



UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES EUROPEAN UNION OF MEDICAL SPECIALISTS

Association internationale sans but lucratif International non-profit organisation

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Training Requirements for the Additional Competence Manual Medicine for European Medical Specialists

European Standards of Postgraduate Medical Training

Preamble

The UEMS is a non-governmental organisation representing national associations of medical specialists at the European Level. With a current membership of 37 national associations and operating through 43 Specialist Sections and European Boards, the UEMS is committed to promote the free movement of medical specialists across Europe while ensuring the highest level of training that will pave the way to the improvement of quality of care for the benefit of all European citizens. The UEMS areas of expertise notably encompass Continuing Medical Education, Post Graduate Training and Quality Assurance.

It is the UEMS' conviction that the quality of medical care and expertise is directly linked to the quality of training provided to the medical professionals. Therefore, the UEMS committed itself to contribute to the improvement of medical training at the European level through the development of European Standards in the different medical disciplines. No matter where doctors are trained, they should have at least the same core competencies.

In 1994, the UEMS adopted its Charter on Post Graduate Training aiming at providing the recommendations at the European level for good medical training. Made up of six chapters, this Charter set the basis for the European approach in the field of Post Graduate Training. With five chapters being common to all specialties, this Charter provided a sixth chapter, known as "Chapter 6", now substituted by the European Requirements, which each Specialist Section was to complete according to the specific needs of their discipline. Regarding Manual Medicine, it is neither a speciality nor a sub-speciality, but consist of additional competence that can be provided by many existing EU specialists (orthopaedic and trauma surgeons, PRM physicians, neurologists, ENT-specialists, rheumatologists and others that are related to the locomotor system). Manual medicine is a typical multidisciplinary competence. Within the regulations of the Bologna process, it is defined as a "Dipoloma of Advanced Studies" (DAS) according to a minimum of 30 ECTS postgraduate Training.

More than 20 years after the introduction of this Charter, the UEMS Specialist Sections, European Boards, and Multidisciplinary Committees (MJC) have continued working on developing these

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European Standards in Medical training that reflects modern medical practice and current scientific findings. In doing so, the UEMS Specialist Sections, European Boards and MJs did not aimed to supersede the National Authorities' competence in defining the content of postgraduate training in their own State but rather to complement these and ensure that high quality training is provided across Europe.

At the European level, the European Union established the legal mechanism ensuring the free movement of doctors through the recognition of their qualifications back in the 1970s. Sectorial Directives were adopted and one Directive addressed specifically the issue of medical Training at the European level. However, in 2005, the European Commission proposed to the European Parliament and Council to have a unique legal framework for the recognition of the Professional Qualifications to facilitate and improve the mobility of all workers throughout Europe. This Directive 2005/36/EC established the mechanism of automatic mutual recognition of qualifications for medical doctors according to training requirements within all Member States; this is based on the length of training in the Specialty and the title of qualification.

Given the long-standing experience of UEMS Specialist Sections and European Boards on the one hand and the European legal framework enabling Medical Specialists and Trainees to move from one country to another on the other hand, the UEMS is uniquely in position to provide specialty-based recommendations. The UEMS values professional competence as *“the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served”*¹. While national law in EU Member States regulates professional activity, it is the UEMS understanding that it has to comply with International treaties and UN declarations on Human Rights as well as the WMA International Code of Medical Ethics.

This document provides definitions of specialist competencies and procedures as well as how to document and assess them. For the sake of transparency and coherence, it is named as “Training Requirements for the additional competence in Manual Medicine for an EU Specialist”. This document aims to provide the basic Training Requirements for this additional MM-competence and should be regularly updated by the UEMS MJC ‘Manual Medicine’ to reflect scientific and medical progress. The three-part structure of this documents reflects the UEMS approach to have a coherent pragmatic document not only for medical specialists but also for decision-makers at the National and European level interested in knowing more about medical specialist and additional competence training.

Definitions of Manual Medicine :

Manual Medicine is the discipline of advanced knowledge and skills in the diagnosis, therapy and prevention of (often-painful) functional disorders of the locomotor system.

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

¹ Defining and Assessing Professional Competence, Dr Ronald M. Epstein and Dr Edward M. Houndert, Journal of American Medical Association, January 9, 2002, Vol 287 No 2

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Therapeutic skills add manual/manipulative techniques to conventional treatments. These techniques introduce, as proven by results of recent neurophysiological research, a substantial change in nociception and nocireaction together with stimulation of pain inhibitory systems.

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

Diagnostics in manual medicine is based on EU specialist's skills in biomechanics, anatomy, neurophysiology, and psychosocial analysis and is usually done in the ambulatory care setting. The history, examination findings, and investigations are all considered in order to generate a working diagnosis. The EU specialist with additional MM competence then discusses and decides with the patient the therapeutic regime, which includes pharmacological prescription and/or manual therapy as well as rehabilitation prescription and advice. The EU specialist with additional MM competence therefore represents an appropriately trained EU specialist with a broad skill set otherwise only available through a multidisciplinary approach.

As dysfunction in the locomotor system most commonly includes pain, there is a perfect indication for manual medicine as an early intervention, thus avoiding the long and sometimes endless path of chronic pain and invalidity.

In the EU, regulations for specialists who practice manual medicine vary considerably from country to country. In many European countries, manual medicine has been legally recognized with additional competence for EU specialists ("DAS" according to the Bologna process). This may include examination, registration and licensing by the government, a university or a Chamber of physicians. In these countries, the profession is regulated and the stipulated educational qualifications are generally consistent, satisfying the requirements of the respectively accrediting agencies. In some EU countries, manual medicine is not recognized formally or practiced. These countries have not yet developed MM-education or established laws to regulate qualified practice of manual medicine.

The UEMS-MJC Manual Medicine (together with the ESSOMM – European Scientific Society for Manual Medicine) has delineated what the MJC believes to be the minimum educational requirements EU specialists need to achieve as additional competence in order to provide MM safely.

I. TRAINING REQUIREMENTS FOR TRAINEES

1. Content of training and learning outcome

Competencies required of the trainee

Before entering training of Manual Medicine (MM), the trainee should be, as a qualified physician, in a training program for an EU specialty or have accomplished a specialty training of a recognized EU medical specialty.

MM would be an additional competence and that requires successful accomplishment of a training in a specialty recognized in the EU and the MM curriculum. MM trainees would typically be specialists or trainees in orthopaedic surgery, neurology, rheumatology, rehabilitation and all other specialties related to the locomotor system.

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The underlying principle as regards this document is that it promotes high standards of care for patient's conditions related to Manual Medicine throughout the European Union and sets the basic requirements in the domains listed above to enable specialists/consultants with additional MM competence to move across European country borders for professional purposes.

Patients conditions related to MM concern especially reversible (i.e. non-structural) painful dysfunctions of intervertebral and peripheral joints as well as of the related soft tissues (i.e. muscle, fascia, and tendon). More precisely, besides many more the following conditions are included:

- So-called non-specific acute and chronic low back pain, including dysfunction of the lumbar spine as well as of the pelvic girdle (i.e. sacroiliac joints and symphysis), see: German National Guidelines for Low Back Pain.
- Chronic pain disease with vertebral components based also on dysfunction
- Acute and chronic disorders and degenerative disease of the cervical spine
- Cervicogenic headache, cervicogenic dizziness, cervicogenic tinnitus
- Dysfunctional thoracic spine disorders, including autonomous reactions of heart, lung and abdominal viscera
- Painful posttraumatic and degenerative disorders of peripheral joints with dysfunctional components

a. Theoretical knowledge and skills

The required knowledge base is determined by basic sciences underpinning the understanding of the dysfunctional clinical conditions that can be diagnosed and treated with the methods of MM.

The basic sciences include

- Anatomy and biology of the different components of the locomotor system
- Biomechanics of the locomotor system including nerves, fascia and soft tissues
- Physiology and pathophysiology of the different components of the locomotor system and their interactions (i.e. with viscera, autonomous nervous system etc.)
- Neurophysiology and biology of pain mechanisms and the biopsychosocial implications

Clinical knowledge and clinical diagnostic skills include

- Conventional as well as specific history taking and clinical examination of the patient
- Palpatory manual and functional examination of the different components of the locomotor system, including segmental irritation examination and pain provocations
- Recording of the clinical evaluation relevant to specific findings in terms of manual medicine

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List of conditions

Disorders or dysfunctions of axial and appendicular structures (bones, joints, connective tissues: muscles, fascia, tendons and nerves):

- Cranium
- Cranio-cervical junction
- Cervical spine
- Cervico-thoracic junction
- Thoracic spine
- Thoraco-lumbar junction
- Lumbar spine
- Lumbosacral junction
- Sacro-iliac joints, pelvic girdle
- Peripheral joints of upper and lower limbs

Visceral organ dysfunction related to biomechanical disorders

Viscero-somatic, somato-visceral, psychosomatic and somato-somatic reflexes

Understanding of the differential diagnosis, relevance and interrelationship to Manual Medicine of the following conditions:

- General neurological semiology
- Neurological disorders, in particular peripheral neuropathies, headache disorders and vestibular/cochlear disorders
- Orthopaedic disorders
- Rheumatologic disorders
- Spinal affections
- Vascular abnormalities
- Paediatric orthopaedic, neurologic and rehabilitational disorders
- Trauma of the spine
- Tumours of the spine and extremities

These conditions define the basis of the core curriculum. By the time, an individual has accomplished the MM curriculum he/she should be able to have:

- Knowledge and understanding of the relevant basis of the medical sciences, population health sciences, pathophysiology and principles of management and care of patients with any of the core clinical conditions
- The ability to know the indication and interpretation of diagnostic tests relevant to MM: laboratory tests, diagnostic imaging techniques, test performance characteristics and especially manual tests like tissue palpation and the tests for mobility, segmental irritation and pain provocation
- An understanding of the modes of action and potential adverse effects of manual medicine therapeutic procedures and experience in advising patients about the risks and benefits of such therapeutic procedures

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- Ability to analyse research and implement recent developments in MM so that their clinical practice is based on best available evidence
- Be able to provide evidence that they are maintaining their general medical as well as their manual medicine knowledge sufficient to ensure a high standard of clinical practice
- An understanding of the healthcare system(s) within their country of training
- Be prepared for their role as future clinical leaders
- Be able to be an effective member and a leader of a multidisciplinary team.

b. Practical and clinical skills

After accomplishing their training in MM, candidates should have the ability to be confident in the following practical procedures

- performing screening examination to identify problems in the locomotor system that deserves additional evaluation
- performing a general examination to identify which regions and tissues within the region are dysfunctional and of relevance at a level appropriate to the treatment skills
- conducting regional palpatory and functional examinations of the tissues of the locomotor system to identify dysfunctions
- conducting palpatory examinations of local tissues to determine the specific dysfunctions considered for manual treatment and the characteristics important in the selection of the treatment modality including indications and contraindications
- conducting different palpatory examinations in order to look at and record elements of segmental irritation, pain provocation, sensory changes, tissue texture changes, examination of range of motion and functional asymmetry, and characteristics of end-feel barrier
- documenting reproducibility and inter-examiner reliability of manual medicine diagnostic tests

c. Competences

To be appointed as a specialist/consultant with additional competence in MM, the medical specialist should show proof of a level of competence sufficient to allow independent clinical practice and be able to care for patients both in acute and chronic situations. The level of performance required may vary from country to country and from post to post. The above

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lists of competencies describe the minimal requirements expected from a “European medical specialist with additional MM competence”.

In addition to the knowledge and skills in practical procedures detailed above an applicant for a specialist post that requires additional MM competence should be able to show evidence of having been personally and continuously involved with the care of patients with as wide a range of common manual medicine problems as possible.

A European medical specialist/consultant with additional competence in MM should regularly inform him/herself in research principles: principles and methods of epidemiological research, principles of clinical research, evidence-based medicine, data analysis and medical informatics, imaging and laboratory techniques, ethics of clinical and basic research, and critical review, as far as MM is concerned.

A European medical specialist/consultant with additional competence in MM should be able to demonstrate ethical behaviour, in keeping with the requirements of their country’s medical registry/statutory body, and provide evidence to this effect. This physician with MM competence would be in good standing with their relevant National Registration Body.

2. Organisation of training

a. Schedule of training

For a “European medical specialist with additional MM competence”, a training including a total of at least 300 hours of contact teaching in theory (33%) and practice (67%) of core Manual Medicine training is recommended, representing at least 30 ECTS credit points (European Credit Transfer System). As manual medicine is an interdisciplinary additional competence, it is also recommended that training in Manual Medicine should initiate after (or at least be affiliated with) a training in an official postgraduate specialty recognized in the EU. Before the trainee may become competent to practice the Manual Medicine additional competence (neither a speciality nor a subspeciality), it is obligatory to finalize this specialty training. Details of these specialties are not part of the training requirements for the core manual medicine training.

As the time between the different courses in manual medicine is required for individual training and for autonomous learning in small groups at least for another 300 hours, the time for the additional competence training in Manual Medicine will normally last more than 18 months. The training should be finalized by a written and oral examination, leading also to a “Diploma of Advanced Studies” (DAS) as a precondition to be recognized as a “European medical specialist with additional MM competence”.

The training period in Manual Medicine will be in keeping with EU requirements and in any case sufficient to ensure that a trainee has met all the required educational and training needs. Specific arrangements for the overall training for any individual trainee would be decided locally and be influenced by relevant national requirements. The list of conditions

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shown above is a guide to the knowledge base required of a multidisciplinary additional competence.

For a trainee to be able to apply for a post in another EU country it would be necessary for there to be a published curriculum, which has been followed by both trainees and their trainers. The curriculum would contain details about the required nature and extent of clinical and practical experiences, the methods by which a trainee is supported in their development and how judgements are made about their progress as regards the development of their knowledge and understanding, the progression of their clinical work and their development as a professional.

b. Curriculum of training

The curriculum is focussed on outcomes but with sufficient flexibility to allow personal development distinguished by the needs of the individual, the centre in which they are training and the country where this is occurring. Training should include teaching skills for generic competences and MM additional competence.

Thus, the curriculum would be based on the following principles for a European specialist with additional MM competence:

- Be a multidisciplinary oriented specialist and a multi-system disease expert
- Be competent in history taking, physical examination, management and continuing care of patients with common and a number of other pathological conditions of the locomotor and functional connected systems (i.e. viscera)
- Communicate effectively with patients, their families and with professional collaborators
- Practise evidence-based care
- Practise cost-effective care
- Understand the nature of, and degree of risk taken in their clinical practice
- Maintain the quality of their practice by being aware of developments in the subject
- Undertake multi-disciplinary team (MDT) work
- Provide clinical leadership also ability to be led and work as part of a multi-disciplinary team
- Demonstrate a lifelong commitment to reflective learning
- Promote the health and well-being of individual patients, communities, and populations
- Teach and support trainees
- Be committed to the health and well-being of individuals and society through ethical practice, profession-led regulation and high standards of personal behaviour and clinical practice
- Have a portfolio of evidence that they have achieved the above goals; especially should they also wish to seek medical practice in a country different from the country in which they trained.

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Different countries will have different approaches to achieve these outcomes but the evidence that they have been achieved should be increasingly of a homogeneous nature that facilitates the learning and experiences of trainees, the engagement of clinical supervisors and ease of recognition of progress and achievements across EU member countries. In addition, such an approach will help provide surety to the public and to individual countries that the training has been of an appropriate standard and that the performance of physicians is likewise of a satisfactory standard.

c. Assessment and evaluation

Countries will use assessment strategies appropriate to their needs. Progressively, there will be a move to a common approach to determining whether an individual is suitable to be recognized as a 'European medical specialist with additional MM competence'. Thus, there will need to be an assessment of knowledge, which would be through a written examination.

This examination would sample from the list of core clinical conditions shown above and test knowledge in the areas of relevant science (basic medical and clinical sciences, population health sciences and behavioural sciences) and clinical practice (diagnosis, investigation and treatment). This testing will be in a 'best of five' format.

These tests would be delivered across Europe on a regular basis. There will be an assessment of knowledge (formative) after 120 hours (according to at least 10 ECTS credit points) of contact training and a second (summative) assessment towards the end of the period of training (i.e. after 30 ECTS credit points). Trainees will be able to retake the summative assessment should they fail it initially.

(Such cognitive testing does not easily allow an exploration of an individual's behaviour in complex and multidisciplinary clinical situations. Situational Judgement Tests would allow such determinations and in due course, these will be introduced, initially in a formative manner.)

Trainees will get support at a number of levels. A trainer will supervise a trainee's laboratory practical work. The trainer will be responsible for providing the trainee with regular feedback as regards their performance and guidance in matters related to the clinical practical procedures that they are delivering. In addition, a Programme Director will lead in an institution (or in a group or network of allied institutions) all training programmes in manual medicine. A trainee will meet with their Programme Director or Course Director on a regular basis, which typically would be at the end of every course, to discuss their work. Such discussions will take the format of an appraisal with the trainee providing information about how they are progressing, accompanied by documented evidence of clinical engagement and achievement of their learning and training outcomes. The purpose of the appraisal is to enable a constructive discussion about how the learning needs of the trainee should be met. Subsequent appraisals will revisit earlier appraisals to determine progress in achieving these needs. The appraisals are not part of any summative assessment process but are designed entirely to support the trainees.

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Assessment of skills in practical procedures will be in the training establishment. Such assessments may include, where appropriate, the use of simulation prior to an assessment in clinical practice.

Clinical experience will be assessed under supervision in the final course of the training by a review of the patients seen by a trainee and for whom the trainee has had a personal responsibility as regards care. Evidence of such engagement will be maintained in a clinical logbook or equivalent. The trainee's trainer together with the trainee will review the logbook in a formative manner. The local Programme or Course Director together with relevant trainers of the attended courses will review the logbook in a summative manner, separately.

Professional behaviours would be part of the assessment strategy too and typically, a 360-degree multi-source feedback (MSF) would occur at the end of the first 120 hours of training and at the start of the final course of training. Such assessments may occur more frequently in some countries. The Programme or Course Director would be central to the discussion and reflection undertaken after each MSF and provide guidance and support in response to comments made by those providing the MSF to a trainee. Additional MSFs would occur if the initial MSF demonstrated a less than adequate performance by the trainee. Local national standards as regards an individual's suitability for clinical practice would determine whether a trainee was competent as a medical specialist with additional MM competence.

In order to be eligible to apply for a post in a country other than that in which one has been trained or to be recognized as a 'European specialist with additional MM competence' all aspects of the above assessment approaches will need to be completed satisfactorily.

d. Governance

The governance of an individual's training programme will be the responsibility of the Programme or Course Director and the institution(s) in which the training programme is being delivered. A trainer will be responsible to the Programme Director for delivering the required training in their area of practice.

II. TRAINING REQUIREMENTS FOR TRAINERS

1. Process for recognition as trainer

a. Requested qualification and experience

A trainer would be a registered medical specialist recognized in the EU and registered too having additional MM competence on a DAS level within his or her own country. They will have satisfied any relevant national requirements as regards accreditation/appraisal/training to be a trainer. A Programme (or Course) Director would be someone who has been/is a trainer and who has considerable knowledge and experience of training doctors.

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Trainers and Programme resp. Course Directors must be in active clinical practice and engaged in training in the training centre or network. Their appointments would be for two years in the first instance. In some countries, their work would be reviewed within the training centre or network on a regular basis at staff appraisals (or equivalent) but in any case, it would be a requirement that their training activities are reviewed every second year of their appointment. Subject to mutual agreement, their position may be continued for a further two years and so on. It would be unlikely for a Programme Director to hold this position for more than five two-year appointments. This would enable a turnover and refreshment of appointees.

Recognition across the EU as regards competence to be a trainer despite practitioners coming from different countries and Directive 2005/36 / EC (Paragraph C2/20) may cover having different routes and extents of training.

b. Core competencies for trainers

A trainer will be:

1. Familiar with all aspects of the overall manual medicine curriculum as it relates to practice within their country
2. Experienced in teaching and in supporting learners
3. Skilled in identifying the learning needs of their trainees and in guiding the trainees to achieve their educational and clinical goals
4. Able to recognize trainees whose professional behaviours are unsatisfactory and initiate supportive measures as needed
5. Trained in the principles and practice of medical education

2. Quality management for trainers

It is presumed that trainers and Programme resp. Course Directors will have their job description agreed with their employer (university, governmental or government-approved organization) which will allow them sufficient time for support of trainees and in the case of Programme Directors, sufficient time for their work with trainers.

It would be unusual for a trainer to have more than 14 trainees in a course. The number of trainees would determine the amount of time each day that would be allocated to their individual support.

Trainers and Course Directors will collaborate with trainees, the Programme Director and their Institution to ensure that the delivery of training is optimal. Feedback from trainees will assist in this regard.

The educational work of trainers and Programme Directors will be appraised typically on no less than an annual basis within their Department/Institution as local circumstances determines.

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Educational support of trainers and Programme Directors will be provided by their Department and Institution and through the Multidisciplinary Joint Committee (MJC) for Manual Medicine of UEMS.

III. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

1. Process for recognition as training centre

a. Requirement on staff and clinical activities

A 'Training Centre' is a place or number of places where trainees are able to develop their manual medicine competence in courses. Such provision may include sites that are condition specific and thus not offer a wide clinical experience such as that provided by a large centre.

Thus, manual medicine training may take place in a single institution or in a network of institutions working together, to provide training in the full spectrum of clinical conditions and skills detailed in the curriculum. This should include a hospital or institution that provides academic activity and is recognized for training in rehabilitation or orthopaedics. Each participating institution in a network must be individually recognized as a provider of a defined section of the curriculum.

A European medical specialist with additional competence in Manual Medicine will lead and manage the training of a trainee. This specialist with additional MM competence will be also active in the practice of clinical manual medicine with personal responsibility for the management of patients with a wide range of locomotor system conditions. Whilst the trainer will not manage patients with all the diagnoses listed above he/she will be able to ensure, by working with the Programme Director and other local trainers that the clinical experience of the trainee will prepare them for clinical work as a multidisciplinary medical specialist with competence in MM. The preparation for being such a multidisciplinary specialist in one country may be different from that needed if the trainee wishes to practice in another country as a medical specialist with additional MM competence.

It is essential that as part of their training trainees will be responsible for caring for patients. This may need the involvement of multiple training sites. The trainee should be involved in the management of new patients, and follow up of patients.

A trainee must have progressively increasing personal responsibility for the care of patients with locomotor system conditions and retain their general medical skills to be able to identify patients who present to a manual treatment but whose underlying clinical problems are not a reversible dysfunction of the locomotor system.

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The staff of a training centre will engage collaboratively in regular reviews of the centre's clinical activity and performance. There will be regular multi-disciplinary meetings to determine optimal care for patients and such meetings will involve both medical and other healthcare staff. There will be clinical engagement with specialities such as rehabilitation medicine, orthopaedic surgery, rheumatology, paediatrics, oral medicine in dental practice, and internal medicine.

Within a manual medicine training centre, there should be a wide range of practical techniques presented so that a trainee will be able to attend all common manual medicine problems.

Specialist staff appointed to a training centre will have completed all training requirements themselves and will have additional training in teaching and mentoring trainee staff. Specialists already in post will undertake training, if they have not already completed this, to enable them to support trainees optimally. Such training and maintenance of skills and knowledge in this area will be part of their job-plan and subject to appraisal (see above).

It would be unacceptable for a trainee to have only one trainer during their entire training period. It would be more usual for a trainee to have a number of named trainers with whom they work in the different courses. Each trainer would cover different aspects of a trainee's clinical training but this individual will not be the only person who will provide educational support for a trainee. (See above for comments about the Programme Director and his/her role). It would be expected that the Trainers or Course Directors in a training centre(s) represent a wide range of manual medicine expertise and that such individuals demonstrate that they remain up to date with their clinical practice, knowledge and educational skills.

There is no specific trainee/trainer ratio required but it would be unusual for there to be less than two teachers in a training centre and for a trainer to have more than fourteen trainees attached to one course at the time. If a trainee moves between a number of centres for their training it is recommended that whenever possible although their trainers may change, their Programme Director should remain the same. Programme Directors may also be trainers.

It is not a requirement that a training centre is also an academic centre but it is desirable that a training centre would have strong academic links and contribute to research and an aspiration so that all training centres will become also involved in the future.

It would be expected that a training centre as described in this document would have been recognized/accredited by the relevant national authority as being suitable for training European medical specialist with additional MM competence. Confirmation of such status of training centres will be by National Representatives to the MJC and Board.

When a manual medicine centre wishes to be recognized as a training centre, they will submit a report to the UEMS MJC of Manual Medicine through their National Representative(s). This will demonstrate that all the necessary educational and training provisions are available in a sustained manner. Subsequently, on a biennial basis a training centre will provide a brief report on its activities to the MJC, again through their National

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Representative(s). This will demonstrate the maintenance of the education and training provision and allow examples of good practice to be disseminated.

b. Requirement on equipment

A training centre would have sufficient equipment to enable the clinical practice expected of a training centre and thus provide the necessary educational opportunities for trainees.

Computing and Information Technology and library resources must be available.

All trainees must engage in clinical audit and have the opportunity to engage in research.

2. Quality Management within Training institutions

Accreditation

Training centers are recognized within their own country as being suitable for being such. It would be expected that training centers would be subject to regular review within their country and this would include data relating to the progress of trainees and their acquisition of specialist accreditation.

Clinical Governance

Almost certainly, training centers will undertake internal audits of their performance as part of the requirements for continuing national recognition/accreditation. It is anticipated that any national evaluation of a training center's performance will also include the demonstration that it is:

- Providing diagnostic and therapeutic procedures and techniques for patients with a wide range of pathologic conditions of the locomotor system
- Providing educational and training support for trainees and others
- Part of a healthcare system that provides immediate access to relevant radiological and other investigations as well as providing when necessary immediate access to other clinical specialties that may be required by their patients.

The National Representative(s) will make the outcomes of such national evaluations available to the MJC and Board.

Training centres should keep records of the progress of their trainees, including any matters relating to Fitness to Practise or other aspects that might affect a trainee's registration with the relevant national body. The Programme Director has specific responsibilities in this regard (see above).

Transparency of training programmes

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It would be expected that a training centre would publish details of the training provision available with details of the clinical service it provides and the trainers. Such information would include the training programme, the nature of the clinical experiences with which a trainee would be engaged and the support and interaction with the trainer and Programme Director. There would be a named individual whom a prospective trainee might contact and discuss the programme.

Structure for coordination of training

There should be a national (or equivalent) programme for training leading to recognition as a European medical specialist with additional MM competence within that country.

The job plans of trainers and of Programme Directors should include sufficient time for them to fulfil their educational and training responsibilities.

Training centres will be recognized and approved by the relevant national authorities.

To assist a European medical specialist with additional MM competence moving from one EU country to another it would be expected that they have satisfactorily completed a training programme. After the examination in manual medicine they may be able to demonstrate that he/she has the required knowledge, clinical skills and competences as well as having demonstrated appropriate professional behaviours. Such accomplishments would be verified both by relevant documents and by comments made by referees.