The physical therapist – a professional profile

February 2014

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Preface

It is with great pleasure that I present to you the new professional profile for the physical therapist. This document is the result of a project involving intensive discussions on the nature of the profession of physical therapist. The document is expected to play an important part in consolidating and clearly defining the domain that physical therapy regards as its field of activity. The project to write this profile was prompted by the need to update the existing profile, which dates from 2005, as well as the desire among the various professional associations for the specialist subdisciplines to revise their own professional competency profiles. This desire stemmed from the need they felt to present a clearer and more concrete description of their profiles for all interested parties, by specifying their own contributions to the range of physical therapy activities and to clearly distinguish them from the various other forms of physical therapy management, which are also organized in professional associations. Since the general professional profile of the physical therapist forms the basis for the specific profiles of the various subdisciplines, it was decided to first revise this general profile. In developing the new profiles, KNGF and the various specialist associations decided to base themselves on the CanMEDS-model (Canadian Medical Education Directives for Specialists).

The professional profiles project was formally launched in December 2011, and involved a steering committee, a project team and task forces for each of the profiles to be developed. The project was led by a project leader and a coordinator. The project team designed the basic formats that were used as a basis for all profiles, and advised the task forces during the course of the project. The project team consisted of representatives of each of the professions involved and of the joint Bachelor’s and Master’s programs.

This general professional profile was developed by the physical therapy task force, which also called on experts for certain specific topics. Two rounds of consultations with feedback groups were held. The first feedback group included practitioners and representatives of educational institutions, who were invited to comment on the structure of the professional profile, the direction in which the project was developing and its preliminary results. At a later stage, a written questionnaire was used to present a draft version to a wide variety of people, including many professors and lecturers and representatives of (medical) professions closely related to physical therapy, as well as educational institutions, the health care inspectorate, health insurance companies, de Federation of Patients and Consumer Organisations in the Netherlands (NPCF), and the Institute for Health Care Quality of the National Healthcare Institute (formerly CVZ). The elaborate and highly relevant feedback they provided has been incorporated in the profile text.

In addition to its primary role of evaluation, the steering group has also provided considerable direct input to the profile. The physical therapy task force and the steering committee have shown great commitment and invested a great deal of effort, for which we are very grateful indeed. A special word of thanks is due to three professors of physical therapy, who have provided extensive comments on several draft versions. The credits page at the end of this document lists all people who have contributed directly to this professional profile. In addition, I would like to express my great gratitude to the people who took part in the feedback rounds but were not part of the project structure as such. This document has indeed turned into a general professional profile of the physical therapist, as its building blocks have been supplied by a wide range of people inside and outside of KNGF. I therefore hope and expect that this document will come to play a major role in the efforts to raise the profile of physical therapy in the coming years.

Henri Kiers, member of the Board of the Royal Dutch Society for Physical Therapy (KNGF)

Quality, Training, Research and Professional Content

February 2014
Introduction

Why a new professional profile?

The professional profile is a description of the domain of physical therapy as it is at the time of writing. It is used by the institutes that train physical therapists by incorporating the competencies described in the profile in their educational programs, while institutions like the Accreditation Organisation of the Netherlands and Flanders (NVAO) and the Health Care Inspectorate base their quality assurance tasks on the competencies and indicators in the profile. Other interested parties include the government, potential consumers, health insurance companies, etc. Health care is a rapidly changing field, and the role of physical therapy is changing with it. Since nobody can predict what health care will actually look like in 5 or 10 years time, it is important to respond to developments in society and changes in the health care system. This makes an up-to-date description of the domain an important document to determine the position of physical therapy.

Developments in society, like the current trend toward individualization, affect the prevailing views about health care. Information technology has become an indispensable part of the health care system and increasingly influences its organizational structure. The demand for care and the role and position of various parties in physical therapy care have changed dramatically and continue to change. Quality of life and people’s choices in this respect have become more important than they used to be. This fits in with the above-mentioned trend toward individualization. Nowadays, the client and the physical therapist jointly decide on the nature and frequency of the interventions. Health is defined differently today, with the focus shifting from disease and care to health and behavior. Patients’ wishes as regards participation in community life have become the criterion for assessing the success of treatment. The nature of health care is changing from supply-driven to demand-driven, and the importance of prevention is increasingly acknowledged. The findings of scientific research are being translated into evidence-based practices, with major social and economic consequences. It is in response to these developments that physical therapy formulates its management strategy. A new professional profile contributes to the implementation of this strategy and hence to the public image of the profession.

Structure of the new professional profile

The new profile document consists of two parts. The first part, comprising three chapters, describes the role and position of physical therapists in the health care system. This description of the domain of physical therapy forms the basis of the work of all physical therapists, including specialist therapists. This domain is described in Chapter 1. Chapter 2 discusses current trends in Dutch society and the Dutch health care system. These developments also influence each other and partly determine the development of physical therapy and physical therapists. Chapter 3 prepares for the second part of this professional profile document, which describes in detail the competencies that physical therapists are expected to possess at level 6 of the European Qualifications Framework (EQF).

For the sake of readability, this document uses “he” for both male and female physical therapists
Part 1

Physical therapy and the physical therapist
Chapter 1 The physical therapy domain

Clients contact a physical therapist because they are experiencing movement problems or other health problems for which movement-related interventions might be indicated. In the case of children or adults who are unable to make conscious decisions, it is the parents and/or informal or professional caregivers who describe the movement problems. The nature of the assistance required can differ greatly, even between clients with apparently comparable problems, as it depends on factors like age and stage of life, social contacts, and domestic and community environment.

Physical therapists offer treatment aimed at recovery, optimization, and maintenance of movements. They use a clinical reasoning process to arrive at a specific physical therapy diagnosis, which is then used to design and implement a program of therapeutic and/or preventive interventions.

The way a physical therapist manages a client is partly based on knowledge derived from medical and biomedical science, human movement science, and behavioral sciences. Physical therapy always uses the most recent scientific insights, methods, and technologies as a foundation for its theory-based rationale, efficacy and efficiency, safety and ethics. The discipline optimizes its collaboration with other health care professionals by using the “International Classification of Functioning, Disability, and Health” (ICF) system developed by the World Health Organization (WHO).

Therapies for which there is no scientific evidence or that are not based on Western rationale are beyond the domain of physical therapy.

1.1 Basic principles

1.1.1 Views on health

Health is an abstract, poly-interpretable concept whose interpretation is influenced by people’s social, cultural, and historical perspectives. The present professional profile uses the definition by Huber et al.: “Health as the ability to adapt and to selfmanagæ, in the face of social, physical and emotional challenges”. This definition emphasizes health as a dynamic, personal, and positive concept. It was developed in response to criticism of the more static definition of health proposed by the WHO in 1948: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

The concept as described by Huber et al. is based on the assumption that people are able to cope with limitations, disorders, or diseases and to live a meaningful and dignified life, provided they possess health skills, or are given opportunities to acquire them. In the case of clients who are unable to make conscious decisions for themselves, others define in good conscience what is meaningful and dignified, while maintaining respect for those whose interests they represent.

Physical therapy is indicated if movement problems result in a person’s ability for adaptation being insufficient, or threatening to become insufficient, and/or being perceived by the client as insufficient. One of the objectives of physical therapy is to counsel a client with an illness or disorder.

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*This document uses the term client, rather than patient, to emphasize the active role of the person seeking care.

*Throughout this document, any reference to “need for assistance”, “living environment”, “personal experience” and “client/person seeking assistance” should be interpreted as including others who represent a person who is unable to make conscious decisions for themselves.

*In the remainder of this document, this is simply referred to as “diagnosis”, as the profile concerns only the domain of physical therapy.

*See KNGF’s vision on therapies at www.fysionet.nl.

*The absolute nature of the word “complete” in the context of well-being may unintentionally result in the WHO definition contributing to the medicalization of society (Huber et al., 2011), since not perceiving a state of complete well-being could be perceived and interpreted as being unhealthy, and thus elicit a demand for medical intervention.

*The ability to read, understand, and apply information about health.
and assist them in managing their problems in order to improve their participation.

In all situations, the physical therapist must remain aware of the frameworks provided by scientific research, professional values, legislation and regulations, ethical principles, and financial constraints.

1.1.2 Views on human movement

“Movement” is defined here in the widest sense, as a form of intentional behavior and activity. It is a relational concept which also has a social dimension. In this view, movement is more than just moving one’s body or parts of it in a predefined anatomical and (arthro)kinematic pattern, or behavior in terms of stability/instability or control and order parameters. Although movement-related behaviors often show a certain stability, they are also flexible enough to respond effectively to a changing environment. Optimized movements are characterized by the type of functional variability that was first described by Bernstein and later by others such as Todorov, Latash, and Levin. This concept means that a particular goal can be achieved through different movements. The movements initiated by a client are determined by the situational, movement-related, and social context plus any impairments that may be present. These body movements can always be realized by means of various body structures and/or body functions. This is the context in which physical therapy addresses the client’s presenting problem.

Health and physical activity are inextricably related. People who get enough exercise are less likely to fall ill, have fewer psychological complaints, find it easier to maintain a healthy weight, and have a lower risk of cardiovascular diseases, diabetes, and various forms of cancer.

1.1.3 Views on care provision

Every client has their own history, identity, health-related skills, social environment, goals in life, and perspective on the future, and the physical therapist must always remain aware of this in his contacts with the client as well as during the diagnostic and therapeutic processes.

Each client has a right to be treated in a personal and dignified way, and physiotherapy treats clients as autonomous within their own preferences and abilities. Huber et al. emphasize that control over one’s own life is a crucial factor in people’s perception of their health. In addition to controlling their own life, clients are also given a key role in the management of their disorder. The clients participate in the decision on the treatment goals and make their own choices from among the available treatment options.

Clients suffering from a chronic illness are supported in their self-management by the physical therapist. Self-management means “the individual ability to effectively manage the symptoms, treatment, physical and social consequences, and lifestyle changes that are inherent to living with a chronic disorder.” Supporting self-management means that the physical therapist encourages the client to adopt an active role, use their experiential knowledge, and clearly express their wishes and goals. An important aspect is that the client should learn to monitor their own health status and to make choices regarding the physical therapy treatment. It is essential that client and therapist make joint decisions. Shared decision making stimulates the process by which clients are assisted in carefully selecting interventions. It is the client’s preferences which ultimately determine the decision, although a physical therapist cannot be forced to perform a treatment for which there is, in his opinion, no indication.

The physical therapist’s treatment is not primarily focused on disease and care. The therapist

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6 Control parameters refer, e.g., to body structures and physiological processes (impairments of the musculoskeletal system).

7 Order parameters refer to the coordination and technical aspects of movements. Changes in control parameters may lead to changes (sometimes sudden changes) in the order parameters, thus changing the coordination of movement.
encourages the client to adopt movement-related behavior that has a favorable effect on their health, and assists them in performing activities. The objective of this approach is to increase or maintain the client’s participation, or to limit the decline of participation. An essential element in the physical therapy view of care provision is prevention. The therapist provides care-related and indicated prevention, both of which are based on the client’s functioning and participation and their movement problems (or impending problems). See section 1.3 for a more detailed discussion.

The physical therapist collaborates closely with those responsible for the education of young clients, those close to the client, informal and professional caregivers, and health care professionals. If a physical therapist is treating a client who is unable to make conscious decisions for themselves, these are also the parties that he asks to give their view on the client’s perception of their activities, movements, and any movement problems. The therapist also asks them to describe how the client’s problems manifest themselves.

The physical therapist then decides whether physical therapy is indicated and whether he possesses the necessary competencies to provide the appropriate assistance. If the client needs not only physical therapy but other forms of assistance as well, the physical therapist refers them back to the referring doctor, or if the client presented without referral, advises them to consult another care provider or a specialist physical therapist.

1.2 Theoretical rationale

1.2.1 Scientific evidence base
The professional practice of physical therapy and the underlying scientific research are largely based on the natural and social sciences, including kinesiology, physiology and pathophysiology, psychology, and sociology, but also disciplines like human movement sciences, health sciences, medical science, and psychoneuro-immunology. Knowledge derived from these domains helps the physical therapist in history-taking, establishing the diagnosis and formulating the treatment strategy. It is also this knowledge which enables the discipline of physical therapy to precisely define the concept of “movement” and explain the complexity and variety of human movements.

On the one hand, physical therapy research focuses on damage (and the underlying mechanisms) to the musculoskeletal system and ways to repair it, as well as the mechanisms controlling the musculoskeletal system, movement-related functioning and participation, and comorbidities that affect movements. On the other hand, it focuses on developing, implementing, and evaluating interventions and valorizing knowledge and innovations. In addition, physical therapy utilizes and participates in the emerging discipline of translational research carried out at university medical centers, as well as in applied research and practical research at the universities of applied sciences and related centers of expertise.

1.2.2 Evidence-Based Practice
The physical therapist works in accordance with the principles of Evidence-Based Practice (EBP). EBP means the conscientious, explicit, and judicious use of current best evidence in making therapeutic decisions jointly with the client. Decision making is based on integrating individual clinical expertise with the best available external evidence from systematic research. It is also determined by the client’s movement problems, their preferences, expectations, and domestic and community

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1 Valorization is the process of deriving societal value from scientific and technological knowledge.
2 Translational research is research to bridge the gap between basic research and clinical practice. It focuses on applying research findings in diagnostics, therapy, or prevention.11
environment. It is the client who ultimately decides, after being informed by the physical therapist on the basis of a mixture of tacit and explicit knowledge, derived from the available knowledge sources. Understanding, identifying, and applying EBP requires clinical reasoning. Clinical reasoning comprises the mental processes of collecting, evaluating, prioritizing, and structuring information by the physical therapist, in order to critically elucidate a movement problem, help to solve it, and evaluate the results. The information used for clinical reasoning includes biomedical sources as well as sources from behavioral and movement sciences. In addition to this specialist knowledge, the physical therapist also bases his evaluation on social and economic considerations. After the client has made their decision and given their consent, the physical therapist may or may not initiate clinical treatment, while continuing to discuss the treatment with the client and acting in accordance with the client’s wishes.

1.2.3 International Classification of Functioning, Disability, and Health
The International Classification of Functioning, Disability, and Health (ICF) was developed by the WHO as a conceptual framework to facilitate communication and collaboration between the various disciplines. As an expert on movement-related functioning, the physical therapist’s primary position is in the "activities" domain of the ICF. The physical therapist uses the IVF framework in his clinical reasoning, in formulating the strategy, in recording and reporting, in monodisciplinary and interdisciplinary communication, in developing guidelines, and in research and training.

1.3 The physical therapist in the context of health care

1.3.1 Scope of activities
Care and cure
Physical therapists work in various health care settings. They collaborate in a variety of contexts in primary care, including neighborhood services, health centers, and collaborative structures to manage client groups and chains of physical therapy practices. A physical therapist collaborates with other physical therapists, including specialist physical therapists, and other professionals, both within the health care system and outside it (municipal governments, welfare services). The physical therapist may also participate in integrated care networks for inpatients and outpatients with certain types of diagnosis.

Within institutional settings, physical therapists work in multidisciplinary teams or at physical therapy departments, mostly in hospitals, rehabilitation centers, nursing homes, and homes for the elderly. Physical therapists working outside institutional settings treat clients at home, working in community teams and existing networks.

KNGF-accredited specialist physical therapists primarily work in specific subdisciplines of physical therapy. Officially recognized subdisciplines within physical therapy are characterized by the use of additional special clinical expertise, knowledge, and skills, by therapists being qualified for a precisely defined domain which is recognized by the professional community as belonging to physical therapy.

Prevention
Prevention has an important place in the physical therapist’s professional practice. The traditional model of prevention – which subdivided preventive measures into primary, secondary, and tertiary prevention – has recently been replaced by a new model, which distinguishes universal, selective, indicated, and care-related forms of prevention. Indicated and care-related prevention focus on individuals and belong to the domain of care, in this case physical therapy, while selective and universal prevention belong to the domain of public health (Prevent model). The Dutch National
Health Care Institute (formerly CVZ) has adopted this new model – which is based on thinking in terms of risks rather than in terms of symptoms/disease – thereby creating more room for preventive interventions in the domain of care (see Figure 1.1).

In the context of treating an individual client, the physical therapist’s management strategy is aimed at indicated and care-related prevention. The goal of indicated prevention is to prevent the development of a disorder or further damage to the client’s health by administering interventions to individuals with a proven elevated risk of this disorder. Care-related prevention aims to help individuals with existing health problems reduce the burden of disease, avoid complications, and support their self-efficacy.

In addition to these types of prevention, the physical therapist also actively engages in activities relating to universal and selective prevention in the public health domain (open market). Universal prevention relates to the population as a whole and aims to reduce the chances that diseases or risk factors develop, and to improve public health in general. Selective prevention aims to identify specific high-risk groups and implement health-promoting prevention programs.

Frictions may arise at the interface between indicated and selective prevention, forcing the physical therapist to make ethical choices.

Clients can also consult physical therapists in their capacity as experts on movements, at meetings organized for specific client groups or at various exercise activities.

Although programs to encourage health-promoting physical activity and selective prevention as such are not part of the physical therapy domain, the current trend is for physical therapists to increasingly venture into these activities, in view of their specific competencies regarding healthy physical activity.

**Policy, education, and research settings**

Physical therapists also work in various other settings, for instance as teachers or lecturers in institutes training physical therapists, as scientific of practice-oriented researchers, or as policy advisers in health care organizations.
1.4 Physical therapy activities

1.4.1 Methodical approach

The physical therapist uses a systematic, goal-oriented and process-based approach. Systematic means that the approach is characterized by intentional, identifiable, and logical coherence, planning, implementation, and reporting. Goal-oriented means that the therapist’s strategy aims to achieve a predefined, clear, and specific goal, together with the client. Process-based means that all aspects of patient management are interconnected and constantly influence each other. The latter implies that the physical therapist continually monitors the treatment and adjusts it accordingly, based on sound arguments. A characteristic of the physical therapy approach is shared decision making, in which the therapist distinguishes between what the client actually does in terms of movements (“actual performance” and “abilities”), what the client is assumed to be able to do (“capacity” and “capabilities”), the practical opportunities provided by the client’s environment and the conditions and context in which the movements take place (“opportunities” and “attractors”), and the client’s motives and motivation to engage in physical activity (“drivers” and “vitality”). This methodical approach enables the physical therapist to provide transparent and verifiable tailored care.

1.4.2 Phases in the methodical approach

As described in the 2011 KNGF guideline on reporting in physical therapy (in Dutch), physical therapy involves three processes, with a cyclic character:

1. The screening process, which uses targeted history-taking, supplemented where necessary by physical examination, to decide whether the patient’s presenting problem lies within the domain of physical therapy.

2. The diagnostic process, in which the physical therapist methodically assesses and analyzes the client’s movement problem and relates this to the client’s request for assistance. This process results in the formulation of a treatment plan which is feasible and in agreement with the client’s wishes, involving explicit goals, or in the client being referred back to the referring doctor or to another care provider.

3. The therapeutic process, in which the physical therapist implements the treatment plan, in consultation with the client, and methodically carries out the indicated treatment. This process also includes the evaluation and conclusion of the treatment. The evaluation involves the therapist evaluating, together with the client, those close to them and other parties involved in the process, the treatment, its result, and the procedures followed, as well as the relation between therapist and client. After the evaluation, the client and the physical therapist jointly decide, based on the results achieved and the information supplied by the therapist, whether the treatment episode can be concluded.

The interaction between client and therapist plays a major role in the physical therapist’s methodical approach. The methodical approach allows the results of the treatment to be evaluated both by fellow care providers and by external parties like the inspectorate.

1.4.3 Management

During the various phases of the methodical approach, the physical therapist implements a

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1 In view of the process nature of the physical therapist’s methodical approach, this involves permanent monitoring.

2 In view of the process nature of the physical therapist’s methodical approach, this is not a matter of a one-off evaluation, but of continuous evaluation. Hence, the term “monitoring” is actually more appropriate. The aim of monitoring is to ascertain, based on the client’s response to the treatment, whether the treatment needs to be adjusted, and to detect any adverse effects of the treatment. Monitoring enables the therapist to frequently implement the plan-do-check-act cycle.
combination of diagnostic and therapeutic management for clients with actual or impending movement problems. An integral part of the physical therapist’s management is that of counseling. Characteristic directly client-related treatment activities in physical therapy include:

- discussing (history-taking);
- testing, measuring, and analyzing;
- formulating the physical therapy diagnosis;
- counseling;
- practicing;
- applying physical modalities;
- applying manual therapy.

Characteristic indirectly client-related treatment activities include:

- recording and consulting information in the client’s file in accordance with the current KNGF guidelines on reporting;
- communicating with others on behalf of the client;
- offering support to people close to the client.

In addition to these activities, there are also supporting activities, which include furthering the development of the profession of physical therapist and activities to improve the therapist’s own professional knowledge and competencies.

1.5 Professional ethic

The professional ethics of physical therapy focuses particularly on the concept of ‘care’ in the widest possible sense. The professional ethics is of a normative nature, a core feature being that it has long-term validity. The physical therapist is aware of the ethics, and not only knows about ethics but also about the inextricably associated legislative framework in which the profession works. Dutch physical therapists are aware that the KNGF’s ethics committee defines the operational conditions for the physical therapist’s ethical reasoning and actions. The committee’s intention in defining these operational conditions is to safeguard the process of ethical reflection at the meso level, in which “care” is defined as a specific activity that includes anything that can help a person to preserve, continue and recover “his or her world” in such a way that he or she can live as satisfactory a life as possible in that world. For a physical therapist, this means that a basic attitude of acting conscientiously requires the moral qualities of attentiveness, responsibility, competence, and responsiveness, qualities which are inextricably intertwined.

The physical therapist is also familiar with the ethical principles laid down in the KNGF document entitled Beroepsethiek en gedragsregels (professional ethics and rules of conduct; in Dutch), which forms the ethical guideline for the entire profession. Based on this professional ethics, the physical therapist is able to engage in permanent reflection on the prevailing values in Dutch society, which is characterized by ethnic, religious, spiritual, cultural, and sexual diversity, and the diversity among the generations (i.e. public morals). The physical therapist is also capable of critically reflecting on the client’s values, enabling him to define the relationship of care, while remaining aware of the influence of his own personal values.

The contextual framework within which the professional community has to realize its responsibility to the public is the national health care system, which has to organize health care in such a way as to

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16 Normative ethics involves analyzing concrete everyday practice from abstract, rational, and sound principles. These principles guide a person’s evaluation of their own actions, in terms of e.g. “What should I do as a physical therapist?” (After Have et al., p. 9 and p. 19.)
keep it affordable and accessible. This means that the physical therapist, in his capacity as a professional and as a human being, may be confronted with moral dilemmas at various (macro, meso and micro) levels. This calls for a scrupulous, deliberate, responsible approach on the part of the physical therapist, based on awareness of the moral dilemmas and on balancing the moral principles in order to decide what is “the right thing to do”, after which he can use these considerations to define his treatment strategy. In these considerations, the physical therapist must at all times be aware that personal ideas, intuitions, and feelings play a conscious or unconscious part in his judgment about the right thing to do. Developments in society and the professional community, as well as personal development, mean that the physical therapist has to be constantly on the alert in this respect. The physical therapist has been trained in clinical reasoning, and is aware that he is operating within a scientific and legal framework. At the same time, he is also a normative professional with the ability to self-reflect within the relationship of care with the client. This implies that the physical therapist takes an interest in the client’s preferences, expectations, and goals (“patient values”). It is on the basis of this process of clinical and normative reasoning, and his capacity for self-reflection, that the physical therapist provides effective, efficient, and appropriate care adapted to these patient values.

1.6 Legal and regulatory context

This section briefly discusses some relevant Dutch laws and regulations, developed by the government or the professional community, which apply to clients and physical therapists and are relevant to the client and the physical therapist’s everyday practice (Table 1.1).

<table>
<thead>
<tr>
<th>Tabel 1.1 Legal and regulatory context</th>
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<tbody>
<tr>
<td><strong>Individual Health Care Professions Act (Wet BIG)</strong></td>
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<td><strong>Disciplinary Law</strong></td>
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<tr>
<td><strong>Care Institutions (Quality) Act</strong></td>
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<td><strong>Health Care (Market Regulation) Act (Wmg)</strong></td>
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<td><strong>Personal Data Protection Act (WBP)</strong></td>
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<td><strong>Medical Treatment Agreement Act (WGBO)</strong></td>
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<td><strong>Modelregeling Fysiotherapeut – Cliënt</strong></td>
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<td><strong>Clients’ Right of Complaint (Care Sector) Act</strong></td>
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<td><strong>Psychiatric Hospitals</strong></td>
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* such as do well, do no harm, show respect for autonomy and justice.
<table>
<thead>
<tr>
<th>Act/Regulation</th>
<th>Description</th>
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<tbody>
<tr>
<td>(Compulsory Admission) Act (Wet Bopz)</td>
<td>at a mental hospital against their will. An important objective of this act is to offer legal protection to people confronted with this.</td>
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<tr>
<td>Reglement Tuchtrechtspraak KNGF (Regulations for disciplinary procedures within KNGF)</td>
<td>Disciplinary procedures are implemented by the Raad voor de Rechtspraak Fysiotherapie (physical therapy disciplinary council). The procedures apply to members of KNGF and any physical therapist who is registered in the Central Quality Register for Physical Therapy (CKR).</td>
</tr>
<tr>
<td>Healthcare Insurance Act (Zvw)</td>
<td>This act came into force on 1 January 2006. Together with the Exceptional Medical Expenses Act (AWBZ) it is part of the Dutch health insurance system. The Zvw obliges anybody who is insured under the AWBZ to take out health insurance. This means all Dutch citizens and those who live abroad but have an income from work in the Netherlands.</td>
</tr>
<tr>
<td>Medical Research involving Humans Act (Wmo)</td>
<td>This act relates to scientific research in which humans are subjected to interventions or are prescribed certain behavioral rules. The act was created to offer extra legal protection to people participating as test subjects in scientific research.</td>
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<tr>
<td>Good clinical practice</td>
<td>This is an international ethical and scientific quality standard on designing, conducting, and reporting on clinical research involving test subjects. Compliance with this standard ensures that the rights, safety, and well-being of the test subjects are protected in accordance with the principles originating in the Declaration of Helsinki, and that data from clinical research are reliable.</td>
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Chapter 2  Supply and demand development in Dutch health care

This chapter discusses the main developments that affect the future profile of the physical therapist.

2.1 Developments in the demand for health care

Demographic developments

The Dutch population is expected to grow to nearly 18 million in 2014. At the same time, the composition of the Dutch population is changing. The share of people over 65 in the total population composition is rising, and the average life expectancy of men and women is expected to rise from 79.2 and 82.9 years, respectively, in 2011 to 87.1 and 89.9 years, respectively, in 2060. The aging of the population implies that not only the proportion of older adults, but also the proportion of very old people is rising (partly as a result of successful health care). The growth and composition of the Dutch population is also influenced by emigration and immigration. Immigration into the Netherlands from both EU and Asian and African countries has risen sharply since 2005. Although immigration has recently fallen as a result of the economic crisis, the number of citizens of non-Dutch origin is expected to start rising again eventually. The number of asylum-seekers entering the country is also expected to rise somewhat, as the influx of these people into the Netherlands is currently relatively small compared to that into other EU countries. The expected increase in cultural diversity will lead to greater variety in clients’ presenting problems, as different cultures have different values and views regarding health care.

The existing cultural diversity in the Netherlands requires physical therapists to familiarize themselves with international health care, with specific genetically determined disorders that used to be rare or absent in the Netherlands, and with the culturally determined perception of such disorders, and of disease and disorders in general. This means that the therapist’s communicative and social skills must also be able to adapt to international behavioral conventions.

Epidemiological developments

The majority of the Dutch population aged 19 years or over have one or more disorders, a percentage which has risen in recent decades. This rise is partly attributable to the increased life expectancy and the resulting aging of the population. Not only has the detection and screening of diseases and disorders improved, resulting in higher survival rates, but the survival rates for certain disorders have also increased, so that people with such a disorder survive longer. Half of all independently living older adults have one or more chronic diseases. Children who would in earlier times have died young, now live much longer, with lifelong impairments. In addition, the incidence of certain disorders, like diabetes and obesity, is actually rising among the Dutch population.

In terms of physical therapy care, this implies large and growing numbers of clients with one or more chronic disorders or diseases, and with more complex health-related presenting problems regarding activities, participation, and pain.

Social developments

In recent decades, Dutch society has become increasingly individualized. In health care, this has led to a more client-centered approach, which implies greater weight being given to the client’s opinion in the decision-making process and treatment. This trend of individualization leads to greater attention being given to personal preferences, which also play a role in the contacts between care providers and their clients. Clients with the same disorder may have very different care needs, depending on their goals and the needs they perceive.
Dutch society increasingly values a healthy lifestyle and the maintenance of health, as well as prevention and the simultaneous treatment of multiple disorders (multimorbidity). The nature of the demand for health care is expected to change, as people will want to continue to participate in society and professional life notwithstanding disease or old age. People will continue to live in their own home longer, whether of their own free will or because of new laws and regulations. And people want to retain control over their own life, and tend to adopt a more critical attitude toward the health care system, based on their own needs.

Modern media enable people to find extensive information about what is possible (technologically or otherwise) in health care. Before consulting a health care professional, they look for information on the internet, and sometimes they come up with a number of possible answers themselves. Clients have often already developed their own ideas about the appropriate therapy. Nevertheless, access to relevant health information does not automatically mean that people are actually able to change an unhealthy lifestyle: such changes may be considerably impeded by various kinds of obstacles (including social or physical factors and people’s implicit views on health and illness).

These developments force the physical therapist to adopt a different approach to clients and their need for care.

2.2 Policy developments

Government has a duty toward its citizens to improve and safeguard the quality of health care facilities, while care providers have a duty to provide appropriate care of sufficient quality. The definition of appropriate care has been elaborated in a national law, the Care Institutions (Quality) Act, in which terms like “effective”, “efficient”, and “client-centered” feature prominently.

The government not only has the task of ensuring the availability of high-quality facilities, but also has to find solutions to the problem of rapidly growing health care costs. It tries to find these solutions in consultation with patient and consumer societies, care providers, and health insurers.

Various policy measures are intended to control costs and to offer efficient health care. Cost control measures are resulting in fewer indications for residential care, which implies a shift in capacity from inpatient care to outpatient care. Financial considerations are inducing nursing homes and homes for the elderly to increasingly outsource services for various components of their care provision to third parties. The care for patients with less intensive care needs have been transferred to municipal authorities through the Social Support Act (Wmo).

One consequence of the Social Support Act that is relevant to physical therapists is that the municipal authorities are taking over a number of tasks, including the provision of facilities for playing, exercising and sports. Physical therapists can contribute to the provision of ‘community health’. The activities under the Social Support Act focus on selective and universal prevention. Physical therapists have the necessary competencies to supervise movement-related activities by various groups, including risk groups.

The trend to provide care closer to the client’s home means that physical therapists can redefine their position in the care spectrum, in collaboration with family physicians, occupational therapists, exercise therapists and others, as a portal for care involving movement-related activities. The physical therapist’s expertise means he is aware of the available exercise options and is able to ensure that these resources are utilized appropriately in the client’s own home, or that clients are referred to

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This is increasing, and with it the costs, due to the aging of the population and the increasing prevalence of chronic diseases as a result of the improved treatment of acute disorders. In addition, technological innovations mean that medical interventions are becoming less invasive and people are less hesitant about undergoing them. At the same time, the number of available health care professionals is decreasing.
neighborhood facilities.

The ever greater demands on physical therapists in terms of practice management, accountability regarding the treatment, and accessibility of the practice to clients increasingly require physical therapists to possess certain business skills. On the other hand, the above developments also offer new opportunities for them. Physical therapists can enter into partnerships with other parties within and outside health care, and can seek contact with other parties in society which may have their own financial sources. The physical therapist’s business sense enables him to make good use of these opportunities.

Future physical therapists will have to further develop such business competencies.

In future, care will increasingly have to be provided by informal caregivers, a trend that seems unavoidable, as it becomes ever more difficult to keep health care available, accessible, and affordable. Citizens will increasingly have to call on their fellow citizens for services that used to be provided by professionals. Physical therapists can play a substantial role in this development, for instance by instructing and counseling informal caregivers about activities like lifting up clients, transfers and helping them overcome their movement problems, in order to ensure that both client and caregiver can continue to cope.

Integrated care and collaboration

Providing appropriate care for people with complex problems associated with chronic diseases and problems relating to multimorbidity requires care to be integrated, that is, offered as one coherent package. This means that care providers have to work closely together and coordinate their care, while the chronically ill clients retain control over their own life, ensuring that the illness is effectively integrated in their life. A number of organizational changes regarding integrated care have already been set in train. The programmed approach to integrated primary care is being applied for a number of common chronic disorders. It involves an interdisciplinary and transdisciplinary approach, avoiding fragmentation and delays.

Another type of integrated care is that of projects based on the Chronic Care Model (CCM). This model focuses on functionality, and hence is less inclined to start treatment immediately when a specific pathology is diagnosed. All care providers are expected to support the client’s self-management, and an interdisciplinary approach is an essential component. The distance between client and care provider is reduced by assigning a permanent care coordinator to each client, with whom they have frequent contacts, whether face to face, by phone, by e-mail, or using other IT applications. A third form of integrated care is the care for residents of facilities offering residential, health care, exercise, and recreational facilities. More integrated health care organizations require effective collaboration. Extreme division of tasks with precisely defined responsibilities is increasingly regarded as undesirable. Tasks will more often be delegated, and physical therapists may well start to use the services of physical therapy assistants. These assistants will not only provide physical therapy interventions and assessments, but, provided they have the necessary competencies, also interventions and assessments in other, related disciplines.

To be able to work in this type of integrated care systems, a physical therapist must have good organizational and collaborative abilities, as well as a clear idea of his own competencies and those of other professionals within and outside the domain of physical therapy and other movement-related care. In projects that focus on helping clients with their movement problems and improving their functional performance and participation, the physical therapist is the obvious professional to assume this coordinating function.

The increasing demand from governments and client and patient organizations for transparency and accountability in health care makes it necessary to assess the actual results of the care provided. The efficacy and transparency of the entire care trajectory is an important quality indicator. These aspects
have been made assessable by the development of instruments like patient reported outcome measures (PROMs). A PROM involves assessing the client’s perception of the final outcome of the entire care trajectory that the client has gone through, rather than the effects of individual processes. This approach requires various care providers to work closely together with each other and with clients, with the client often constituting the gold standard. PROMs also allow lessons to be learnt about the quality of care provided, and this obviously requires joint evaluation, coordination, and transparency.

Client organizations are important partners in health care, and physical therapists can support them in providing useful and evidence-based education to clients.

**Prevention**

One of the ways the government is trying to reduce the costs of health care is by stimulating specialist knowledge about prevention. In their personal contacts with clients, physical therapists are focusing more and more on prevention and are engaging in activities for the purpose of care-related and indicated prevention, relating to individual clients. While treating a client, the physical therapist is constantly on the alert to detect any risk factors, diseases, or disorders that the client is not yet aware of. However, the therapist will only initiate investigations if there are specific reasons to suspect a disorder or movement problem (case-finding). At the same time, evidence is growing that sufficient physical activity has a favorable effect in terms of preventing various diseases and improving the health status of patients with chronic diseases. Enhancing physical fitness thus appears to be an alternative to medication, or should at least be prescribed to supplement medical treatment.

The prevention-oriented approach also means that, more than before, physical therapists should seek to collaborate with partners outside health care. Potential partners include especially municipal authorities, which have recently been assigned major healthcare-related tasks under the Social Support Act. Others include sports organizations and companies offering wellness activities. All those involved, above all the clients themselves, benefit from rational, seamless but clear-cut transitions between physical activities, regular sports activities and health care activities as defined in the Individual Health Care Professions Act (BIG). This implies that physical therapists will have to establish their position not only as professionals addressing movement problems, but also as innovative entrepreneurs who can build networks in their neighborhood and with client organizations.

**2.3 Professional developments**

The discipline of physical therapy is developing under the influence of political and social factors, as well as that of the internal dynamics inherent in any domain of knowledge. Developments within physical therapy arise in response to changes in the problems for which clients seek assistance from physical therapists.

**Participation**

One of the goals of physical therapy is to optimize patients’ movement-related functioning in relation to participation; the disease-based model has been replaced by a partnership between therapist and client. This is why treatment goals in physical therapy are now being formulated in terms of activities and participation. Clients often have high expectations about what health care can do to enable them to achieve the intended level of participation, which can result in dilemmas for care providers.

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9 Out-of-hours GP services, walk-in offices, and other small-scale health centers play an important role in providing access to the care system, and the available opportunities for physical activity, such as neighborhood recreational facilities, play a major preventive role, as does the availability through modern media of easy-to-understand and directly relevant information about health and illness.
for instance if a client expects too much of a physical therapist, or because a particular type of health care proves to be unavailable to a particular client. While some clients express no specific wishes, others rigidly hold on to their initial preferences. Such situations can only be solved through open communication, in which the client’s previous experiences of therapy and their current situation are explicitly discussed and taken into account.

Communication
Modern communication systems offer new opportunities, including large numbers of web-based personalized sources of information. There is a need for appropriate communication focusing on functionality and participation, not only among care providers but also between care providers and clients. A physical therapist can help his client by linking his specific knowledge about movements and related subjects to the client’s movement problem. Social media can be used for communication, allowing the therapist to respond to the client’s presenting problem while respecting the client’s control over their own life and treatment.

Scientific research
The national and international scientific evidence base for physical therapy has been considerably extended over the last 25 years. Scientific research into physical therapy has greatly increased, as is clear from the considerable rise in the number of professors, researchers, and PhD projects at university departments, and lectureships at universities of applied sciences. KNGF has developed a whole range of mono- and multidisciplinary evidence-based guidelines that physical therapists can consult. There is a need for translational research to increase the applicability of basic scientific knowledge and to bridge the gap between theory and practice. Research programs on physical therapy are collaborating with related (medical) disciplines.

The growing number of high-quality research studies has greatly improved our understanding of the mechanisms that determine the course and success of physical therapy. This development requires increasing specialization of the physical therapy community.

Research findings increasingly indicate that sufficient physical activity has favorable effects on people’s general health status, especially that of the chronically ill. This has opened up new avenues for movement-related interventions. One of the physical therapist’s tasks is that of disease prevention and reducing the incidence of inactivity-related diseases.

2.4 Technological developments
Health care is making ever more use of internet technology and other technological resources. The concept of eHealth has a wide range of meanings and is defined as “technological support for health care to improve clients’ health status”. Lack of funding and manpower in the health care system will accelerate the introduction of eHealth. There are also intrinsic advantages to eHealth, such as that it offers assistance that fits in well with the concept of self-management. eHealth involves monitoring one’s own medical status or a number of body functions, and communicating the results to a care provider. eHealth also includes telemonitoring, which enables a client to do exercises at home which the care provider can follow on-screen from a distance, allowing them to give feedback on the client’s performance. Domotics and robotics are also often regarded as examples of eHealth. Domotics involves the use of modern technology to enable people to stay in their own home longer, for instance using equipment that can switch itself off, or personal alarm devices. These developments affect the relation between care provider and client.

2.5 Training and expertise of the physical therapist
The sequence of training options for physical therapists include a Bachelor’s degree course and a Master’s degree course, which may be followed by a PhD program. The Bachelor’s program results in
the title of physical therapist at the EQF 6 level and allows the student to be included in the BIG register as an all-round physical therapist for individual health care. This also enables the student to enroll in various Master’s degree courses at universities of applied sciences (called HBOs in Dutch). A physical therapist with a Master’s degree possesses specific competencies in one of the specialist subdisciplines of physical therapy, enabling him to provide appropriate and high-quality care in the context of complex client care within his own subdiscipline, as well as to contribute to practice-oriented research. There is also a Research Master program, offered by Dutch universities, known as Fysiotherapiewetenschap (physical therapy science), resulting in an MSc degree, which can be followed by a PhD project. Universities are currently developing new Master’s degree programs, and there are also plans to develop a university-based Bachelor’s program on physical therapy.

Dutch universities have started to collaborate with teaching hospitals, as well as with the HBOs (universities of applied science), reflecting the demand for physical therapists at the EQF 7 level.

KNGF is encouraging the establishment of chairs of physical therapy at universities and lecturerships at HBOs, to meet the need for a more scientific approach to the discipline. A number of such chairs and lecturerships have been realized in the last decade. KNGF is funding university chairs, while ensuring an appropriate distribution across the main areas of interest within physical therapy. The increase in the number of scientists with a PhD degree at the universities and HBOs has led to a large increase in the number of PhD projects. Lecturers and professors are taking an ever more active part in teaching programs, and their extensive scientific knowledge is resulting in a higher quality of evidence-based teaching.

As of 2025, KNGF policy requires that any physical therapist applying for inclusion in the KNGF Central Quality register (CKR) must possess a Master’s degree at the EQF 7 level. Any additional requirements for inclusion in the various quality registers for specialist subdisciplines are set by the associations of specialist physical therapists. KNGF, the educational institutions and the associations of specialist physical therapists are collaborating to effectuate this transition.

Future physical therapists will be able to handle complex problems, will be more likely to work in interdisciplinary settings, and will be authorized to carry out more diagnostic and therapeutic activities.
Chapter 3  The competent physical therapist

Professional expertise development in physical therapy happens at two levels, that of the profession as a whole and that of the individual professional. At the level of the profession, expertise development means a process of progress in the development of the profession as a whole, including characteristics such as building and making accessible a “Body of Knowledge and Skills”. In addition, it means a development toward increased awareness and recognition of the specific domain of expertise. At the level of the individual professional, expertise development means the process by which the individual physical therapist expands his own knowledge, expertise, and professional judgment, and integrates new insights in his professional practice. These two processes are inextricably intertwined, but have different goals. The two processes are combined in this general professional profile of the physical therapist, which applies to every physical therapist. In this profile, expertise is no longer regarded as the sum total of knowledge, skills, and attitudes, but as integrated sets of qualifications denoted by the term “competency”. In this context, a competency is interpreted as the ability to use one’s knowledge, skills, attitudes, values, and role interpretations to act appropriately in complex professional situations, and the ability to justify and reflect upon choices and decisions made in the process.

3.1  Context and level

The description of the competency profiles in part 2 of this professional profile document is based on the European Qualifications Framework (EQF). The aim of the EQF is to promote international student and employee mobility and to facilitate lifelong learning. The EQF allows educational levels to be compared between countries, thus contributing to the transparency of the various educational systems in Europe.

To a large extent, competencies relate to a specific subject and context. Whether someone is competent in a particular situation depends on the degree to which they possess the necessary expertise and experience that is relevant to solving certain problems in the context in which they appear.

The key concepts used in EQF to describe levels are as follows:

- The level of complexity of skills is determined by both the description of the context and the person’s knowledge.
- Independence and responsibility together constitute the ability to collaborate with others and to take responsibility for one’s own results and those of others.
- Knowledge is the set of facts, principles, theories, and working methods relating to the profession of physical therapist.
- Skills:
  - applying knowledge and reproducing, analyzing, integrating, evaluating, combining, and applying it in one’s professional practice;
  - problem-solving skills;
  - ability to learn and develop;
  - information retrieval skills;
  - communicative skills.

3.1.1  The physical therapist at the EQF 6 level

The context for a physical therapist at the EQF 6 level has been described as ‘an unknown, changeable living and working environment, which may include other countries. Physical therapists trained and functioning at the EQF 6 level have to meet the following quality criteria:

- The physical therapist possesses advanced knowledge of the discipline of physical therapy and adjoining disciplines relevant to physical therapy.
– The physical therapist shows critical understanding of theories and principles.
– The physical therapist possesses advanced skills, enabling him to use professional expertise and innovative abilities to solve complex and unpredictable problems, and using these advanced skills to manage complex situations, make autonomous decisions and take responsibility for them, in both predictable and unpredictable professional situations and contexts.
– The physical therapist takes responsibility for promoting his own professional development as well as that of the people employed or managed by him.

3.1.2 The physical therapist at the EQF 7 level
The context for a physical therapist at the EQF 7 level has been described as “an unknown, changeable living and working environment with a high level of uncertainty, which may include other countries”. Physical therapists trained and functioning at the Master’s level (EQF 7) have to meet the following quality criteria:

– The physical therapist possesses highly specialized knowledge at advanced level for physical therapy and the adjoining disciplines relevant to physical therapy, which functions as a basis for original ideas and/or research.
– The physical therapist is critically aware of problems of physical therapy and the adjoining disciplines relevant to physical therapy, as well as the interfaces between the various disciplines.
– The physical therapist possesses the problem-solving skills required for research and/or innovation, enabling him to develop new knowledge and procedures, and to integrate knowledge from various disciplines. He uses these skills in complex and unpredictable situations or contexts to independently select, implement, and transform strategic approaches, and to make autonomous decisions and take responsibility for them.
– The physical therapist manages and transforms complex and unpredictable professional contexts that require a new strategic approach. This includes not only complex situations relating to the diagnostics, prognostics, and/or therapy for one client, but also complex situations relating to professional practice at micro, meso, or macro level. He analyzes the problem in a multifactorial and multidimensional approach, after which he formulates a targeted strategy to solve it, discusses this with the client and implements it where possible.
– The physical therapist takes responsibility for contributing to the development of professional knowledge and practice and/or for critically reviewing the strategic performance of teams.

3.2 Competency profile of the physical therapist

3.2.1 Structure of the competency profile
The physical therapist’s competencies have been structured on the basis of the CanMEDS model, which focuses on seven competency areas.\(^1\) We decided to describe the competencies in terms of areas, to fit in with the system used for medical disciplines (Royal Dutch Medical Association – KNMG) rather than in terms of roles, as the original CanMEDS model does. In our view, the description in terms of competency areas does more justice to the integrated application of competencies in the central competency area of “physical therapy activities”.

The competency profile is structured as follows:
– seven competency areas;
– a description of each competency area;
– four so-called key competencies for each competency area;
– indicators as operationalizations of the key competencies.

The competencies have been formulated on the basis of verbs indicating behaviors. The description of the competencies is based on the therapist’s actual behavior in professional situations.
Figure 3.1 The CanMEDS model applied to physical therapy
3.2.2 The competency areas

Seven competency areas have been distinguished:

1. **Physical therapy activities**: The physical therapist uses the methodical approach to provide explicit, conscientious, and judicious assistance to clients with movement problems. His behavior is professional by the standards of the current state of the discipline. He collects and interprets data to enable him to make diagnostic, prognostic, and therapeutic decisions according to the EBP principles within the boundaries of the physical therapy profession. He provides up-to-date, effective, curative and preventive care in accordance with ethical principles.

2. **Communicating**: The physical therapist ensures high-quality assistance to his clients and aims at a high level of client satisfaction by keeping up an effective relationship with the client and those close to them and/or others involved. The physical therapist clearly, transparently, effectively, and efficiently communicates with the client during the therapy process, both verbally and non-verbally.

3. **Collaborating**: Where necessary, the physical therapist collaborates with the relevant professionals, health insurers, and civil society organizations and government bodies. He participates in collaborative networks and makes the best possible use of the available expertise to ensure high-quality care.

4. **Knowledge sharing and scientific research**: The physical therapist works according to the principles of Evidence-Based Practice, contributes to the development of his own and other practitioners’ clinical expertise and contributes to scientific research.

5. **Acting in the interest of society**: The physical therapist balances the interests of his client against the interests of others seeking assistance and the interests of society. He practices his profession in a socially responsible way, taking account of factors like sustainability, professional ethics, the legal context, and the social and cultural context.

6. **Organizing**: The physical therapist works toward a well-organized practice in order to carry out his profession effectively and efficiently. In a way, the physical therapist acts as a manager for his own professional activities, as well as for the work of other care providers. The physical therapist makes decisions regarding the deployment of resources and staff, goal and priority setting, and policy-making. He organizes his own work, while balancing professional activities and the need to further develop both himself and, where relevant, the care organization for which he works.

7. **Professional conduct**: The physical therapist provides high-quality care to his clients, with integrity, sincerity, and commitment. He takes responsibility for his actions and carefully balances his personal and professional roles. He is aware of the limits of his competencies, and acts accordingly. His attitude is transparent and he is prepared to accept assessment of this actions. He is aware of ethical dilemmas, is familiar with ethical standards and complies with laws and regulations.

3.2.3 Physical therapy activities – detailed description

The physical therapist uses the methodical approach to provide explicit, conscientious, and judicious assistance to clients with movement problems. “Physical therapy activities” is the central competency area, which utilizes all the other competencies. Physical therapy treatment in the stricter sense focuses on professional expertise.

The physical therapist is familiar with the domains of knowledge that are relevant to his own ideas and actions, and can retrieve information on medical research quickly and efficiently. The physical therapist uses the methodical approach to carry out history-taking (if necessary through proxies) and physical examination and uses the outcome to formulate rational hypotheses about the possible causes and consequences of the findings, identifying rational links between the findings at the three ICF levels and the environmental and personal factors that influence them. He builds up a coherent view of his client’s perception of the movement problems they experience in their social and cultural context, the ways in which the client moves in their specific environment and the client’s
musculoskeletal system with its impairments. The physical therapist possesses the manual skills necessary for examination and treatment. Based on the hypotheses he has formulated, he proposes an effective strategy for supplementary diagnostics, treatment, care, and prevention, while respecting the wishes of the client and their relatives, basing himself on the customary approach, and on a rational and evidence-based approach to medicine. The physical therapist makes appropriate use of technology and is aware of the advantages and disadvantages of particular interventions.

Within the competency area of “physical therapy activities”, four competencies have been formulated, relating to the three phases of the methodical approach to physical therapy treatment (see Section 1.4.2). The matrix shows the relation between the physical therapy processes, the eight process steps described in KNGF’s 2001 practice guideline for reporting in physical therapy (in Dutch) and the four competencies for the competency area of “physical therapy activities”.

<table>
<thead>
<tr>
<th>Physical therapy process</th>
<th>Eight steps</th>
<th>Competency area 1</th>
</tr>
</thead>
</table>
| Screening process        | 1a. Presentation  
  1b. Identifying presenting problem  
  1c. Screening for serious pathology  
  1d. Informing and advising | 1.1 Screening  
  The physical therapist screens the client through targeted history-taking, supplemented where necessary by physical examination, in order to decide whether the client’s health problem falls within the domain of physical therapy. |
| Diagnostic process       | 2. Supplementary history-taking (using proxies if necessary)  
  3. Supplementary investigations  
  4. Analysis | 1.2 Diagnostics  
  The physical therapist methodically identifies and analyzes the movement problem and relates this problem to the client’s presenting problem. |
| Therapeutic process      | 5. Treatment plan  
  6. Treatment | 1.3 Treatment  
  The physical therapist applies the treatment strategy he has established in consultation with the client and methodically implements the indicated treatment, again in consultation with the client. |
|                         | 7. Evaluation  
  8. Conclusion | 1.4 Concluding the treatment  
  The physical therapist concludes the treatment, in consultation with the client. |

### 3.3 Body of knowledge and skills

In order to select the appropriate intervention for a particular client, and implement it correctly at the appropriate moment, the physical therapist needs to possess skills and knowledge from the following core domains: functional anatomy, biomechanics, (neuro)physiology, pathology, and psychology, but also from knowledge domains like health science, health economics, and organization science. The 2008 *National diploma supplement and National Transcript for Physical Therapy* functions as the “body of knowledge and skills” and is based on the EQF 6 level.  

Specialist physical therapists have described the body of knowledge and skills relevant to their specialist discipline, derived from the above core areas, at the EQF 7 level, in professional profiles for individual specialist subdisciplines.
References


Part 2

Competency profile for physical therapists
### Part 2  Competency profile for physical therapists

<table>
<thead>
<tr>
<th>1</th>
<th>Physical therapy activities</th>
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<tr>
<td></td>
<td>The physical therapist uses the methodical approach to provide explicit, conscientious, and judicious assistance to clients with movement problems. His behavior is professional by the standards of the current state of the discipline. He collects and interprets data to enable him to make diagnostic, prognostic, and therapeutic decisions according to the EBP principles within the boundaries of the physical therapy profession. He provides up-to-date, effective curative and preventive care in accordance with ethical principles.</td>
</tr>
</tbody>
</table>

| 1.1 | Screening |
|     | The physical therapist screens the client through targeted history-taking, supplemented where necessary by physical examination, in order to decide whether the client’s health problem falls within the domain of physical therapy. |
|     | The physical therapist: |
|     |   o explains the objectives, procedure, and methods of the screening process; |
|     |   o uses open and closed questions to identify the client’s health problem and their expectations regarding its solution; |
|     |   o uses the methodical history-taking procedure (identifying the nature, localization, course, and severity of signs and symptoms and their interrelatedness); |
|     |   o carries out a physical examination if necessary and uses relevant measurement instruments; |
|     |   o uses the pattern recognition approach in analyzing the client’s health problem; |
|     |   o assesses whether he is competent and authorized to make a decision on whether physical therapy is indicated or contra-indicated; |
|     |   o uses his knowledge of the physical therapy domain to make a decision on whether physical therapy is indicated or contra-indicated; |
|     |   o records and documents the decision on whether physical therapy is indicated or contra-indicated in accordance with the current guidelines and the prevailing laws and regulations; |
|     |   o presents his decision to the client for consideration, mentions the arguments that led him to this decision, answers any questions the client may have about it, and advises the client regarding the further procedure(s); |
|     |   o informs the client about reporting to the client’s family physician, if applicable; |
|     |   o reports in writing to the client’s family physician, if applicable. |

| 1.2 | Physical therapy diagnosis |
|     | The physical therapist methodically identifies and analyzes the movement problem and relates this to the client’s presenting problem. |
|     | The physical therapist: |
|     |   o explains the objectives, procedure, and methods of the diagnostic process for physical therapy; |
|     |   o identifies the client’s health problem, the environment in which the movement problem arose and the client’s social and cultural background insofar as this is relevant to their movement problem; |
|     |   o identifies factors impeding or facilitating healthy behavior / behavioral changes; |
|     |   o describes the client’s health problem in terms of the ICF classification; |
|     |   o analyzes the client’s health problem and identifies logical connections between the ICF dimensions (clinical reasoning) according to the principles of Evidence-Based Practice; |
|     |   o translates clinical uncertainty regarding the physical therapy diagnosis into questions that can be answered using generally accepted and emerging knowledge, uses a carefully selected strategy to look for answers, interprets the answers, and applies the results of his search strategy; |
|     |   o selects and justifies the selection of measurement instruments that can help identify and analyze the client’s (potential) health problem; |
|     |   o uses measurements/assessments to identify and analyze the client’s health problem, and interprets the findings of the instruments, history-taking, and physical examination in relation to the client’s health problem; |
|     |   o formulates, justifies, and substantiates the physical therapy diagnosis of the client’s health problem, and discusses this diagnosis with the client; |
|     |   o gives an indication of the expected course of the health problem and identifies the factors that influence this course; |
|     |   o works in accordance with the practice guideline that is relevant to the client’s health problem and justifies any deviations from this guideline; |
|     |   o records and documents the diagnostic process in accordance with the current guidelines and the prevailing legislation and regulations. |
### 1.3 Physical therapy treatment

The physical therapist applies the treatment strategy he has established in consultation with the client and methodically implements the indicated treatment, in consultation with the client.

<table>
<thead>
<tr>
<th>The physical therapist:</th>
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<tbody>
<tr>
<td>o translates clinical uncertainty regarding the physical therapy diagnosis into questions that can be answered;</td>
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<tr>
<td>o designs a treatment plan, in consultation with the client and based on the principles of Evidence-Based Practice, and then discusses the resulting plan again with the client;</td>
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<td>o stimulates self-management;</td>
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<tr>
<td>o formulates the definitive treatment plan including the final goal and subgoals in SMART terms, as well as the nature, combination, sequence, and frequency of the planned physical therapy interventions, presents the final goal and subgoals to the client, acts in accordance with the practice guideline relevant to the client’s health problem and justifies any deviations from this guideline;</td>
</tr>
<tr>
<td>o advises the client about choosing the appropriate physical therapist, the appropriate specialist subdiscipline or care providers from other (medical or allied health) disciplines;</td>
</tr>
<tr>
<td>o records and documents the physical therapy treatment plan in accordance with the current guidelines and the prevailing legislation and regulations;</td>
</tr>
<tr>
<td>o implements the treatment plan in accordance with the principles of Evidence-Based Practice and, if necessary, uses technical devices in a safe and careful manner;</td>
</tr>
<tr>
<td>o assesses, evaluates, analyzes, and records the interventions and the course of the therapeutic process in terms of the treatment effects, using measurement instruments, and if necessary adjusts the treatment plan;</td>
</tr>
<tr>
<td>o reports on the course of the physical therapy process to third parties in accordance with the current guidelines and the prevailing legislation and regulations;</td>
</tr>
<tr>
<td>o supports the client’s self-efficacy and independence by means of innovative technology;</td>
</tr>
<tr>
<td>o if necessary, refers the client to other care providers outside the physical therapy domain if there are indications for a different type of treatment than physical therapy.</td>
</tr>
</tbody>
</table>

### 1.4 Concluding the physical therapy treatment

The physical therapist concludes the treatment, in consultation with the client.

<table>
<thead>
<tr>
<th>The physical therapist:</th>
</tr>
</thead>
<tbody>
<tr>
<td>o evaluates the treatment, its result, and the procedures followed, as well as the relation between therapist and client, together with the client and their relatives and other parties involved in the process;</td>
</tr>
<tr>
<td>o reports on the results of the physical therapy treatment to the referring physician and other professionals involved.</td>
</tr>
</tbody>
</table>

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SMART stands for: Specific, Measurable, Achievable, Realistic and Time-bound.
2 Communicating

The physical therapist ensures the provision of high-quality assistance to his clients, and aims at a high level of client satisfaction by keeping up an effective relationship with the client and their relatives and/or others involved. The physical therapist clearly, transparently, effectively, and efficiently communicates with the client during the treatment process, both verbally and non-verbally, while remaining aware of the client’s cultural background.

### 2.1 The physical therapist builds up an effective therapeutic relationship with the client.

The physical therapist:
- maintains a relationship with the client characterized by respect, empathy, responsiveness, confidentiality, and a sense of safety, throughout the entire care process;
- identifies the preferences and needs of the client and their relatives in relation to solving the health problem;
- informs, encourages, adjusts, and sets boundaries while remaining aware of cultural diversity, without compromising the professional relationship between therapist and client;
- stimulates the client’s own sense of responsibility in solving the problem, depending on his assessment of the client’s capacities.

### 2.2 The physical therapist listens attentively and obtains information from the client in an efficient and effective manner, while respecting the client’s privacy.

The physical therapist:
- chooses the interview techniques, justifying his choice, and implements them with the client and their relatives and others involved;
- selects an appropriate form of communication with the client and their relatives and others involved, justifying this choice.

### 2.3 The physical therapist discusses the information regarding goals and procedures with the client and their relatives and/or others involved.

The physical therapist:
- talks to the client’s relatives and/or others involved if necessary, using a methodical approach adapted to the person’s perspective and language skills;
- counsels the client and their relatives and others involved as regards goal setting and choosing interventions;
- enters into an informed consent agreement with the client and their relatives and/or others involved.

### 2.4 The physical therapist appropriately reports on the client, verbally or in writing

The physical therapist:
- records and reports on the treatment process to other care providers, health insurers, and others involved with the client;
- ensures, where applicable, that a written report is sent to the referring physician;
- reports to others within and beyond the physical therapy domain, provided the client has consented to this;
- prepares appropriate reports on the progress and results of his treatment to other care providers involved with the client.
3 **Collaborating**

The physical therapist collaborates with the relevant professionals, health insurers, and civil society organizations and government bodies. He participates in a collaborative network and utilizes the available expertise to ensure high-quality assistance.

### 3.1 The physical therapist collaborates with other professional care providers involved in the care process.

The physical therapist:
- effectively and efficiently participates in case consultation meetings;
- effectively and efficiently includes other professional care providers involved in the care process, as well as informal caregivers, in the process of care provision;
- effectively and efficiently collaborates in a team, and is aware of the consequences of his own actions for other care providers involved;
- refers clients effectively and efficiently to other care providers if the diagnosis or treatment calls for this;
- takes the arguments of other professional care providers and informal caregivers involved with the client into account in his considerations, and makes rational decisions effectively and efficiently;
- corrects himself and others in an appropriate manner and within the prevailing legislation and regulations.

### 3.2 The physical therapist consults with colleagues.

The physical therapist:
- uses his expertise to advise colleagues;
- is aware of possible conflicts of interest among various parties, balances the interests of all those involved, and acts accordingly, within the prevailing legislation and regulations.

### 3.3 The physical therapist cooperates with health insurers.

The physical therapist:
- collaborates effectively and efficiently and respects the competencies and qualifications of others;
- takes account of health insurers’ arguments in the process of care provision, balances these arguments, and makes rational decisions effectively and efficiently;
- collects from health insurers the information required for the process of care provision, in an appropriate manner and in accordance with the prevailing legislation and regulations;
- reports to health insurers in an appropriate manner and in accordance with the prevailing legislation and regulations;
- submits claims to health insurers or charges the client in an appropriate manner and in accordance with the prevailing legislation and regulations;
- enters into discussions and exchanges of views with health insurers about the quality of the physical therapy care being provided and about aspects of the collaboration.

### 3.4 The physical therapist collaborates with the relevant civil society organizations, government bodies, and/or professional associations.

The physical therapist:
- maintains effective relationships with civil society organizations that are relevant to the process of care provision (including patient associations) and government bodies;
- enters into discussions and exchanges of views with civil society organizations that are relevant to the process of care provision (including patient associations), government bodies, and professional associations, about the legitimacy and quality of care provision;
- collaborates with organizations to promote innovations in physical therapy and health care in general;
- enters into collaborations with various partners within and outside the health care system in order to find new opportunities on the market for movement-related facilities and services.
4 Knowledge sharing and scientific research

The physical therapist contributes to the development of his own clinical expertise and that of others, as well as to scientific research, while acting in accordance with the relevant legislation and regulations, and also contributes to the process of innovation, in order to produce new knowledge and procedures, and to disseminate knowledge.

4.1 The physical therapist advances the knowledge of his clients and their relatives and/or others involved, his colleagues, and any other professionals and informal caregivers involved.

The physical therapist:
- designs strategies to advance knowledge;
- collects, selects, and designs educational and instructional materials;
- participates in tutorial conversations with trainees;
- gives presentations for clients, colleagues, and/or others;
- publishes information for clients, colleagues, and others;
- contributes to conferences on physical therapy.

4.2 The physical therapist contributes to scientific research.

The physical therapist:
- identifies and reports gaps in the available knowledge relating to the professional practice and knowledge domain of physical therapy, and takes appropriate action;
- is able to translate problems encountered in his professional practice into research questions;
- participates in scientific research, under supervision;
- collects data for basic and/or practice-oriented research in accordance with the appropriate standards and the prevailing legislation and regulations;
- supplies data for basic and practice-oriented research in accordance with the appropriate standards and the prevailing legislation and regulations;
- contributes to innovative projects.

4.3 The physical therapist applies research findings judiciously.

The physical therapist:
- collects information from the international scientific literature;
- interprets information from the international scientific literature;
- applies information from the international scientific literature when providing physical therapy care, based on the principles of Evidence-Based Practice;
- uses guidelines judiciously.

4.4 The physical therapist designs and implements a personal development program.

The physical therapist:
- critically reflects on and evaluates his own practices within the physical therapy process, based on his own expectations;
- asks others to provide feedback on his own process of reflection;
- asks critical questions about his own professional practices, in relation to expectations expressed by others;
- sets himself personal objectives and chooses the appropriate learning strategies to achieve them.
### 5 Acting in the interest of society

The physical therapist balances the interests of his client against the interests of others seeking assistance and the interests of society. He practices his professional in a socially responsible way, taking account of factors like sustainability, professional ethics, the legal context, and the social and cultural context.

#### 5.1 The physical therapist recognizes the determinants of illness and health.

The physical therapist:
- recognizes and interprets factors that affect the client’s health and takes them into account in his physical therapy strategy;
- is constantly on the alert to detect any risks of diseases or disorders that the client is not yet aware of (case-finding).

#### 5.2 The physical therapist promotes the health of clients as well as public health.

The physical therapist:
- participates in the public debate about health, the need for help, health care, and physical therapy care, based on a range of perspectives;
- ensures easy access to care while remaining aware of the economic effects;
- contributes to innovations in health care.

#### 5.3 The physical therapist acts in accordance with the relevant legal regulations and the professional code of conduct.

The physical therapist:
- acts in accordance with the values and standards defined in professional codes of conduct, the public domain and the prevailing legislation and regulations;
- acts in accordance with his own legal position and the legal position of his clients, including professional confidentiality.

#### 5.4 The physical therapist intervenes when adverse effects of care manifest themselves or health care incidents occur.

The physical therapist:
- recognizes his own errors, corrects them, and prevents recurrence;
- remains alert, records complaints, and responds to them in a satisfactory manner;
- informs the client of available complaints procedures and the relevant services;
- pays attention to, recognizes and reports incidents, errors, and undesirable situations in health care, using the appropriate procedures within the prevailing legislative framework (i.e. the Health Care Inspectorate);
- pays attention to and recognizes signs that clients may have been subject to abuse, and reports this following the appropriate procedures within the prevailing legislative framework.
### 6 Organizing

The physical therapist works toward a well-organized practice, in order to carry out his profession effectively and efficiently. The physical therapist acts as a manager for his own professional activities, as well as for the work of others. He organizes his own work, while balancing professional activities and the need to further develop both himself and the care organization for which he works.

#### 6.1 The physical therapist plans and organizes his own work, in consultation with colleagues working within the same organization.

The physical therapist:  
- plans, organizes, and manages his own care provision process in terms of:  
  - presence and availability;  
  - feasibility and suitability;  
  - efficacy and efficiency;  
  - confidentiality;  
  - cost control;  
  - legitimacy and lawfulness;  
  - practice management;  
- deploys resources and staff efficiently and efficiently;  
- formulates realistic expectations for himself in order to ensure a balanced life;  
- maintains and improves his own expertise.

#### 6.2 The physical therapist effectively and efficiently participates in interprofessional networks.

The physical therapist:  
- plans, organizes, and manages his own work in the context of interprofessional networks in terms of:  
  - presence and availability;  
  - feasibility and suitability;  
  - efficacy and efficiency;  
  - secrecy and confidentiality;  
  - cost control;  
  - legitimacy and lawfulness;  
  - practice management;  
- monitors and innovates expertise within the interprofessional network.

#### 6.3 The physical therapist works effectively and efficiently within a health care organization.

The physical therapist:  
- participates actively in, or leads, a multidisciplinary team, and effectively applies the principles of organization and management;  
- takes the basic principles of health care organization into account;  
- applies the principles that promote efficient meetings;  
- contributes to the quality assurance policy of the organization for which he works;  
- offers advice to the management team, whether at their request or at his own initiative;  
- is actively involved in policy development.
### 7 Professional conduct

The physical therapist provides high-quality care to his clients, with integrity, sincerity and commitment. He takes responsibility for his actions and carefully balances his personal and professional roles. He is aware of the limits of his competencies and acts within them or engages another practitioner. He is prepared to accept being assessed by others. He is aware of ethical dilemmas, is familiar with ethical standards, and complies with laws and regulations.

#### 7.1 The physical therapist adopts a professional attitude in his relationship with the client.

The physical therapist:
- adopts a competent, attentive, responsive, and conscientious attitude;
- acts in a methodical, explicit, and efficient way;
- records and reports;
- respects the boundaries of his professional domain;
- takes responsibility and is prepared to be held accountable.

#### 7.2 The physical therapist adopts a professional attitude in interprofessional relationships.

The physical therapist:
- adopts a competent, attentive, responsive, and conscientious attitude;
- acts in a methodical, explicit, and efficient way;
- records and reports;
- takes responsibility and is prepared to be held accountable.

#### 7.3 The physical therapist behaves in a suitable professional way.

The physical therapist:
- is sensitive to moral issues;
- justifies and substantiates his moral considerations;
- asks others to critically evaluate his moral considerations;
- considers the client’s presenting problem and asks himself what is “the right thing to do” in this particular case, and relates his answer to the interests of the client, his own interests, the interests of others in the client’s social environment and the interests of society;
- takes and manifests responsibility for his moral considerations.

#### 7.4 The physical therapist practices his profession in accordance with the ethical values customary in the profession.

The physical therapist:
- complies with the legal, ethical, and medical rules of conduct;
- recognizes ethical dilemmas;
- recognizes and addresses unprofessional behavior.
Epilogue

This professional profile clearly defines the boundaries of the professional domain. The consequences for the design of the curriculum at educational institutions can be easily derived from the descriptions of competencies and their specification in terms of indicators. However, the health care system reflects the current status of society. The demand for physical therapy fluctuates and is partly determined by the health care consequences of the public debate. This professional profile can play a part in the process of translating the outcomes of the public debate into political decision-making and hence into adjusted services by physical therapists. Hence, the professional profile needs to be a living document, with a short turnover time. Only then can it respond effectively to relevant changes in health care. We need to consult with professional associations and with educational institutions to find a procedure that allows continued evaluation of the professional profile in the face of new developments.

As a professional association, KNGF has a public responsibility. We want to offer transparent information on the care that our members can provide, and as such want to accept our responsibility for the quality of physical therapy provided. This professional profile is an important instrument in this respect, enabling both therapists and clients to know what to expect.

Henri Kiers
Member of the Board of the Royal Dutch Society for Physical Therapy (KNGF)

Quality, Training, Research and Professional Content

February 2014
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