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EDITORIAL

Render to physiatrist the things that are physiatrist's. In Italy, the Supreme Court confirms that physiotherapy without medical diagnosis is unlawful practice of medicine: what about the rest of Europe?

Giorgio FERRIERO [1, 2] *, Giovanni IOLASCON [3, 4], Klemen GRABLJEVEC [5, 6], Mauro ZAMPOLINI [7, 8]

[1]Unit of Physical and Rehabilitation Medicine, Scientific Institute of Tradate, Istituti Clinici Scientifici Maugeri IRCCS, Tradate, Varese, Italy; [2]Department of Biotechnology and Life Sciences, University of Insubria, Varese, Italy; [3]Italian Society of Physical and Rehabilitation Medicine (SIMFER), Rome, Italy; [4]Department of Medical and Surgical Specialties and Dentistry, Luigi Vanvitelli University of Campania, Caserta, Italy; [5]President of the European Society for Physical and Rehabilitation Medicine – ESPRM; [6]Department for Rehabilitation of Patients after Traumatic Brain Injury, University Rehabilitation Institute, Ljubljana, Slovenia; [7]UEMS PRM Section President; [8]Department of Rehabilitation, Hospital of Foligno, USL Umbria2, Perugia, Italy

*Corresponding author: Giorgio Ferriero, Department of Physical Medicine and Rehabilitation, Scientific Institute of Tradate, Istituti Clinici Scientifici Maugeri IRCCS, via Roncaccio 16, 21049 Tradate, Varese, Italy. E-mail: giorgio.ferriero@icsmaugeri.it

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Recently, the Italian Supreme Court,[1] the highest court in the ordinary jurisdiction, reaffirmed the importance of diagnosis and medical oversight, a critical step for patient safety,[2] and a fundamental condition to establish the appropriateness for the treatment. The verdict ruled out that if physiotherapists, whose educational program does not qualify them to make medical diagnoses, carry out healthcare treatments without a medical prescription, it could constitute unauthorised practice of medicine, since they are replacing the physician by performing activities reserved for medical professionals. According to the Italian Supreme Court: "The autonomy recognized to the physiotherapist may be exercised solely within the scope of the physiotherapist's professional profile and competencies and, in any event, in relation to diagnoses and prescriptions that are exclusively within the medical domain. This entails a preliminary identification of the clinical issue and the necessary rehabilitative response, as well as the assessment of outcomes. Such autonomy must be exercised in compliance with the prerogatives established by national rehabilitation legislation, which assign to the physician and physiatrist the responsibility for defining the individualized rehabilitation program and for the formulation of specific therapeutic interventions."

This verdict represents a change of paradigm with respect to the current clinical practice since the direct access to physiotherapy without medical referral happens in the private practice,[3, 4] it is wished in the national health system by the Italian Chamber of Physiotherapists,[5] and it is reported even in some guidelines dedicated to physiotherapists.[6] Direct access to physiotherapy is claimed to be a time-, cost- and clinically-effective care pathway, even if the certainty of evidence is reported to be very low.[7, 8] It is uncertain whether direct access is safe for patients with varying levels of complexity.

If it seems obvious that referral modality could save time, this is not wasted time, but necessary – and dependent by the health system organization – to formulate di-

agnosis and prescribe the most tailored and appropriate rehabilitation, not only physiotherapy. Moreover, considering that direct access to physiotherapy is more applied to musculoskeletal disorders, the health systems usually ask to patients to wait weeks before any request of treatment, since these disorders are frequently self-limitating.[9] Anyway, despite this attempt to increase efficiency, waiting lists for physiotherapy continue to rise.[10] On the other hand, while there are reports showing this sort of advantage,[7] it has also been demonstrated that many patients do not truly self-refer,[11] because they also consult the physician to receive or confirm a diagnosis,[12] appropriately recognizing diagnosis as a medical responsibility.[11]

Direct access to physiotherapy does not seem to have a consistent impact on musculoskeletal consultations in general practice.[12] Therefore, there is no clear and consistent organizational and economic impact of patient direct access to physiotherapy on the workload of the practices.[12] Analyzing the economic aspects, the reduced costs have been attributed only to the use of fewer diagnostic procedures scans and prescription costs.[12] This is an expected finding as physiotherapists are not generally authorized to do diagnostic scans or blood tests, and it is not necessarily aligned with best practice guidelines. On the other hand, the direct access approach is judged not be cost saving for the health systems, owing to the increase in the use of physiotherapy services that is likely to result.[13] In fact, it is expected that in case of implementation of the direct access, demand would increase and more investment in services would be necessary.[11] Moreover, the direct access to physiotherapy poses another economic problem since this approach is characterized by fluctuations in service demands, but funding is usually fixed.[11]

The most important consideration in this debate is the ethical issue of the direct access approach. Recalling the Italian Supreme Court verdict,[1] the utmost weakness of the direct access approach is the lack of a medical diagnosis. According the Court, physiotherapists are not allowed to "formulate a diagnosis and a session plan based on pain and discomforts reported by the patient". Timely and accurate diagnosis is an essential first step to achieving optimal patient outcomes: a missed diagnosis is a diagnostic error.[14] In many countries, physiotherapists have not the ability to formulate a medical diagnosis, necessary to practice in a direct access model,[15] because they do not have the authority to independently order diagnostic tests such as X-rays, MRIs, or blood tests.[16] When physiotherapists are working in direct access settings may refer about diagnosis-centered uncertainty, which can affect the quality and safety of care.[17] A possible consequence of a missed diagnosis is that physiotherapists working as first contact practitioners are at increased risk of litigation, most frequently related to musculoskeletal conditions.[18]

The unclear advantages of the direct access model have been found in studies comparing physiotherapist-led care *versus* physician-led care, where the latter was a general practitioner.[7, 8] However, primary care and outpatient rehabilitation led by Physical and Rehabilitation Medicine (PRM) physicians are complementary approaches in a comprehensive healthcare.[19] The comparison between PRM-led care and physiotherapist-led care has not been explored in the current literature. The role of rehabilitation in significantly reducing healthcare costs and the burden on healthcare providers is emphasized in the recent World Health Assembly's resolution.[20] This year, the PRM section of the European Union of Medical Specialists (PRM UEMS) published the position statement on outpatient rehabilitation.[21] This important document offers a perspective on rehabilitation services in community settings, emphasizing the role of PRM physicians as part of a multi-professional team. Moreover, it delineates the comprehensive role of PRM physicians in these settings, encompassing clinical assessment, investigations, medical diagnosis, comprehensive treatments including medical interventions, and supervision and training of junior medical workforce.

Physiotherapists practicing in direct access model of care must acquire the required competencies to ensure adequate and safe patient care assuming physicians' roles.[15] These competences are already part of the medical skills of PRM physicians.[22] In some parts of Europe, direct access to physiotherapy is the norm in countries like the Netherlands, Norway, Sweden and England.[23] It might not be a coincidence that in these very countries the number of PRM physicians is below the European average (Table I).[24, 25] It is possible to argue that in these countries, the number of PRM physicians is low because of such pathways hindering the needs-based expansion of PRM workforce. On the other hand, as the number of PRM physicians is low, implementation of direct access to physiotherapy has been implemented as an easier solution. However, the unbalanced number of physiotherapists and PRM physicians (Table I) organizationally goes against the WHO resolution to strengthen rehabilitation in health systems by expansion of multidisciplinary workforce.[20] WHO does not advocate for disproportionate expansion of one discipline alone and not for disciplines to replace each other.

At the heart of comprehensive rehabilitation lies the

Table I.—*Average number per 100,000 inhabitants of clinicians in Europe and in the four countries where direct access to physiotherapy is a norm.*[24, 26]

	Europe	UK	Netherland	Norway	Sweden
Physiatrists	3.00	0.27	1.65	2.14*	1.88
Physiotherapists	135.0	104.4	215.0	214.5	166.3
Ratio physiatrists/physiotherapists	0.022	0.002	0.008	0.010	0.011

Individual Rehabilitation Project (IRP), which represents "the core of person-centered rehabilitation" and serves as the essential framework for all rehabilitative interventions.[26] This project, grounded in the principles of the International Classification of Functioning, Disability and Health (ICF), requires the coordinated integration of multiple professional disciplines, each contributing specialized expertise that extends far beyond the scope of physiotherapy alone. The rehabilitation matrix encompasses speech and language therapists addressing communication and swallowing disorders, occupational therapists focusing on activities of daily living and environmental adaptation, neuropsychologists managing cognitive and behavioral aspects, social workers facilitating community integration, and numerous other specialized professionals depending on individual patient needs.

In an era characterized by increasing chronicity and escalating complexity of health conditions, the notion that direct access to physiotherapy alone could adequately address the multidimensional needs of patients with disabilities becomes not only reductive but potentially harmful to optimal patient outcomes. The growing prevalence of complex comorbidities, neurological conditions, and age-related functional decline demands a sophisticated, medically-supervised approach that can orchestrate this diverse professional expertise within a coherent therapeutic framework. The physiotherapist, while undoubtedly valuable within this multidisciplinary team, represents only one component of a much larger therapeutic ecosystem that cannot be adequately managed through fragmented, profession-specific interventions operating in isolation from comprehensive medical assessment and coordination.

To summarize, in some countries direct access of physiotherapy may be considered unlawful (Italy), since physiotherapy can be provided only following a medical diagnosis and prescription. The shortage of PRM physicians may present the substitution of doctors with physiotherapists as necessary and apparently beneficial. On the other hand, there is a question of legal responsibility of the treating individual in case of mistakes in treatment, that might be understand as malpractice due to insufficient information on patient medical conditions. We believe that a better solution in line with WHO resolution is the expansion of PRM workforce throughout Europe. The disciplines involved in rehabilitation need to work more collaboratively with each other to bring about a high quality and comprehensive care for their patients.

Future studies, stronger in methodology than those now available, and more in-depth economic and legal analyses will address regulators and legislators to the most ethical, safe and appropriate organization of outpatient rehabilitation.

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