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1 **Is keep/refer decision making an integral part of national guidelines for the**
2 **physiotherapy profession within Europe? A review.**

3

4 **Abstract**

5 Background: Keep/refer decision as the ability to independently determine whether a patient's
6 condition is suitable for physiotherapy management (keep) or not (refer), is regarded as an
7 core element in the World Confederation of Physical Therapists' (WCPT) Guideline for
8 Standards of Physical Therapy Practice. However, it is currently unknown how individual
9 European countries have implemented this in their national guidelines.

10 Objectives: To determine if keep/refer decision making abilities are an integral part of
11 national guidelines for the physiotherapy profession of member countries of the European
12 Network of Physiotherapy in Higher Education (ENPHE).

13 Data Sources: A review was performed including medical databases, the grey literature and
14 personal correspondence with professional ENPHE member associations. To gain the
15 information of interest, all eligible documents were reviewed.

16 Results: 11 national guidelines for the physiotherapy profession could be obtained. Two
17 additional member associations use European guidelines as their national ones. Despite the
18 fact that in the WCPT guidelines keep/refer decision making abilities are clearly described as
19 a core element, there exists huge inconsistency as to how various European (with direct and
20 non direct access systems) countries have included them in their national guidelines.

21 Conclusion: Despite the fact that most ENPHE member countries deem a close collaboration
22 between health care professionals important and that physiotherapists should know the

23 limitation of their expertise, keep/refer decision making abilities as explicitly stated in the
24 WCPT guidelines were not included in the majority of guidelines that were reviewed.

25

26 **Keywords:** *Keep/refer decision making ability, physiotherapy, national competency*
27 *guidelines.*

28

29 **Introduction**

30 Patients can consult a physiotherapist in two ways: In a direct access system, patients can
31 refer themselves to physiotherapeutic services without the need for prior examination by a
32 medical professional. On the other hand, in a non direct access system, patients can consult a
33 physiotherapist only after having seen a medical professional [1]. While proponents of a
34 direct access system argue with the benefit of an overall reduction of health care costs [1,2],
35 opponents fear that physiotherapists might fail to recognise various significant (sometimes life
36 threatening) medical pathologies with possible negative consequences for the patient's health
37 [3]. However, independent from how patients have access to physiotherapy, the
38 physiotherapist is required to independently examine the patient and make a decision on,
39 whether or not the patient is suitable for physiotherapeutic management [4]. Despite the low
40 prevalence of serious conditions affecting the neuro-musculoskeletal system [5], existing
41 literature provides strong evidence that physiotherapists are capable of contributing to
42 patient's safety by recognizing the presence of a wide range of systemic diseases and various
43 pathologies which require (further) medical management [2, 3, 6] Goodman and Snyder [7]
44 give sensible reasons, why all physiotherapists should be capable of making an independent
45 and proper keep/refer decision:

- 46 “1) Clients may obtain a signed prescription for physical therapy based on similar past
47 complaints of musculoskeletal symptoms without direct physician contact.
- 48 2) Medical specialization: Medical specialists may fail to recognize underlying systemic
49 disease.
- 50 3) Disease progression: Early signs and symptoms are difficult to recognize, or symptoms
51 may not be present at the time of medical examination.
- 52 4) Patient/client disclosure: Client discloses information previously unknown or undisclosed
53 to the physician.
- 54 5) Client does not report symptoms or concerns to the physician because of forgetfulness,
55 fear, or embarrassment.”

56 In a recent review, Boissonnault and Ross [6] extracted 78 published case reports and case
57 series from the literature where multiple screening strategies performed by physiotherapists
58 and subsequent referral for further medical evaluation finally led to the diagnosis of a wide
59 range of different pathologies (such as metastatic cancer, infection, spinal fracture, various
60 visceral diseases) as underlying cause(s) of the patients’ complaints. Of those 78 cases, 58
61 patients (74,4 %) were examined by a medical professional before they were sent for
62 physiotherapeutic management. Only a small proportion of patients consulted a
63 physiotherapist without prior consultation of a medical professional [6]. This review
64 highlights that the ability to autonomously decide (using proper screening strategies) whether
65 a patient’s condition is suitable for physiotherapeutic intervention (keep), or not (refer) is not
66 solely important for physiotherapists who work in a direct access system, but for all
67 physiotherapists [6].

68 With good reason, the WCPT Guidelines for Standards of Physical Therapy Practice [8] state
69 that “where the examination, diagnostic process, or any change in status reveals findings
70 outside the scope of knowledge, experience, and/or expertise of the physiotherapist, the
71 patient/client shall be so informed and referred to the appropriate professional“ [8].
72 Furthermore, the European Core Standards of Physiotherapy Practice [9] clearly demand that
73 every physiotherapist should be capable of carrying out “a risk assessment prior to each
74 treatment for every patient“ [9]; and a close collaboration with other health professionals is
75 desirable in order to provide effective patient management [9]. In this context, the European
76 Core Standards of Physiotherapy Practice [9] directly refer to the WCPT Declaration of
77 Principle [10] where it says that “ when the diagnosis is not clear or the required
78 intervention/treatment is beyond the capacity of the physical therapist, the physical therapist
79 shall inform the patient/client and provide assistance to facilitate a referral to other qualified
80 persons. Furthermore, the physical therapist will consult with the referring medical
81 practitioner if the treatment programme or a continuation of the programme are not in accord
82 with the judgement of the physical therapist“. In addition, it is explicitly suggested that all
83 member organisations should try to fulfill all aspects described in the standards in order to
84 provide the physiotherapist with the knowledge necessary as “part of their professional
85 responsibility” [8].

86 Despite the fact that the professional guidelines published by the WCPT [8, 10] and its
87 European branch [9] clearly deem keep/refer decision making abilities to be important, it is
88 not clear whether this is also reflected in individual national guidelines for the physiotherapy
89 profession of various European countries that are also member associations of the European
90 Network of Physiotherapy in Higher Education (ENPHE).

91 Therefore, a review was conducted in order to analyse if and in how far keep/refer decision
92 making abilities are an integral part of all professional physiotherapy guidelines of ENPHE
93 member associations. In addition, it was considered to be important if European countries
94 with a direct access system to physiotherapy are more likely to have keep/refer decision
95 making abilities included in their guidelines than European countries with a non direct access
96 system where patients require a referral by a medical professional.

97 **Methods**

98 Search

99 In order to collect national guidelines of ENPHE member countries, medical databases
100 (Medline, Web of Science, CINHAL, Proquest and EMBASE) were initially searched using
101 the terms “national guidelines“, “standards of practice“, “competency guidelines“ or
102 “professional profile“. These terms were used in combination with either physiotherapy or
103 physical therapy together with the country of interest. Furthermore, the grey literature (via
104 Google, YAHOO and BING) was also searched using the same search terms. At the same
105 time, 25 national physiotherapy associations of ENPHE member countries were contacted
106 (via e-mail) [11] several times between 23/12/15 and 19/02/16 with a formal request to send
107 us their national guidelines (preferably an English language version if one existed). If
108 ,however, no English or German version was available, Google translater was used to
109 translate the documents into English. An email to the European branch of the WCPT (ER-
110 WCPT) was sent to request if there existed a definitive European collection of the
111 professional guidelines of all the individual European countries.

112 Eligibility criteria

113 For our review, we targeted documents which serve as national guidelines for the
114 physiotherapy profession of all 29 ENPHE member countries.

115 **Results of the search**

116 Analysis of the documents

117 A summary of the relevant passages of the individual documents can be found in *Table 1*. We
118 looked for text passages that describe the physiotherapists' professional obligation to make an
119 accurate and independent decision to either keep or refer a patient to a medical professional.
120 If, however, keep/refer decision making abilities were not explicitly mentioned, we also
121 looked for text passages that demanded close collaboration with the referring medical/other
122 health care professionals and/or feedback in the case of any unusual events that might occur
123 during the examination and/or develop during the course of the therapy. In order to see
124 whether a country has a direct or non direct access system to physiotherapy service, we used
125 the information provided on the official homepage of the WCPT.

126 Results of the literature search and return rate of personal correspondence

127 No national guidelines for the physiotherapy profession were found in the medical databases.
128 The grey literature was therefore searched and the national guidelines from the United
129 Kingdom (UK) [12], Ireland [13], the Netherlands [14] and Austria [15, 16, 17] were found.
130 Subsequently, an email was sent to the remaining 25 physiotherapy associations from ENPHE
131 member countries and to the official email address as listed on the ER-WCPT website and
132 answers were received from Belgium [18], Denmark [19], Germany [20], Italy [21], Lithuania
133 [22], Norway [23], Switzerland [24], Slovenia [9], Malta, Sweden and the Czech Republic
134 [25]. Sweden and Malta ,however, responded that they (currently) do not have national
135 guidelines for the physiotherapy profession. Slovenia directly translated the ER-WCPT

136 guidelines [9] into Slovenian and sent us the English version. The Czech Republic uses the
137 European Physiotherapy Service Standards [25] and sent us the English document. The
138 Norwegian physiotherapy association informed us that they do not have any professional
139 guidelines. Instead, they sent us the ‘ Framework for the Norwegian Physiotherapy Education
140 [23]‘ which we reviewed and included into our analysis. The national guidelines from
141 Switzerland [24] refer to the ‘Berufsordnung des Schweizer Physiotherapie Verbandes‘ [26]
142 and its ethical guidelines for additional information. We therefore searched the grey literature
143 and found the document which was subsequently included into our analysis. Unfortunately,
144 we did not receive a response from the remaining 14 ENPHE member associations (Bulgaria,
145 Croatia, Estonia, Finland, France, Greece, Iceland, Latvia, Lebanon, Montenegro, Poland,
146 Portugal, Spain and Turkey). In addition, we did not receive a reply to our formal request to
147 the ER-WCPT.

148 Translation of the documents

149 Belgium, Italy, Denmark and Norway do not have an English version of their guidelines. We
150 therefore translated the documents using Google Translator. The national guidelines from
151 Austria, Germany and Switzerland needed no translation since the lead author is from Austria
152 and fluent in German.

153 Results of individual guidelines

154 The results in *Table 1* reveal that even among those countries that generally mention
155 keep/refer decision making abilities in their national guidelines (Denmark, Belgium, the
156 Netherlands, UK, Italy, Ireland), there is no clear consensus where the patient needs to be
157 referred to or who should be consulted. Denmark, Belgium, the Netherlands, the United
158 Kingdom and Italy use the more general term ‘health care professional/provider‘ to where the

159 patient shall be referred, whereas Germany and Switzerland (even though these two countries
160 do not explicitly mention the keep/refer decision making process) require their
161 physiotherapists to contact the referring medical professional. Ireland very clearly
162 distinguishes between ‘graduate entry level physiotherapists‘ and ‘senior physiotherapists‘ or
163 ‘clinical specialists‘. Again, however, Ireland does not mention a medical professional who
164 should be consulted but (only) talks about a ‘higher level of authority‘.

165 In the case of Austria, keep/refer decision making abilities do not appear to play a vital role in
166 the ‚Berufsprofil‘. This document contains one paragraph that describes the physiotherapist’s
167 professional responsibility to determine if the referral by the medical professional is suitable
168 from the perspective of the physiotherapy profession, or not [15]. It further says that this
169 responsibility is especially important in the case of changes in the patient’s health status [15],
170 but a clear description of the keep/refer decision making process is missing. However, in a
171 more recent paper describing the future role of physiotherapists as part of a primary health
172 care system [17], physiotherapists are required to screen their patients whether there exists an
173 indication for movement based intervention (physiotherapy), or not. Again, this document
174 demands a close collaboration with other ‘health care professionals‘ but there is no further
175 definition on which health care professionals (medical professionals, psychologists,
176 pharmacists) should be included in such a interdisciplinary collaboration.

177 Interestingly, even though it is undeniable that medical professionals have the appropriate
178 educational background and diagnostic resources to, in the last instance, rule in/out serious
179 medical conditions, only Germany [20] and Switzerland [26] very clearly mention that this
180 specific professional group should be contacted. Others [12, 13, 14, 17, 18, 19, 21] use more
181 general terms such as ‘health care providers‘, ‘(health care) professionals‘ or even ‘higher
182 level of authority‘. On the other hand, Germany and Switzerland do not directly require its

183 physiotherapists to make an independent keep/refer decision but solely to contact the referring
184 medical professional while countries such as Denmark, Belgium, the United Kingdom, the
185 Netherlands, Italy and Ireland demand that the patient (if deemed necessary) be referred
186 directly by the physiotherapist.

187 Lithuania sent a document, which not only applies to the physiotherapy profession but is seen
188 more as a guideline for professions that deal with rehabilitation in general including
189 Physiotherapy, Occupational Therapy and Adapted Physical Activity [22]. This document
190 does not specifically mention keep/refer decision making abilities but generally requires that
191 the therapists should be able to make “ an independent decision in a difficult situation that
192 requires an innovative (holistic) approach“ [22].

193 The biggest surprise were the results from the Scandinavian countries. Although Sweden is
194 regarded as the homeland of the professional physiotherapy movement [27], the Swedish
195 physiotherapy association informed us that they do not have any national guidelines for the
196 physiotherapy profession. Norway does not have individual professional guidelines either.

197 This was especially unexpected given the fact that Norway has a prestigious Manual Therapy
198 Association [28] and with Freddy Kaltenborn a pioneer of Manual Therapy [29]. Instead, the
199 Norwegian Physiotherapy Association sent us an ‘Educational Framework‘ of what
200 physiotherapy graduates are expected to learn during their undergraduate degree. This
201 document mentions that the programme should be in “accordance with national and
202 international guidelines“ but no further specification of what that exactly means could be
203 found. For Finland, which has also a long tradition of physiotherapy education dating back to
204 the end of the 19th century [30], it was unfortunately impossible to obtain any guidelines.

205 Only Denmark requires that physiotherapists should know the limitation of their own
206 expertise and recognize the potential need of other health care providers [19]. The results

207 from the Scandinavian countries were unexpected since in those countries, patients do not
208 need (at least in the private sector) prior examination and referral from a medical professional
209 [31].

210 Results in the context of the access system to physiotherapeutic service

211 For countries that do not have a direct access system (Austria, Belgium, Germany,
212 Switzerland) [31], the national guidelines of Belgium most specifically mention the keep/refer
213 decision making process as a professional obligation for qualified physiotherapists. In the case
214 of Austria, the ‘Berufsbild‘ [15] does not explicitly mention keep/refer decision making
215 abilities at all. It only requires the physiotherapists to determine if the referral is suitable from
216 the perspective of the physiotherapy profession, or not [15]. Switzerland requires its
217 physiotherapists to keep the referring medical professional up to date about the course of the
218 treatment and the general outcome of the intervention [26], but keep/refer decision making
219 abilities as an explicit requirement are missing.

220 In countries where patients can refer themselves to physiotherapy directly in the private sector
221 but not in the public system [31] (Italy, Lithuania, Ireland, Denmark, Czech Republic,
222 Slovenia, the Netherlands, Norway), only Italy, the Netherlands, Denmark and Ireland
223 demand that physiotherapists must be able to decide about the appropriateness of
224 physiotherapy for their patients. Slovenia has translated the ER-WCPT guidelines into
225 Slovenian and therefore also requires its physiotherapists to be able make an accurate
226 keep/refer decision.

227 In countries (UK) with direct access in both the public system and the private sector [31], it is
228 mandatory that all qualified physiotherapists should have the professional autonomy to be
229 able to determine when to keep or refer a patient.

230 In general, the regulatory requirement for professional autonomy over keep/refer decisions
231 does not seem to correlate exclusively with the national health care system in each country.
232 For instance, Belgium with no direct access system to physiotherapy [31] very clearly
233 requires its qualified physiotherapists to know when to refer a patient [18]. In contrast,
234 Norway with a direct access system at least for the private sector [31] does not mention
235 keep/refer decision making attributes in its ‘Educational Framework‘ at all [23].

236 **Discussion**

237 This review provides a unique insight into how individual ENPHE member associations
238 include keep/refer decision making abilities into their national guidelines for the
239 physiotherapy profession. This review also gives insight into the different interpretations of
240 those specific abilities in individual national guidelines of ENPHE member associations. This
241 is seems of significance in the light of recent changes within the European Mobility and
242 Migration Policy [32] which make it easier for physiotherapists to have their qualifications
243 recognized and subsequently allow them to work in different European Union member
244 countries [33]. Given the fact that the keep/refer decision making process is a core element in
245 the WCPT guidelines [8], the authors of this review believe that there exists no valid reason
246 why this specific attribute, as part of the clinical reasoning process [34], should be omitted
247 from the guidelines of some professional physiotherapy associations. Having said this, in the
248 WCPT guidelines it is acknowledged that there is some room for interpretation based on
249 individual national health care regulations [8]. However, the ability to make an independent
250 keep/refer decision is certainly important for all physiotherapists to ensure patients‘ safety and
251 should not depend on whether physiotherapists work in a direct or non direct access system
252 [6, 7, 35]. Specific training in making keep/refer decisions and clinical triage has already

253 shown to enable physiotherapists who work in the United States Armed Forces to be highly
254 effective in recognizing sinister conditions which require medical attention [36].

255 **Limitations**

256 There are two major limitations of this review that need to be mentioned. Firstly, and to our
257 disappointment, it was not possible to obtain national guidelines from all ENPHE member
258 organisations. Despite the fact that we contacted all ENPHE member associations several
259 times via email, we did not receive an answer from all countries. In two cases (Sweden and
260 Malta), we were notified that no national guidelines exist. As a consequence, it is impossible
261 to get a complete European-wide overview of the importance of keep/refer decision making
262 abilities as part of national guidelines. Secondly, only one country, whose first language is not
263 English (the Netherlands) seems to have an English version of their guidelines. Lithuania also
264 submitted a document which was in English. However, these were not the actual professional
265 guidelines. When we requested the original Lithuanian guidelines so that we could translated
266 them ourselves, we did not get a response back. For other countries (Belgium, Denmark,
267 Norway, Italy) it was necessary to translate them into English using Google Translator. The
268 fact that Google Translator, despite its usefulness and availability, is obviously not an
269 officially acknowledged translator, there may be some translational mistakes/shortcomings.
270 As a consequence, we have no certainty if we have either missed important passages that
271 specifically mention keep/refer decision making abilities or our translation of the supposedly
272 correct passage was not one-hundred percent correct. Since the main author is from Austria,
273 there were no difficulties in ensuring an accurate translation of the German speaking
274 guidelines (Austria, Switzerland, Germany). Slovenia directly translated the English version
275 of ER-WCPT [9] guidelines into Slovenian and therefore caused no difficulty with the

276 translation. The Czech Republic uses the European Physiotherapy Service Standards [25]
277 which are also in English and required no further translation either.

278

279 **Conclusion**

280 This review is the first to assess whether keep/refer decision making abilities are specifically
281 mentioned in the national guidelines of European countries which are also a member
282 organisation of the ENPHE. Most surprisingly, not all ENPHE member countries seem to
283 have yet developed individual national guidelines for the physiotherapy profession. Despite
284 the fact that these specific abilities are undoubtedly an important part of the physiotherapeutic
285 decision making process [4, 34], they are not explicitly mentioned in all national guidelines
286 that we were able to review. Even though international guidelines [8, 9, 10] clearly deem
287 those abilities crucial for every physiotherapist and the literature is full of case reports where
288 physiotherapists helped to detect a wide range of systemic pathologies [6], those abilities are
289 not included as a specific requirement in all guidelines that we were able to review. Despite
290 the clear description of those abilities in the WCPT guidelines [8] (which are prescriptive and
291 leave no room for interpretation), most countries have made some amendments for their own
292 guidelines.

293 **Recommendations**

294 Future research should concentrate on analysing in how far qualified physiotherapists and
295 physiotherapy students (in both, direct and non direct access system) across Europe are
296 capable of making an accurate keep/refer decision as part of their clinical reasoning process.
297 There have been some studies on qualified physiotherapists in Germany [37] and Switzerland
298 [38]; data from other European countries is currently missing. In addition, it is the authors'

299 opinion that there should be a European wide consensus about keep/refer decision making
300 abilities as a mandatory content of all national guidelines (regardless of whether there exists a
301 direct or non direct access system to physiotherapy). Moreover and most importantly, these
302 specific abilities should be a compulsory part of every undergraduate physiotherapy
303 curriculum across all European Universities.

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306 **Conflict of interest**

307 None.

308

309

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425 **Table 1**

| ENPHE Member Association | Professional Guideline (Original Title) | Relevant Keep/Refer statement (English translation) | Guideline date | Native language version (YES/NO) | Direct translation of ER-WCPT guideline (YES/NO) | Direct access to physiotherapy (YES/NO) | Differentiated regulations for generalist versus specialist grades (YES/NO) |
|--------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------------------------|--------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------------------|
| Denmark | Etiske retningslinjer for Danske Fysioterapeuter | Physiotherapists refer patients to colleagues or other health professionals when the limit of own area of competence has been reached and it is estimated that other competencies are necessary to ensure optimal patient care. (p.5) | Unkown | YES | NO | YES (but only for the private sector) | NO |
| Norway | RAMMEPLAN FOR FYSIOTERAPEUTU TDANNING | Physiotherapist program shall be in accordance with national and international health education policy guidelines (p.4). | 2004 | YES | NO | YES (but only for the private sector) | NO |
| Lithuania | Descriptor of the study field of Rehabilitation | Take an independent decision in a difficult situation that requires innovative (holistic) approach (17.4.2.) | 2015 | YES | NO | YES (but only for the private sector) | NO |
| Belgium | Beroeps- en Competentieprofiel van de kinesitherapeut in België | Depending on the results of the first screening and taking the findings in the clinical examination the physiotherapist, in consultation with the patient, decides to set in treatment, give the necessary advice or refer to another health care provider. (p.18) | 2010 | YES | NO | NO | NO |
| Germany | Berufsordnung des deutschen Verbandes für Physiotherapie | If any peculiarities during the examination or the course of the treatment occur, consult with the referring medical practitioner if deemed necessary (p.2). | Unkown | YES | NO | NO | NO |
| Ireland | Therapy Project Office; Physiotherapy Competencies | <u>Graduate Entry level:</u> “Recognizing own limitations and liaising with senior staff and other team members when appropriate.“ (p. 11) <u>Senior competencies and Clinical Specialist:</u> “Recognizing when it is appropriate to refer decisions to a higher level of authority and include colleagues in the decision making process.“ (p. 13 and p. 16) | 2008 | YES | NO | YES (but only for the private sector) | YES |
| The Netherlands | The professional profile of the physical therapist | Depending on the results of the first screening and the findings from the physiotherapeutic evaluation, the physical therapist makes decision in consultation with the patient with regard to the treatment to be started, advice or referral.“ In direct access, the physical therapist determines in the first screening whether further physiotherapeutic | 2006 | NO | NO | YES (but only for the private sector) | NO |

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|----------------|---------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-------------------|-----|----------------------------------------|----|
| | | analysis is useful. Depending on the outcomes, diagnostic physiotherapeutic evaluation is subsequently done or the patient is referred.“ (p.17) | | | | | |
| Austria | Berufsbild Physiotherapie. MTD Ausbildungsverordnung. PhysiotherapeutInnen in Primary Health Care- best point of service. | <u>Primary Health Care:</u> Communication with other health care providers. Screening what kind of or whether movement based intervention is indicated. <u>MTD Ausbildungsverordnung:</u> 4. Recognize authority/competence of other medical/health care professions. <u>Berufsbild:</u> Independently assess if referral by medical practitioner is suitable from the perspective of the physiotherapy profession (p. 20); Especially important in the event of changes in the patient’s health status (p.21). | 2004 2006 2014 | YES YES YES | NO | NO | NO |
| United Kingdom | Standards of Proficiency | “Registrant physiotherapists must know the limits of their practice and when to seek advice or refer to another professional.“ (p. 7) | 2013 | YES | NO | YES | NO |
| Italy | LA FORMAZIONE “CORE” DEL FISIOTERAPISTA | Refer the patient to another (health care) professional when their activity is required and when the situation is beyond the therapists professional and / or experience and/or competence (page. 72). | 2013 | YES | NO | YES (but only for the private sector) | NO |
| Slovenia | European Core Standards of physiotherapy practice (Slovenian translation) | Refer to original document | 2008 | No | Yes | YES (but only for the private sector) | No |
| Switzerland | Berufsbild Physiotherapie. Berufsordnung des Schweizer Physiotherapie Verbandes | <u>Berufsordnung des Schweizer Verbandes:</u> Inform referring doctor about course of the treatment and treatment outcome (p. 3). Promote interdisciplinary collaboration within various health professions (p. 3). | 2009 2013 | Yes | NO | NO | NO |
| Czech Republic | European Physiotherapy Service Standards | / | 2003 | NO | YES | YES (but only for the private sector) | NO |

