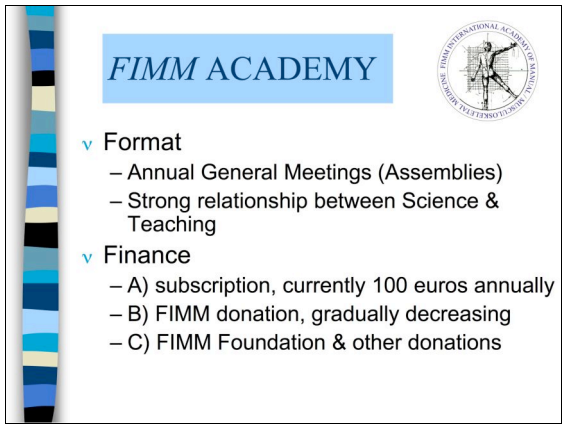

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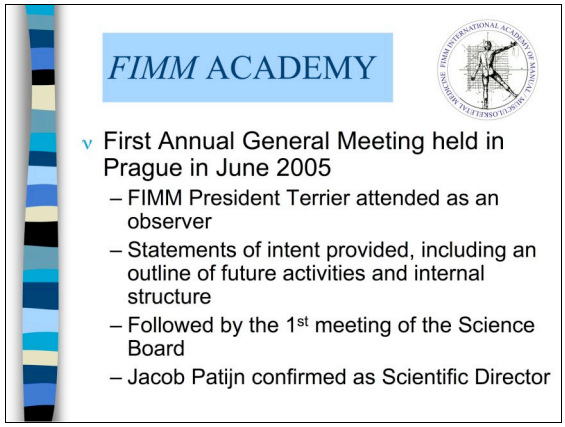

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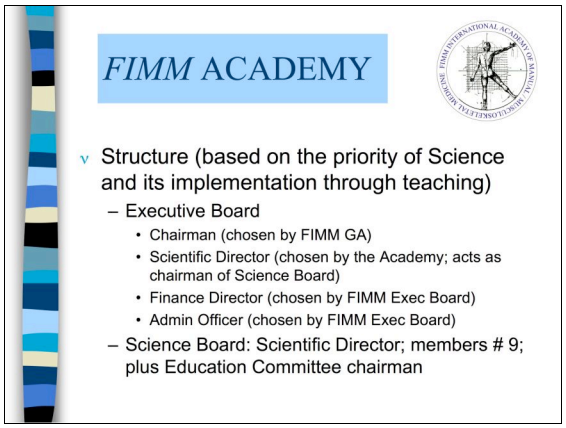

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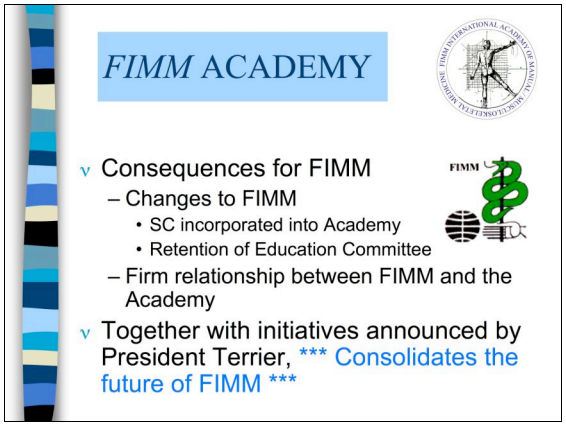

Fig. 70

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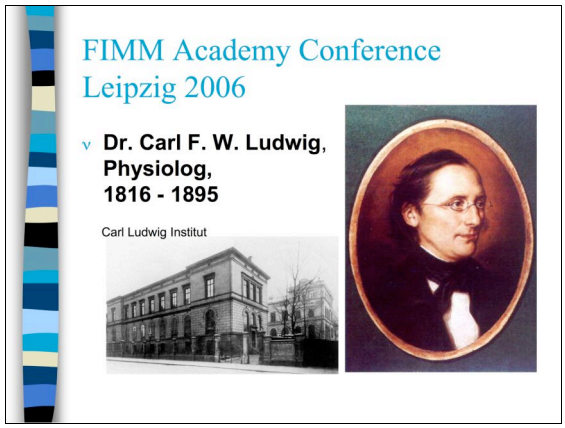

Fig. 73

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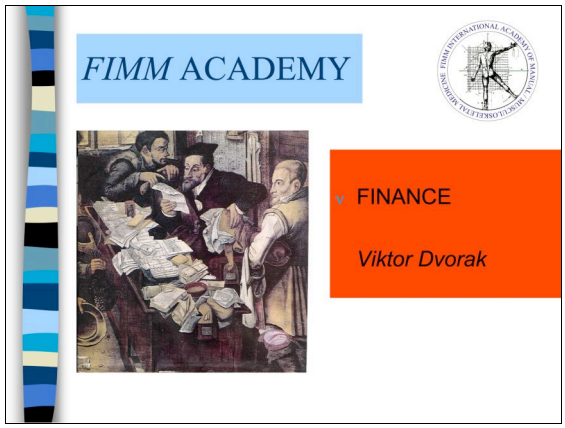

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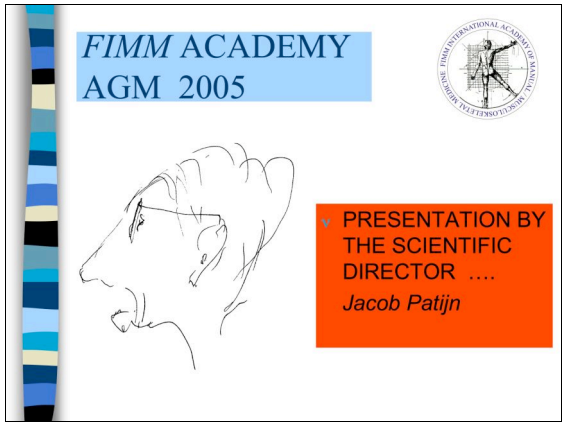


Fig. 80

The report of the Scientific Director of the FIMM Academy

Presented to the General Assembly at Gatwick London on September 9, 2005

Prof. Jacob Patijn

(FIMM International Academy of Manual/Musculoskeletal Medicine)

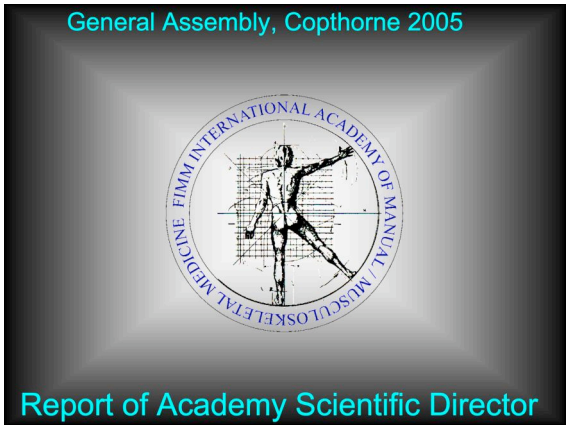
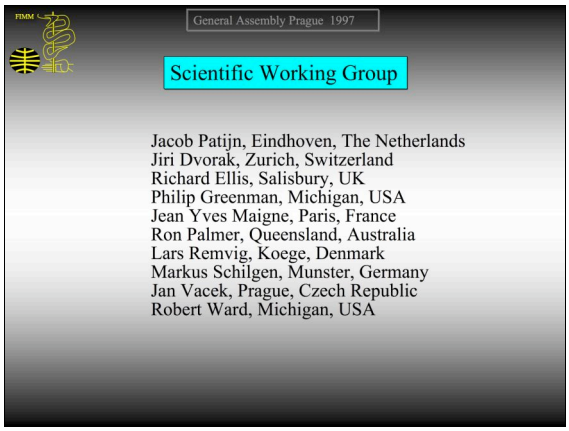


Fig. 81

Fig. 82



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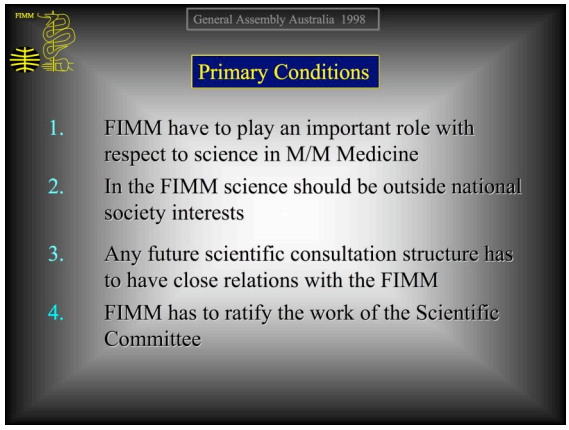

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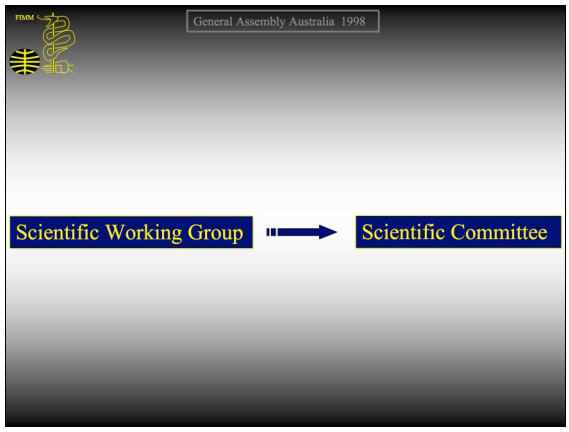
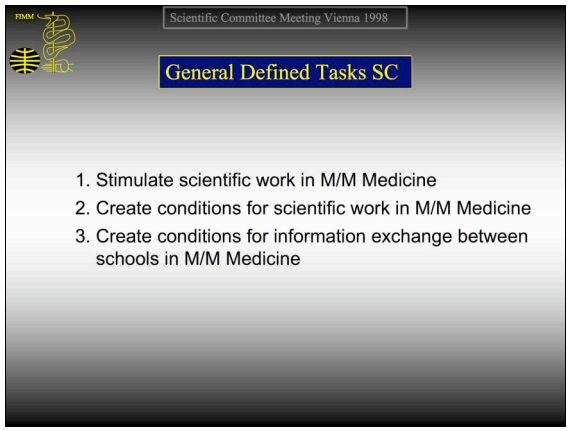


Fig. 85



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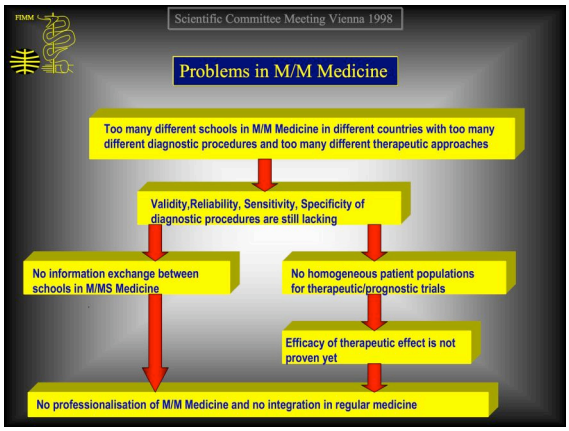
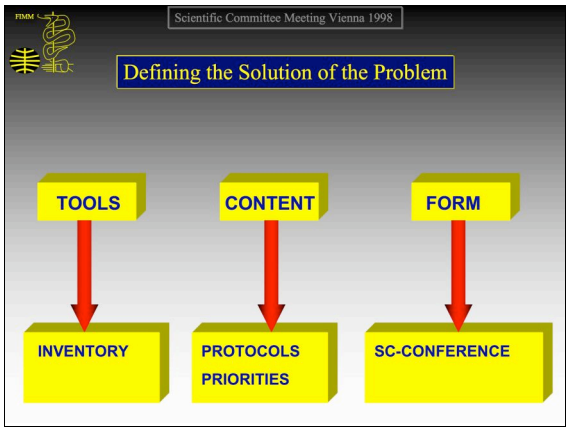


Fig. 87



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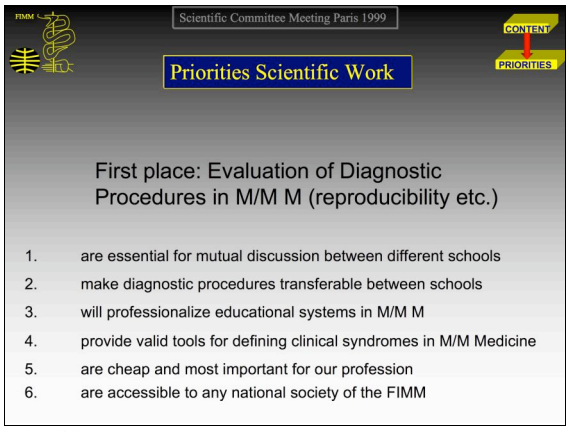

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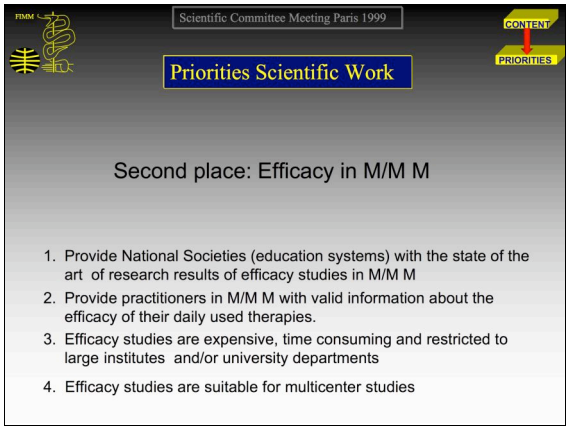

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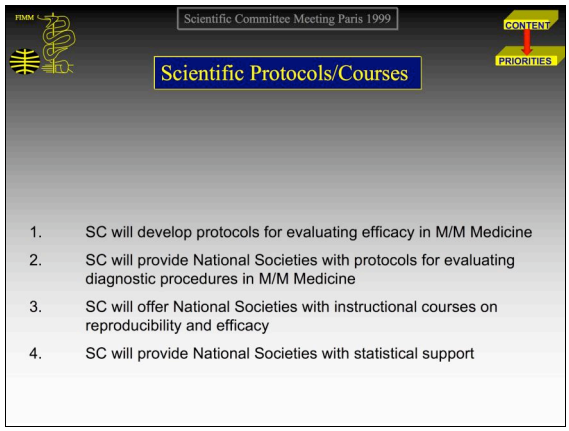

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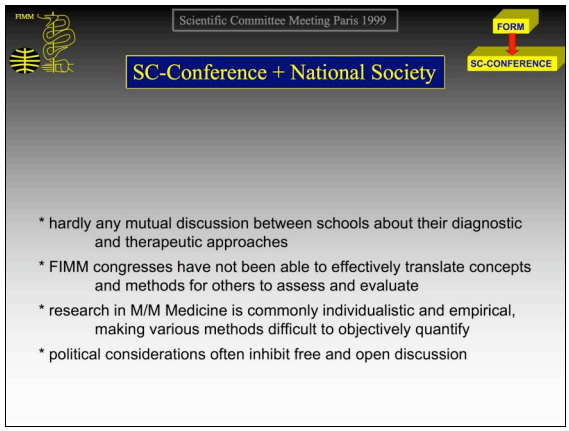


Fig. 92

Fig. 93

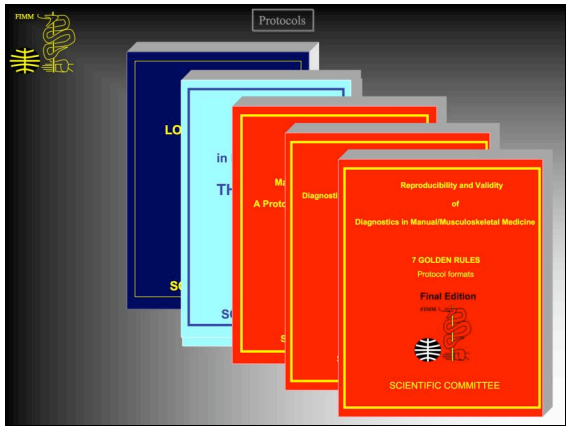
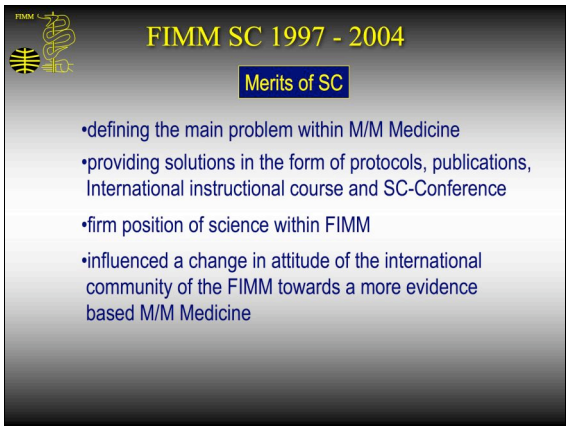


Fig. 94

Fig. 95

Fig. 96



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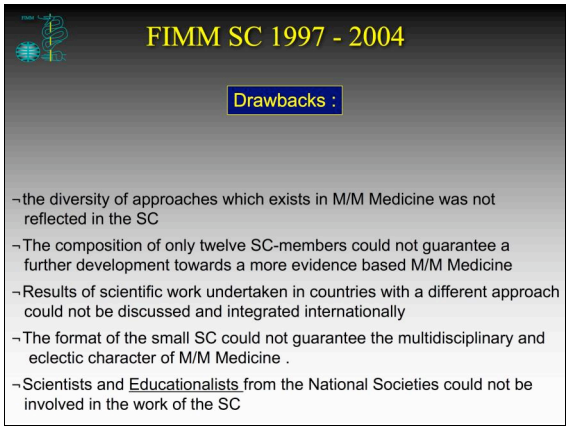

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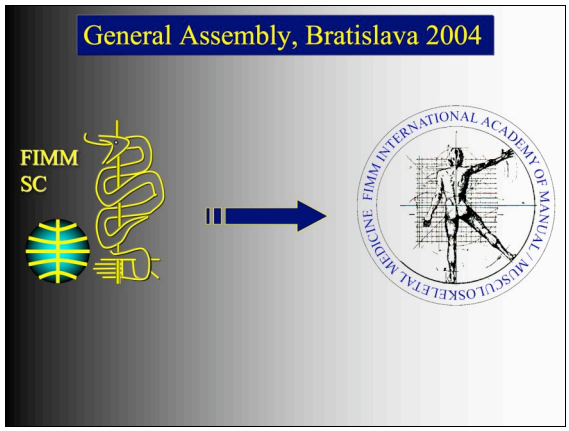

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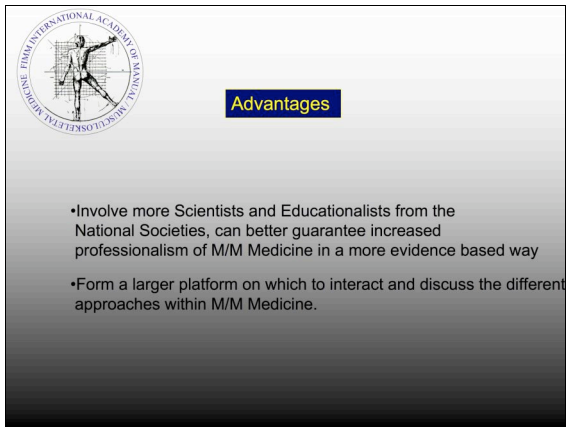

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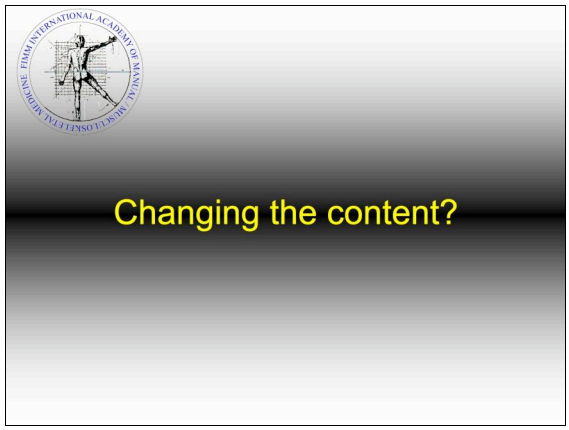

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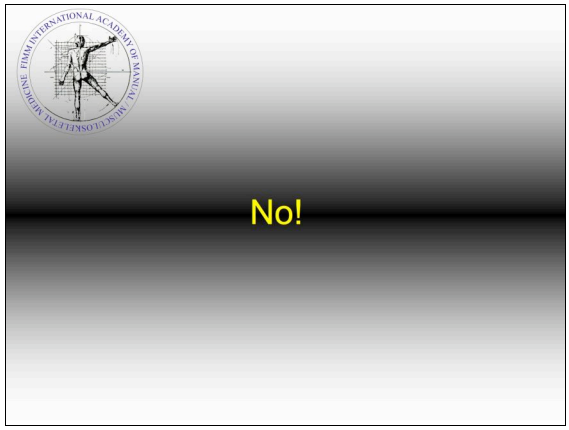

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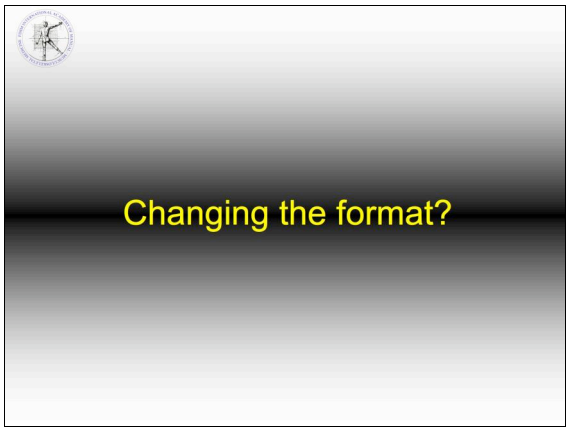
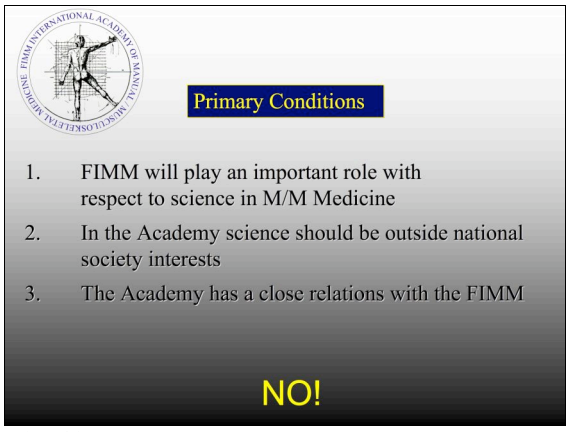


Fig. 103

Fig. 104



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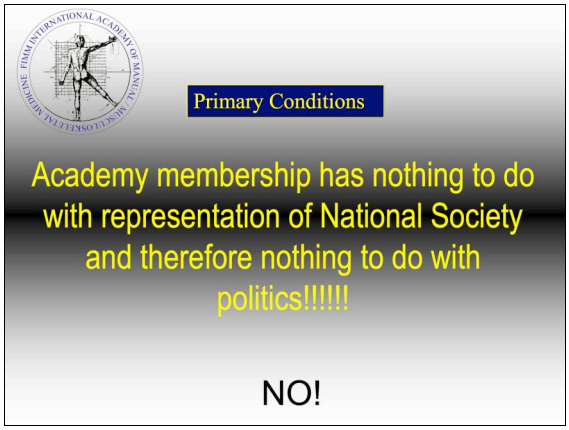
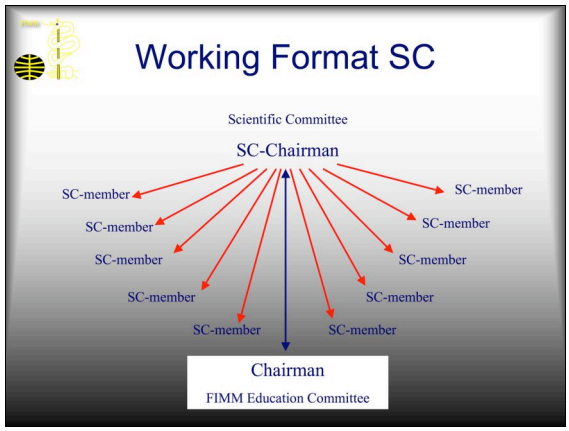


Fig. 106

Fig. 107



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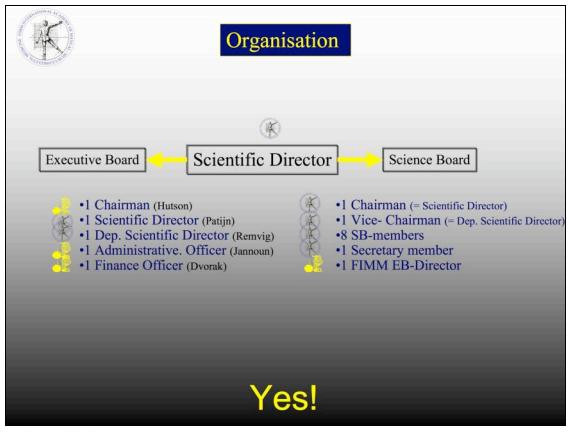
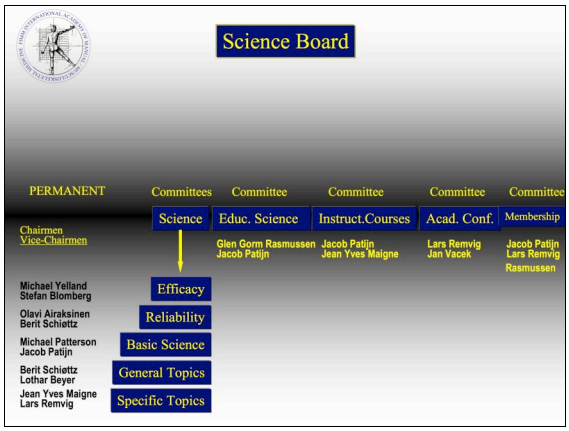


Fig. 109

Fig. 110



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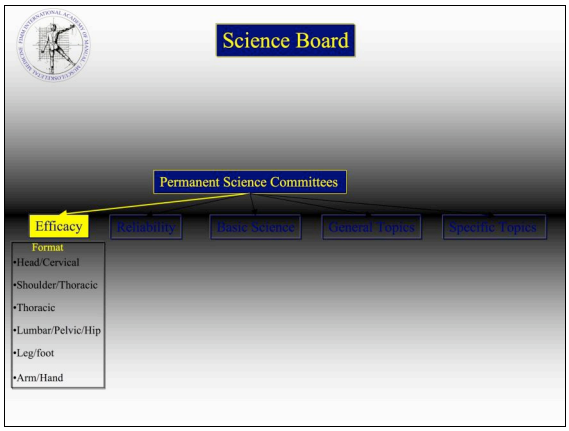

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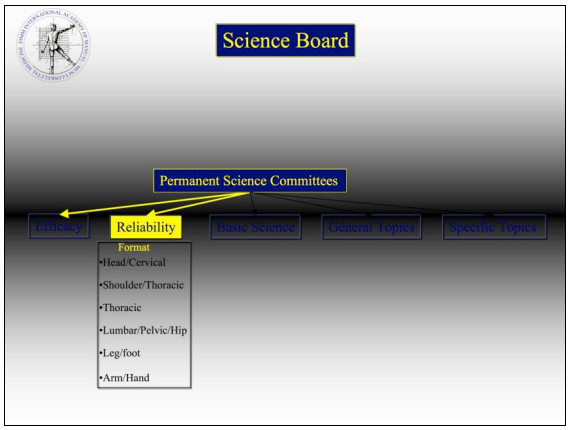

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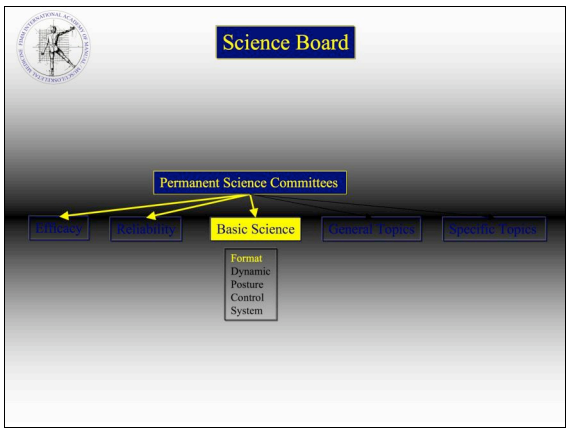

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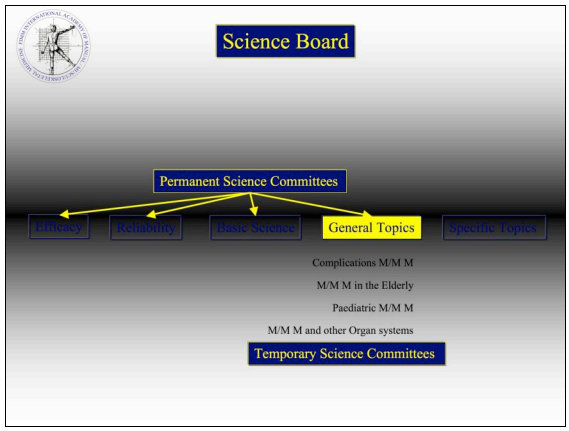

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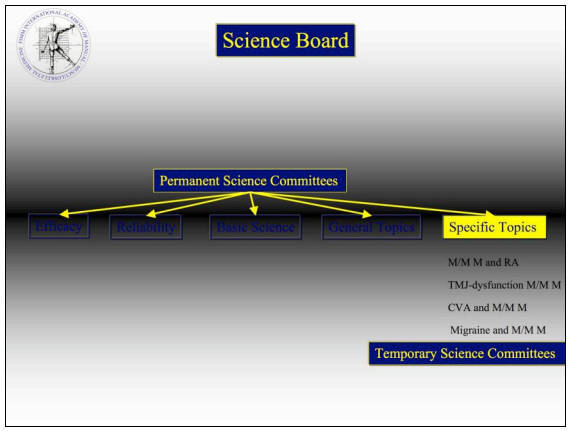

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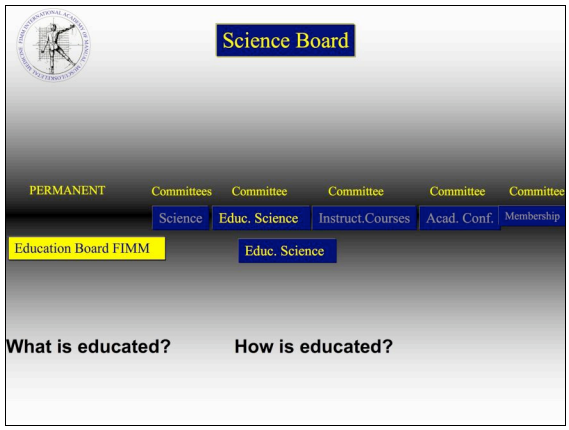

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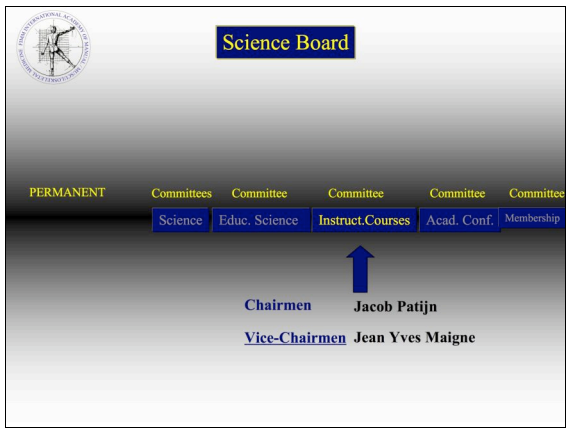
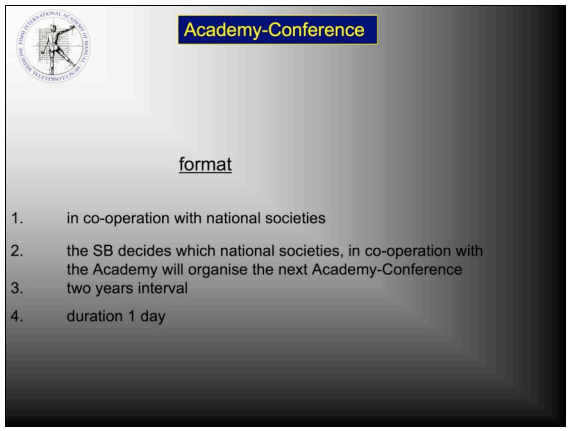


Fig. 118

Fig. 119



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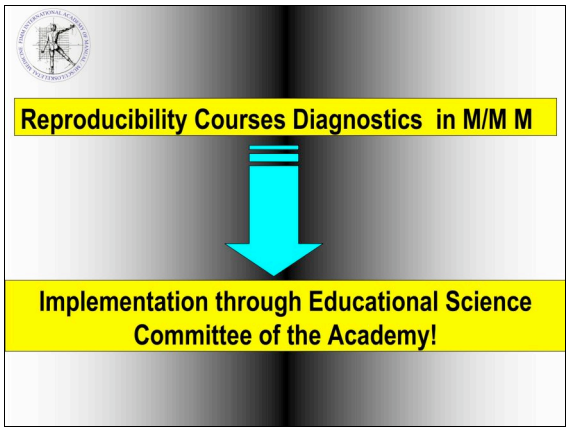

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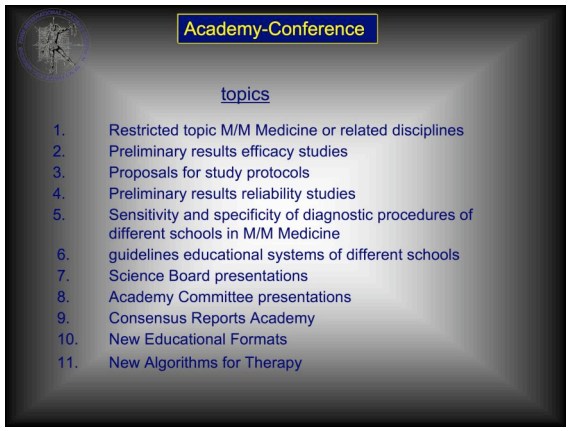

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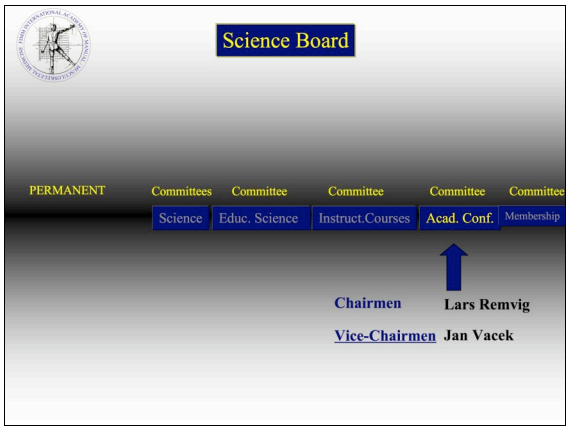
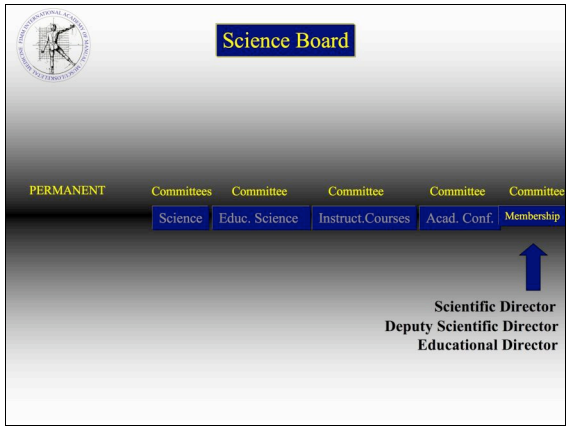


Fig. 121

Fig. 125

Fig. 122



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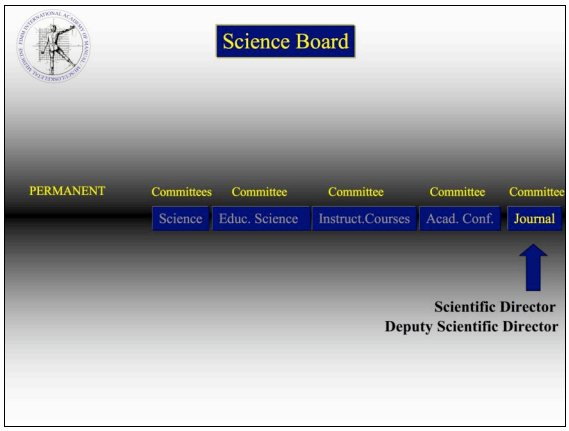
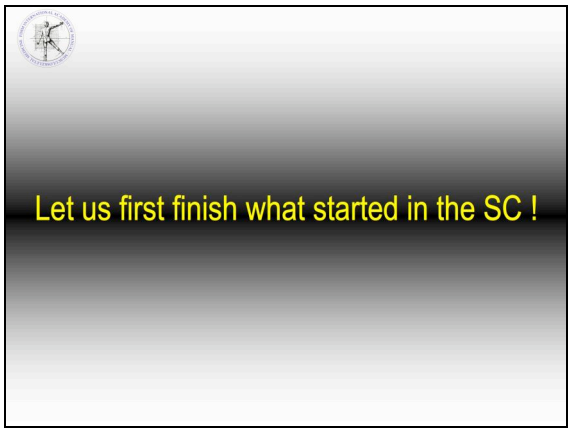


Fig. 127

Fig. 128



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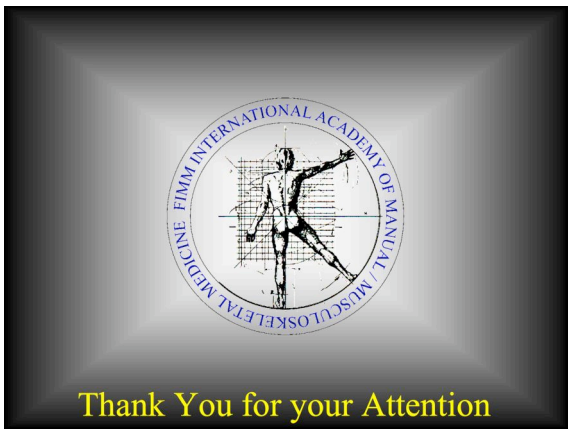

Fig. 130

Thanks to the United Kingdom!

Dr. Roderic MacDonald
President of the British Institute of
Musculoskeletal Medicine BIMM
23 British Grove, Chiswick
LONDON W4 2 NL
UNITED KINGDOM

Baden, September 12, 2005 / BT

Dear Dr. MacDonald

On behalf by FIMM I would like to thank you and the British Institute of Musculoskeletal Medicine BIMM for the wonderful invitation to the General Assembly of FIMM held in London Gatwick on September 9, 2005.

It was a marvellous event with an excellent local organiser. The social programme and the gala dinner were of high class.

Thank you very much.

Best wishes and regards

Dr. Bernard Terrier
President FIMM

Assemblée générale de la FIMM 2006

The General Assembly of FIMM 2006

Die Generalversammlung der FIMM 2005

Moscou (Russie)
Moscow (Russian Federation)
Moskau (Russland)

Invitation par la Ligue russe des professionnels en médecine manuelle

By Invitation of the Russian League of Professionals in Manual Medicine

Einladung durch die Russische Liga der Berufsleute in Manueller Medizin

Moscow (Russian Federation) Hotel Mir ****
9 Bolshoy Devyatinsky Pereulok,
36 Novy Arbat Street
RUSSIAN FEDERATION
Tel: +7 (095) 290 95 18
Fax +7 (095) 252 01 40
hotelmir@dol.ru
http://www.otelmir.ru/english/

Visa
All delegates and their partners need a visa.
Please ask for support before April 18, 2006.

Hotel room reservations
Please make your hotel room reservations by Fax +7 (495) 434 31 01
or email snn00@list.ru (Sergei Nikonov).

Transportation
For cheapest possible transportation please contact:
FIS Travelservice, Blocherstrasse 2
CH-3653 Oberhofen, Switzerland
phone: +41 (0)33 244 14 14
fax: +41 (0)33 244 14 40
ris@fisski.ch
contact: Mrs. Caroline Ris.

Agenda

1. Opening by the President
2. Presentation of the Russian League of Professionals in Manual Medicine
3. Presentation of the representatives of the national societies (limited to 4 minutes per presentation)
4. Matters arising from the minutes of the last General Assembly (London Gatwick – United Kingdom)
5. Report from the President
6. Report from the Secretary General
7. Report from the Treasurer
8. Report from the Auditors
9. Election of Auditors
10. Report from the Chairman of the Policy Committee: FIMM Policy 2010.
11. Matters concerning the FIMM structure and strategy
    (Establishing the Executive Board [EB], the Education Board [EduB] and the Health Policy Board [HPB])
12. Changes of the FIMM Statutes according to decisions taken during agenda point 11
13. Report from the Chairman of the Education Committee
14. Report from the FIMM International Academy of Manual/Musculoskeletal Medicine
15. Report from the FIMM Foundation
16. Admission of new members
17. Elections
    - 17.a Election of the FIMM Executive Board (Executive Committee)
    - 17.b Other electoral and conformation procedures
18. Information on the next FIMM Congress 2007
19. Date and place for the General Assembly 2007
20. Any other Business
21. Closing of the General Assembly by the past President

L'ordre du jour

1. *Ouverture par le Président*
2. *Présentation par la Ligue russe des professionnels en médecine manuelle*
3. *Présentation des délégations des Associations Nationales (limitée à 4 minutes par présentation)*
4. *Remarques sur le procès-verbal de la dernière Assemblée générale (London Gatwick – Royaume-Uni)*
5. *Rapport du Président*
6. *Rapport du Secrétaire Général*
7. *Rapport du Trésorier*
8. *Rapports des Commissaires aux comptes*
9. *Nomination des Commissaires aux comptes*
10. *Rapport du Président du Policy Committee: la FIMM, sa mission, 2010.*
11. *La stratégie et la structure de la FIMM*
    (l'établissement du Executive Board [EB]*, du* Education Board [EduB] *et du* Health Policy Board [HPB]*)*
12. *Changement des Statuts de la FIMM selon les décisions prises pendant le point 11 de l'ordre du jour*
13. *Rapport du Président du Education Committee*
14. *Rapport de l'Académie International de Médecine Manuelle de la FIMM*
15. *Rapport de la Fondation de la FIMM*
16. *Admission de nouveaux membres*
17. *Élections*
    - *17.a Élections du Comité de Direction de la FIMM*
    - *17.b Autres procédures électorales et confirmations*
18. *Information concernant le Congrès de la FIMM en 2007*
19. *Date et place de la prochaine Assemblée générale en 2007*
20. *Divers*
21. *Conclusion de l'Assemblée générale par l'ancien Président*

Tagesordnung

1. Eröffnung durch den Präsidenten
2. Präsentation durch die Russische Liga der Berufsleute in Manueller Medizin
3. Vorstellung der Delegierten der nationalen Gesellschaften (maximal 4 Min. pro Präsentation)
4. Punkte aus dem Protokoll der letzten Generalversammlung (London Gatwick – Vereinigtes Königreich)
5. Bericht des Präsidenten
6. Bericht des Generalsekretärs
7. Bericht des Schatzmeisters
8. Bericht der Kassenprüfer
9. Wahl der Kassenprüfer
10. Bericht des Vorsitzenden des Policy Committee: Das FIMM Leitbild 2010.
11. Die Strategie und Struktur der FIMM
    (Die Einführung des Executive Board [EB], des Education Board [EduB] und des Health Policy Board [HPB])
12. Änderungen der Statuten gemäß den Beschlüssen unter dem Tagesordnungspunkt 11
13. Bericht des Vorsitzenden des Education Committee
14. Bericht der Internationalen FIMM Akademie für Manuelle Medizin
15. Bericht der FIMM Stiftung
16. Aufnahme neuer Mitglieder
17. Wahlen
    17.a Wahl des FIMM Executive Board (Executive Committee)
    17.b Andere Wahl- und Bestätigungsprozeduren
18. Informationen zum FIMM Kongress 2007
19. Datum und Ort der Generalversammlung 2007
20. Varia
21. Schluss der Generalversammlung durch den Past Präsidenten

Programme Programme Programm

Mardi 16 mai 2006
Tuesday, May 16, 2006
Dienstag, den 16. Mai 2006

Arrivée des membres du Comité exécutif
Arrival of Members of the Executive Committee
Ankunft der Mitglieder des Exekutivkomitees

Mercredi 17 mai 2006
Wednesday, May 17, 2006
Mittwoch, den 17. Mai 2006

09.00-18.00 *Réunion du Comité exécutif*
Executive Committee meeting
Tagungen des Exekutivkomitees

Arrivée des délégués
Arrival of the delegates
Ankunft der Delegierten

19.30 *Dîner russe «de bienvenu»*
*sont invités les délégués et les membres du comité exécutif **
Russian Welcome Dinner
Invited are FIMM delegates and executives *
Russisches Welcome Dinner
Für FIMM Delegierte und Mitglieder des Exekutivkomitees *

Jeudi 18 mai 2006
Thursday, Mai 18, 2006
Donnerstag, den 18. Mai 2006

09.00-16.00 *Assemblée générale de la FIMM 2006*
FIMM General Assembly 2006
Generalversammlung der FIMM 2006

20.00 *Dîner de la FIMM **
FIMM Dinner *
FIMM Dinner *

Vendredi 19 mai 2006
Friday, May 19, 2006
Freitag, den 19. Mai 2006

Départ des délégués
Departure of delegates
Abreise der Delegierten

Congrès international sur «Réflexothérapie et Médecine Manuelle au XXI^{ème} siècle» le 19-20 mai 2006 à Moscou

International Congress «Reflexotherapy and Manual Medicine in the XXI. Century», Moscow, May 19-21, 2006

Internationaler Kongress «Reflexotherapie und Manuelle Medizin im XXI. Jahrhundert» Moskau 19.-21.Mai 2006

** Par membre deux représentants sont invités au Dîner russe «de bienvenu». Les représentants supplémentaires et les compagnons et les compagnes sont bienvenus à leurs propres frais. Dîner de la FIMM à vos propres frais.*
* To the Russian Welcome Dinner two delegates per FIMM member are invited. Additional representatives and partners are welcome at their own cost. FIMM Dinner at own cost.
* Zum Russischen Welcome Dinner sind pro FIMM Mitglied zwei Delegierte eingeladen. Zusätzliche Delegierte und persönliche Partner sind willkommen (eigener Kostenbeitrag). FIMM Dinner mit eigenem Kostenbeitrag.

Fédération Internationale de Médecine Manuelle
International Federation for Manual/Musculoskeletal Medicine
Internationale Gesellschaft für Manuelle Medizin
Международная Федерация Мануальной Медицины

CH-5400 Baden • Kurplatz 1 • Switzerland • Phone: ++41 56 203 95 55 • Fax: ++41 56 221 71 91

Assemblée générale 2006 – General Assembly 2006 – Generalversammlung 2006
Inscription – Registration – Anmeldung

À retourner s.v.p.: **Please return to:** **Bitte senden an:**	**Fax No. : 007 495 434 31 01** **E-Mail : snn00@list.ru**

Prière aux délégués de la FIMM de s'inscrire par http://www.fimm-online.org ou par fax ou Email.
FIMM delegates please register by going to http://www.fimm-online.org or by fax or E-mail.
FIMM Delegierte registrieren sich bitte über http://www.fimm-online.org oder per Fax oder Email.

Faites votre réservation de LOGEMENT directement par téléfax +7 (495) 434 31 01 ou email snn00@list.ru (M. Sergei Nikonov) s.v.p.
Please make your HOTEL ROOM reservations by fax +7 (495) 434 31 01 or email snn00@list.ru (Sergei Nikonov).
Bitte reservieren Sie Ihre HOTEL ZIMMER direkt Fax +7 (495) 434 31 01 oder Email snn00@list.ru (Sergei Nikonov).

Salutation – Salutation – Anrede:	
Titre – Titel – Titel	
Prénom – Firstname – Vorname	
Nom – Name – Name	
Société – Society – Gesellschaft	
Adresse – Address – Adresse	
Code postale – Zip Code – Postleitzahl	
Ville – City – Stadt	
Pays – Country – Land	
Téléfon – Telephone – Telefon	
Téléfax – Fax – Fax	
Portable – Mobile – Mobil	
E-mail – E-Mail – E-Mail	
FIMM: Fontionaire – Staff – Funktionär	❒ non - no - nein ❒ oui - yes - ja
Russian Welcome Dinner: 17 / 05 / 2006*	❒ no ❒ 1 pers. ❒ 2 pers. ❒ 3 pers.
FIMM Dinner: 18 / 05 / 2006*	❒ no ❒ 1 pers. ❒ 2 pers. ❒ 3 pers.
Remarque – Remark – Anmerkung	

** Par membre deux représentants sont invités au Dîner russe «de bienvenu». Les représentants supplémentaires et les compagnons et les compagnes sont bienvenus à leurs propres frais. Dîner de la FIMM à vos propres frais.*
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CH-5400 Baden • Kurplatz 1 • Switzerland • Phone: ++41 56 203 95 55 • Fax: ++41 56 221 71 91

General Assembly 2006

May 17 - 18, 2006, Hotel Mir, Moscow (Russian Federation)

Visa support procedure

Step 1: Ask for visa support using the form on the FIMM website. Send the first page of your valid passport to fax no. +7 (495) 434 31 01.

Step 2: The local organizer in Moscow will prepare support documents.

Step 3: The Russian Embassy or Consulate in your region will receive support documents from the local organizer in Moscow.

Step 4: By fax you will receive confirmation documents from the local organizer in Moscow.

Step 5: Apply for visa at the Russian Embassy or Consulate in your region using the confirmation documents.

FIMM visa service 2006

Assemblée générale 2006

Le 17 - 18 mai 2006, Hôtel Mir, Moscou (Russie)

Assistance pour obtenir le visa

- **1er pas:** Demandez l'assistance en remplissant le formulaire au-dessous. Envoyez la première page de votre passeport valide au no.de téléfax +7 (495) 434 31 01.
- **2iem pas:** L'organisateur local à Moscou va préparer les documents d'assistance pour obtenir le visa.
- **3iem pas:** L'ambassade ou le consulat russe situé dans votre région va recevoir les documents d'assistance envoyés par l'organisateur local à Moscou.
- **4iem pas: Par téléfax**, vous allez recevoir les documents de confirmation pour obtenir le visa par l'organisateur local à Moscou.
- **5iem pas:** Demandez votre visa à l'ambassade ou le consulat russe situé dans votre région en présentant les documents de confirmation.

FIMM visa service 2006

Generalversammlung 2006

17. – 18. Mai 2006, Hotel Mir, Moskau (Russland)

Ablauf der Visum Unterstützung

Schritt 1: Beantragen Sie die Visum Unterstützung mit dem nachfolgenden Formular. Senden Sie die erste Seite Ihres gültigen Passes an die Fax Nr. +7 (495) 434 31 01.

Schritt 2: Der lokale Organisator in Moskau wir die Unterstützungsdokumente vorbereiten.

Schritt 3: Das Russische Konsulat bzw. die Russische Botschaft in Ihrer Region erhält die Unterstützungsdokumente durch den lokalen Organisator in Moskau.

Schritt 4: Per Fax werden Sie die Bestätigungsdokumente durch den lokalen Organisator in Moskau erhalten.

Schritt 5: Beantragen Sie mit den Bestätigungsdokumenten beim Russischen Konsulat bzw. bei der Russischen Botschaft Ihrer Region ein Visum für Russland.

FIMM visa service 2006

Fédération Internationale de Médecine Manuelle
International Federation for Manual/Musculoskeletal Medicine
Internationale Gesellschaft für Manuelle Medizin
Международная Федерация Мануальной Медицины

CH-5400 Baden • Kurplatz 1 • Switzerland • Phone: ++41 56 203 95 55 • Fax: ++41 56 221 71 91

Assemblée générale 2006 – General Assembly 2006 – Generalversammlung 2006
Assistance pour obtenir le visa – Visa support – Visa Unterstützung

À retourner s.v.p.: **Please return to:** **Bitte senden an:**	**Fax No. : 007 495 434 31 01** **E-Mail : snn00@list.ru**

Tous les délégués et leurs compagnons et compagnes ont besoin d'un visa. Demandez l'assistance avant le 18 avril 2006 s.v.p..
All delegates and their partners need a visa. Please ask for support before April 18, 2006.
Alle Delegierten und ihre Begleiter benötigen ein Visum. Bitte beantragen Sie die Visum Unterstützung vor dem 18. April 2006.

Prière d'envoyer la première page de votre passeport valide à M. Sergei Nikonov, no. de téléfax +7 (495) 434 31 01.
Please send the first page of your valid passport to Sergei Nikonov, fax no. +7 (495) 434 31 01.
Senden Sie bitte die erste Seite Ihres gültigen Reisepasses an Sergei Nikonov, Fax Nr. +7 (495) 434 31 01.

Salutation – Salutation – Anrede:	
Prénom – Firstname – Vorname	
Nom – Name – Name	
Date de naissance – Birth Date – Geburtsdatum	
Adresse – Address – Adresse	
Ville – City – Stadt	
Pays – Country – Land	
Téléfon – Telephone – Telefon	
Téléfax – Fax – Fax	
E-mail – E-Mail – E-Mail	
Date d'expiration du passport: Passport date of expiry: – Reisepass gültig bis:	
Date d'arrivé – Arrival date – Ankunftsdatum	
Date de départ – Departure date – Abreisedatum	
Visa pour combien de jour? Visa for how many days? – Visum für wiev. Tage?	
Ambassade ou consulat: Embassy or Consulate: – Botschaft od. Konsulat:	ville: city: – Ort:
Remarque – Remark – Bemerkung	

✔ Je confirme que j'ai envoyé la première page de mon passeport valable au no. de téléfax +7 (495) 434 31 01.
I sent the first page of my valid passport to fax no. +7 (495) 434 31 01.
Ich habe die erste Seite meines gültigen Reisepasses an die Fax Nr. +7 (495) 434 31 01 gesandt.

✔ Pour mon compagnon ou ma compagne j'envoie une demande séparée.
I will send a separate request for my partner.
Ich sende für meine Begleitperson einen separaten Antrag.

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Международная Федерация Мануальной Медицины

CH-5400 Baden • Kurplatz 1 • Switzerland • Phone: ++41 56 203 95 55 • Fax: ++41 56 221 71 91

Assemblée générale 2006 – General Assembly 2006 – Generalversammlung 2006
Programme social – Cultural programme – Gesellschaftliches Programm
Inscription – Registration – Anmeldung

À retourner s.v.p.: **Please return to:** **Bitte senden an:**	**Fax No. : 007 495 434 31 01** **E-Mail : snn00@list.ru**

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Titre – Title – Titel	
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Code postal – ZIP code – Postleitzahl	
Ville – City – Stadt	
Pays – Country – Land	
Téléfon – Telephone – Telefon	
Téléfax – Fax – Fax	
Mobile – Mobile – Mobiltelefon	
E-mail – E-Mail – E-Mail	

May 19 - 21, 2006	❑ Guided tour of Moscow ❑ The State Armoury and the Diamond Fund ❑ The Bolshoy Theatre ❑ Excursion to Kolomna ❑ Excursion to Star City	❑ The Kremlin ❑ The State Tretyakov Gallery ❑ The Arbat street and Moscow Metro ❑ Night Moscow ❑ Excursion to Kuskovo
May 21, 2006	❑ Friendly dinner Party (50 € per Person)	
May 22 - 24, 2006	❑ Guided tour of St. Petersburg ❑ Tsarkoe selo – Peterhgof (Petrodvorets) ❑ «The golden Ring of Russia» ❑ The town of Vladimir ❑ Lunch in historic place – the Nikolayevski Palace	❑ The Hermitag ❑ The Marinski Theatre ❑ The Town of Sergiev Posad ❑ The town of Suzdal ❑ Excursion on the rivers and canals of St. Petersburg ❑ Night St. Petersburg – Belye Nochi («White Nights»)
How many persons?		


Académie Internationale pour
la Médicine Manuelle/
Musculo-articulaire de la FIMM
DEMANDE D'ADHÉSION
L'Académie de la FIMM, créée en septembre 2004 lors de l'Assemblée Générale de la FIMM (La Fédération Internationale de la Médecine Manuelle / musculo-articulaire), remplace l'ancien Comité Scientifique de la FIMM dont la composition était limitée à douze membres. L'Académie inclura un nombre bien supérieur de scientifiques et d'éducateurs qui s'engageront au moyen de groupes de travail et de corps dédiés dans des débats consensuels sur des sujets tels que la recherche de base, l'efficacité, les procédures de diagnostic, les complications dans la médecine M/M et l'enseignement international. L'Académie sera pluridisciplinaire et fournira un forum lors des conférences de l'Académie pour la présentation de résultats préliminaires du travail scientifique en matière de médecine manuelle/musculo-articulaire et de propositions pour la mise en oeuvre de la science par l'enseignement. Les domaines relevant de la science et de l'éducation sont sous la responsabilité du Conseil Scientifique (présidé par le Directeur Scientifique, Dr. Jacob Patijn). Les futurs membres seront élus démocratiquement par les membres de l'Académie. Les statuts d'association de l'Académie sont disponibles sur le site web de la FIMM : www.fimm-online.org. L'administration de l'Académie repose dans les mains du Conseil Exécutif (Président, Michael Hutson).
L'adhésion est ouverte à tout praticien médical individuel actif dans le domaine de la médecine manuelle / musculo-articulaire et aux diplômés universitaires dont le cabinet est associé à la médecine manuelle / musculo-articulaire. Toute demande est bienvenue et devra être soutenue par un parrain et un second et par un curriculum vitae qui démontre une expérience dans le domaine de la recherche scientifique et/ou de l'enseignement.
La souscription annuelle actuelle est de € 100. Les formulaires de demande peuvent être téléchargés depuis le site web de la FIMM, ou en alternative en contactant le responsable administratif de l'Académie, le Dr. Usamah Jannoun. Les formulaires de demande remplis accompagnés d'un CV doivent être renvoyés au Dr. Jannoun à l'adresse suivante:
1 New England Cottages, Handcross Road, Balcombe, West Sussex. RH17 6JU, Angleterre, Royaume-Uni ou par courriel à: orthmed@doctors.org.uk
Dr. J. Patijn (Directeur scientifique) Dr. M. Hutson (Président du Conseil Exécutif),
Dr. U. Jannoun (Responsable Administratif), Dr. V. Dvorak (Responsable financier).

FIMM Internationale Akademie für Manuelle Medizin

ANTRAG AUF MITGLIEDSCHAFT

Die FIMM Akademie, die im September 2004 auf der Generalversammlung der FIMM (Internationale Gesellschaft für Manuelle Medizin) eingerichtet wurde, ersetzt das frühere Wissenschaftliche Komitee der FIMM. Während das Wissenschaftliche Komitee auf zwölf Mitglieder beschränkt war, wird die Akademie eine wesentlich größere Anzahl von Wissenschaftlern und Ausbildern umfassen. Diese werden sich in Projekt- und Arbeitsgruppen an der Konsensfindung für Themen wie Grundlagenforschung, Wirksamkeit, diagnostische Prozeduren und Komplikationen der Manuellen Medizin beteiligen und sich darüber hinaus für die internationale Lehre und Ausbildung engagieren. Die Akademie wird interdisziplinär arbeiten. Auf Akademie-Konferenzen bietet sie ein Forum für die Präsentation vorläufiger Forschungsergebnisse aus dem Bereich der Manuellen Medizin und für Vorschläge zur Umsetzung wissenschaftlicher Erkenntnisse in der Ausbildung. Die Belange von Wissenschaft und Ausbildung liegen in der Verantwortung des Wissenschaftlichen Beirates (unter Vorsitz des Wissenschaftlichen Direktors Jacob Patijn), dessen zukünftige Mitglieder von den Mitgliedern der Akademie demokratisch gewählt werden. Die Statuten der Akademie finden sich auf der FIMM-Website www.fimm-online.org. Die Verwaltung der Akademie liegt in den Händen des Vorstandes (Vorsitzender: Michael Hutson).

Die Mitgliedschaft ist offen für Mediziner, die auf dem Gebiet der Manuellen Medizin praktizieren, und für Universitätsabsolventen, deren Arbeit mit der Manuellen Medizin im Zusammenhang steht. Anträge sind willkommen; sie sollten von einem vorschlagenden und einem befürwortenden Bürgen unterstützt werden, sowie auch durch einen Lebenslauf, aus dem Erfahrungen in Forschung und/oder Lehre hervorgehen.

Gegenwärtig beträgt der jährliche Mitgliedsbeitrag € 100. Antragsformulare können Sie von der FIMM-Website herunterladen. Alternativ erhalten Sie sie über den Generalsekretär der Akademie, Dr. Usamah Jannoun. Senden Sie den ausgefüllten Antrag zusammen mit ihrem Lebenslauf an Dr. Jannoun unter der postalischen Anschrift:

1 New England Cottages, Handcross Road, Balcombe, West Sussex, RH17 6JU, England, U.K. oder per eMail an: orthmed@doctors.org.uk!

Dr. J. Patijn (Wissenschaftlicher Direktor); Dr. M. Hutson (Vorsitzender des Vorstandes),
Dr. U. Jannoun (Generalsekretär), Dr. V. Dvorak (Schatzmeister).

FIMM Academia Internacional de Medicina Manual/ Músculo-Esquelética

SOLICITUD DE ADMISIÓN

La Academia FIMM, fundada en septiembre de 2004 por la Asamblea General de FIMM (Federación Internacional de Medicina Manual/Músculo-Esquelética), sustituye el antiguo Comité Científico FIMM, que estuvo limitado a doce miembros. La Academia se conformará por un número mucho mayor de científicos y pedagogos que, a través de equipos de investigación y grupos de trabajo coincidirán en el debate consensuado sobre asuntos como la investigación básica, eficacia, procedimientos de diagnóstico, complicaciones en la Medicina M/M y enseñanza internacional. La Academia será multidisciplinar y constituirá un foro a través de la Conferencia de la Academia para la presentación de resultados preliminares de trabajos científicos sobre Medicina Manual/Músculo-Esquelética y las propuestas para la implementación de la ciencia a través de la enseñanza. Los asuntos científicos y pedagógicos serán responsabilidad de la Comisión Científica (presidida por el Director Científico Jacob Patijn), cuyos miembros futuros serán elegidos democráticamente por los miembros de la Academia. Los estatutos de la Academia están disponibles en el sitio Web de la FIMM, www.fimm-online.org. La administración de la Academia está en manos de una Comisión Ejecutiva (Presidente, Michael Hutson).

Pueden ser miembros los practicantes médicos individuales en el campo de la Medicina Manual/Músculo-Esquelética y los graduados universitarios cuya actividad esté relacionada con la Medicina Manual/Músculo-Esquelética. Se admiten solicitudes que deberán ir apoyadas por un proponente y un secundante y por un curriculum vitae que avale la experiencia en investigación científica y/o la enseñanza.

La cuota anual de suscripción es de € 100. Los impresos de solicitud pueden descargarse del sitio Web de la FIMM o bien poniéndose en contacto con el encargado de administración de la Academia, Dr. Usamah Jannoun. Las solicitudes cumplimentadas serán enviadas al Dr. Jannoun, acompañadas por un CV:

1 New England Cottages, Handcross Road, Balcombe, West Sussex. RH17 6JU, England, UK o por correo electrónico a: orthmed@doctors.org.uk

Dr. J. Patijn (Director Científico) Dr. M. Hutson (Presidente Comisión Ejecutiva),
Dr. U. Jannoun (Oficial Administrativo), Dr. V. Dvorak (Oficial Financiero).

Международная академия мануальной скелетно-мышечной медицины МФМСМ (FIMM)

ЗАЯВЛЕНИЯ О ПРИЕМЕ В ЧЛЕНЫ

Академия МФМСМ, основанная в сентябре 2004 г. на Генеральной ассамблее МФМСМ (Международная федерация мануальной скелетно-мышечной медицины), заменяет существовавший ранее Научный комитет МФМСМ, ограничивавшийся двенадцатью членами. В состав Академии будет входить гораздо большее число ученых и педагогов-теоретиков, которые будут в составе специальных комиссий и рабочих групп заниматься обсуждением таких тем, как фундаментальные исследования, эффективность, диагностические процедуры, осложнения в мануальной скелетно-мышечной медицине и международное обучение. Академия будет заниматься большим количеством дисциплин и выступать в роли форума на конференциях Академии для представления предварительных результатов научной работы в области мануальной скелетно-мышечной медицины и предложений по внедрению научных результатов путем обучения.
Научные и образовательные вопросы входят в компетенцию Научного совета (под председательством Директора по науке Джейкоба Патижна (Jacob Patijn)), будущих членов которого будут выбирать демократично члены Академии. Устав Академии можно найти на веб-сайте МФМСМ: www.fimm-online.org. Управление Академией осуществляет Исполнительный комитет (Председатель Майкл Хатсон (Michael Hutson)).

Членами Академии могут стать частные врачи, практикующие в области мануальной/ скелетно-мышечной медицины, и выпускники университетов, практика которых связана а мануальной/ скелетно-мышечной медициной.
Заявления на вступление в члены приветствуются, и должны поддерживаться лицом, предлагающим новую кандидатуру, и лицом, выступающим за принятие этой кандидатуры, а также резюме, демонстрирующим опыт в области научных исследований и/ или преподавательской деятельности.

На данный момент ежегодный членский взнос составляет 100 евро. Форму заявления можно загрузить а веб-сайта МФМСМ, либо обратившись к сотруднику администрации Академии д-ке Усаме Джаннуну (Dr. Usamah Jannoun). Заполненные формы а приложением резюме следует отослать д-ке Джаннуну по адресу:

Нью-Ингланд Коттаджес 1, Хэндкросс-роуд, Болкомб, Уэст-Сассекс, RH17 6JU Англия, Соединенное Королевство (1 New England Cottages, Handcross Road, Balcombe, West Sussex, RH17 6JU England, UK) или по электронной почте: orthmed@doctors.org.uk.

Д-ж Дж. Патижн (Директор еМнауке), д-ж М. Хатсон (Председатель Исполнительного комитета, д-ж У. Джаннун (сотрудник администрации), д-ж В. Дворак (Dr. V. Dvorak) (фининспектор).