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METHOD



Development of an updated version of the Code of Ethics of Italian physiotherapists: rationale and methodology

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ABSTRACT

Background: A number of technological, demographic, cultural, organisational and social issues emerged since the current code of ethics of physiotherapists in Italy was published in 2012, making an update mandatory. The development process of a Code of Ethics is understudied and underreported, leading to a lack of consensus. This article describes the methodology employed for developing an updated version of the Code of Ethics, implementing a participatory model.

Methods: A mixed, multi-step methodology was applied, involving 38 local orders and 74,401 physiotherapists across Italy. Consultation with professional institutions, a literature review, and a comparison of other codes of ethics were conducted. A questionnaire was developed and distributed to all members, and four focus groups were organised to discuss the emerging themes.

Results: The basis for updating the current code of ethics was built on various sources, such as literature and other codes of ethics, as well as the involvement of all physiotherapists nationwide.

Conclusions: The proposed approach could serve as an example for developing or updating a code of ethics using a participatory model, in order to enhance engagement and participation in professional governance processes.

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Introduction

A Code of Ethics is a document that defines the fundamental values, principles, and norms guiding the conduct of members of a profession. It articulates shared ethical commitments and provides a framework to support ethical decision-making in clinical practice and professional relationships, particularly in

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situations involving uncertainty or conflicting obligations [1]. A code of ethics also promotes professional accountability by establishing standards against which conduct can be evaluated [2].

Like all healthcare workers, physiotherapists face complex ethical situations in their practice, such as understanding and balancing the needs and preferences of patients, their families and other professionals in the context of their moral duties.

The deontological code has a specific relevance, in a pluralistic context, in the elaboration of a set of ethical principles and rules, which explicit the intrinsic values of the profession. This is particularly important in order to justify specific behaviours related to the practice within a professional field in the context of the emerging challenges due to the rapid changes in technologies and the transformations in society. The role of code can be outlined between the intrinsic ethics of the profession and the legal framework, which often derives from a complex intermediation between different ethical theories in our pluralistic society [3,4].

Internationally, physiotherapy codes of ethics share a common purpose but vary in structure and scope. Many are informed by international frameworks such as those developed by World Physiotherapy [5]. Across countries, most codes address similar ethical domains and concepts [6], including beneficence and non-maleficence (appropriateness of cure and care of the patients), responsibilities towards patients (e.g. respect of their dignity, autonomy through informed consent, confidentiality), professional competence and integrity, collaboration with colleagues, and duties to society and public health, respect of human rights and avoidance of discrimination.

According to Law 42/1999 (Italia. Legge 26 febbraio 1999, n. 42, Disposizioni in materia di professioni sanitarie, pubblicata nella Gazzetta Ufficiale – Serie Generale n. 50 del 2 marzo 1999), alongside the professional profile and the educational system, the code of ethics is one of the pillars on which the specific scope of activity and responsibilities of healthcare professions are based, considering the protection of the patient. Therefore, practicing a profession requires balancing those needs with resource limitations, the length and quality of treatments, and working within the constraints and opportunities afforded by health policies and institutional systems in both the private and public sectors.

The profession of physiotherapy has been regulated in Italy since 1994 (Italia. Decreto Ministeriale 14 settembre 1994, n. 741, Regolamento concernente l'individuazione della figura e del relativo profilo professionale del fisioterapista, Gazzetta Ufficiale – Serie Generale n.6 del 9 gennaio 1995) and the Italian Physiotherapy Association (Associazione Italiana Fisioterapisti - AIFI) published the current Code of Ethics, approved in 2011 and first introduced in 2012 (<https://aifi.net/professione/codice-deontologico>, accessed 1st April 2025). The first code was introduced in 1995 and updated in 1998 by the Italian Association of Rehabilitation Therapists (Associazione Italiana Terapisti della Riabilitazione – AITR), which is now known as AIFI.

The 2012 Code structures physiotherapy ethics around fundamental rights, professional autonomy and responsibility, and conduct rules. Main domains include the fundamental rights and the centrality of the person, general principles and rules of conduct of the profession, the relationship with the person and collaboration with health professionals, and institutions. While setting standards for safety and research, the text specifically highlights a requirement for constant monitoring and updates.

However, from 2012 a number of changes emerged at different levels [7,8], on a demographic level (increase of the elderly population), on a social level (increase of multiculturalism), on a technological level (telerehabilitation, artificial intelligence, neurotechnologies), on an informational level (spread of ICT and social network), and on environmental level (transformation of the concept of health, towards one health and the need of sustainability), on a national legal level (new rules for healthcare professionals concerning informed consent, respect of autonomy and responsibilities) and international legal level (data protection regulation, trials regulation, regulation of new technologies as AI). These issues were integrated alongside evolved patient partnership models and current regulatory changes regarding digital transparency, professional image and role. This makes it mandatory to update the code of ethics in order to support Italian physiotherapists in their daily practice, supporting and orienting in the context of emerging challenges.

The National Federation of Orders of Physiotherapists (Federazione Nazionale degli Ordini dei Fisioterapisti – FNOFI) has therefore undertaken a process of reviewing and updating the current code. FNOFI is an organisation that brings together all the professional Orders of physiotherapists of the Italian Republic and includes all legally recognised professionals.

It is made up of 38 territorial Orders and includes 74,401 members, making physiotherapists the third largest healthcare profession in the country, and the largest in the field of rehabilitation (<https://www.fnofi.it/>, accessed 12 June 2025).

With the aim of involving all the Italian physiotherapists in the development of an updated code of ethics, a process of 'participation' and 'engagement' was implemented, based on the current Code of Ethics.

This paper describes the rationale and the methodology used for the development of an updated version of the Code of Ethics for Italian physiotherapists.

Rationale

The development of the updated code of ethics was based on the principle that the people who would ultimately use it should be involved in creating it [9]. Involving end users in the development process fosters understanding, engagement and commitment to the code, thereby enhancing its ethical sharing and acceptability. Furthermore, the participation in the process and the contribution in co-designing encourages the rational recognition of the moral values and the interior acceptance and personal commitment, facilitating the interpretation and application in moral behaviour of everyday practice.

Previously, participatory approaches have been implemented in other contexts, such as nursing and pharmacy [8,10], as well as in the physiotherapy field [11,12]. However, the process was limited to the analysis of other ethical codes and the involvement of various stakeholders, including physiotherapists [11] or focus groups-based methodology involving members of the national professional association [12].

The participatory multi-step methodology, involving stakeholders and professional community – together with the review of literature and codes comparison (both of the profession of physiotherapist and other professions), on a theoretical level – is a way to guarantee a substantive validity of the process of elaboration of the new code. Furthermore, a framework of benchmarking strategy should be employed to consider different sources and support the discussion towards a comprehensive final document. In addition, the engagement of consultants external of the profession with expertise in bioethics, law and communication, enables the process to be supported in a non-self-referential way and allows the issues to be explored, interdisciplinary discussed and defined with a broader and more effective perspective.

Based on this framework, to involve all Italian physiotherapists employed in different fields and more professional representative institutions, a participatory process was implemented, starting from the current code of ethics and other relevant sources.

Methods

A mixed methodology with multiple steps was used. Table 1 describes the timeline of key events within the process of development of the revised code.

The methodological approach was intentionally grounded in a strategy combining multiple data sources (institutional consultation, literature review, and comparative analysis of existing ethical codes) with progressive participatory steps. This framework aligns with contemporary models for the development of ethical guidelines in healthcare professions, which emphasise co-design, transparency, and iterative validation with end users. Such an approach supports substantive validity and reduces the risk of producing a merely normative or top-down document detached from clinical practice, professional identity [9], and social emerging needs.

The Board of Directors of FNOFI identified the members of the working group, taking into account the representativeness of the profession and the presence of expert consultants in bioethics, law and communication. The working group included eight physiotherapists representing FNOFI, one physiotherapist representing the scientific society (AIFI), one physiotherapist representing the university sector, one philosopher with a specific expertise in bioethics and law, one lawyer and one journalist specialised in communication. The working group started its activities in April 2025.

The current Code of Ethics published in 2012 by the AIFI was sent to the following groups of physiotherapists at the same time: Boards of Directors of all territorial orders; university teaching staff and

Table 1. Timeline of key events in developing the revised code of ethics.

When (2025)	What
April	Establishment of the working group
April–July	Suggestions collection from local orders
April–July	Search and analysis of literature and other codes of ethics
August	Synthesis of emerging areas based on previous sources
September	Pilot study on questionnaire feasibility and usefulness
October	Questionnaire sent to all FNOFI members
October	Learning programme within the Italian Continuing Medical Education Programme
November–December	Face-to-face focus groups
Further steps (2026)	
Preliminary text drafting to be approved by the Board of Directors of FNOFI	
Review of the preliminary text by the National Council of FNOFI, and other stakeholders	
Final review and approval by the FNOFI Central Committee	
Final approval by the FNOFI National Council	

FNOFI: Federazione Nazionale degli Ordini dei Fisioterapisti (National Federation of Orders of Physiotherapists).

degree course directors; the Scientific Society (AIFI) with the request to suggest possible additions or changes for each item. For each group, the secretariat was emailed a form containing all the articles of the current code, including the article number and text. The following fields were to be completed: ‘need for rewording’, ‘any proposed rewording’ and ‘reasons for the proposed rewording’, through a free-text box related to each article. In addition, at the end of the form, a space was available for submitting suggestions for new topics.

Simultaneously, the working group conducted a literature search on PubMed (the full search string is provided in [Appendix A1](#)) and searched for codes of ethics relating to other health professions in Italy and physiotherapy associations in other countries *via* their institutional websites.

Two reviewers independently screened the studies. Eligible studies included all primary research designs explicitly referred to ethics and bioethics within the context of physiotherapy practice. All types of primary studies both qualitative and quantitative were included with no restrictions to time, geographical location, setting and language. The results were narratively synthesised by two independent reviewers to identify principles and themes.

Three members of the working group conducted a non-independent analysis of the other Italian and foreign codes in order to identify themes that were not present in the current code, themes that were described differently (taking into consideration the different legal framework in different countries), and any missing themes. The search was conducted by the institutional website of professional associations and Codes were included when they were published within the last 10 years. Three members of the working group independently analysed the codes and disagreements were resolved through discussion until consensus was reached.

The three sources (the results of the consultations, the literature and the other codes of ethics) were then compared and synthesised by the members of the working group to highlight the areas where the greatest inconsistencies or gaps in coverage arose, based on responses of the Boards of Directors of all territorial orders, and to outline elements identified from the analysis of the literature and other codes but not emerged in the consultations. These issues were included in a questionnaire sent to all Italian physiotherapists, to further explore the perceived relevance of the topics. The survey was designed to ensure complete anonymity of responses and to allow only one submission per registered participant, using the ‘one response per respondent’ setting provided by the SurveyMonkey platform (SurveyMonkey Inc., San Mateo, California, USA).

The questionnaire consisted in 11 items whereby respondents could indicate their level of agreement regarding the relevance of the item around a 5-point Likert scale, from ‘not at all relevant’ to ‘extremely relevant’. It was intentionally kept concise to encourage participation.

Items covered the following issues: shared care planning; consent in situations of vulnerability; management of medical errors; legal issues relating to minors; involvement of carers, family members or tutors; emerging technologies; challenges on communication with the use of social networks; expectations regarding prognosis; teaching activities; professional autonomy; equitable access to services, promotion of public health, and environmental sustainability; moral injury.

To further increase the response rate, reminder messages were disseminated during the data-collection period *via* both institutional e-mails and official FNOFI social media channels, inviting members to participate and share their views on the ethical principles of the profession.

To further enhance adherence to the survey and knowledge of issues among potential respondents, a learning programme was developed as part of the national Continuing Medical Education programme [13] was proposed to all Italian physiotherapists regarding the content of the documents obtained by the sources.

The questionnaire was submitted to a group of undergraduate students for a pilot test to assess the clarity and understanding of the items, as well as the time required to complete it.

Based on the issues raised by the institutions, literature and the codes of ethics analyses and the responses to the questionnaire, face-to-face focus groups were conducted. Participants were members of Board of Directors of territorial orders, or their delegates. All Board of territorial orders were invited to participate. Each focus group was moderated by an expert in group management and based on the framework of 'World café' [14]. This structured, inclusive methodology involves small groups of people discussing preselected topics at round tables according to a set of defined rules and questions to generate new ideas and solutions. During the focus groups, flip charts were provided to each group so that the moderator and participants could record discussion points. After each round, the table facilitators presented the small group reports to the subsequent table participants. Finally, facilitators presented their reports to all the participants.

Ethical review and approval were not required for this study in accordance with national legislation and institutional requirements, because this is a non-interventional, organisational research involving voluntary participation of adult healthcare professionals in questionnaires and focus groups and did not include the collection of sensitive personal data. Participants were informed about the aims of the study and provided informed consent prior to participation. Participation was voluntary and respondents were free to withdraw at any time without consequences. All data were anonymised and reported in aggregate or non-identifiable form. Focus groups were organised by an external provider (INTOO, Milan, Italy), which was responsible for collecting participation consent, and ensuring compliance with applicable data protection regulations (General Data Protection Regulation, GDPR). All participants were informed about the purpose and procedures of the activities. According to the framework of *world café*, focus group discussions were not recorded and all identifying information was removed during the transcription process.

Once all the data had been collected, a comprehensive analysis of the themes was carried out by grouping the themes at each stage with the support of generative artificial intelligence systems (Google NotebookLM). Each report generated by the artificial intelligence systems was reviewed in order to guarantee a 'human oversight' by the working group, in order to avoid bias, output limitations, algorithmic brittleness (e.g. vulnerability to errors, breakdowns, or failures, and hallucinations) [15].

Results

A total of 30 out of 38 boards of directors of territorial orders responded (79%). Suggestions for additions or changes to each item in the current Code of Ethics were received from 25 orders and the scientific societies, while four territorial orders responded, declaring that they had no suggestions to make (Figure 1).

The working group selected 4 codes of ethics of other health professions in Italy (the National Federation of Medico-Surgical and Dental Orders – Federazione Nazionale degli Ordini dei Medici-Chirurghi e degli Odontoiatri (FNOMCeO) (last update: 2020); the National Federation of the Midwifery Profession – Federazione Nazionale della professione ostetrica (FNOPO) (2017); the National Federation of the Orders of Radiography Technicians and of Technical, Rehabilitative and Prevention Health Professions – Federazione Nazionale Ordini dei TSRM e delle professioni sanitarie tecniche, della riabilitazione e della prevenzione (FNO TSRM e PSTRP) (2021); the National Federation of Nursing Professions – Federazione Nazionale Ordini professioni Infermieristiche (FNOPI) (2025). It also included six physiotherapists' associations from other countries: Switzerland (2016), United Kingdom (2019), Spain (2021), United States (2020), Australia (2023), Canada (2022). The group also considered the policy statement published by World

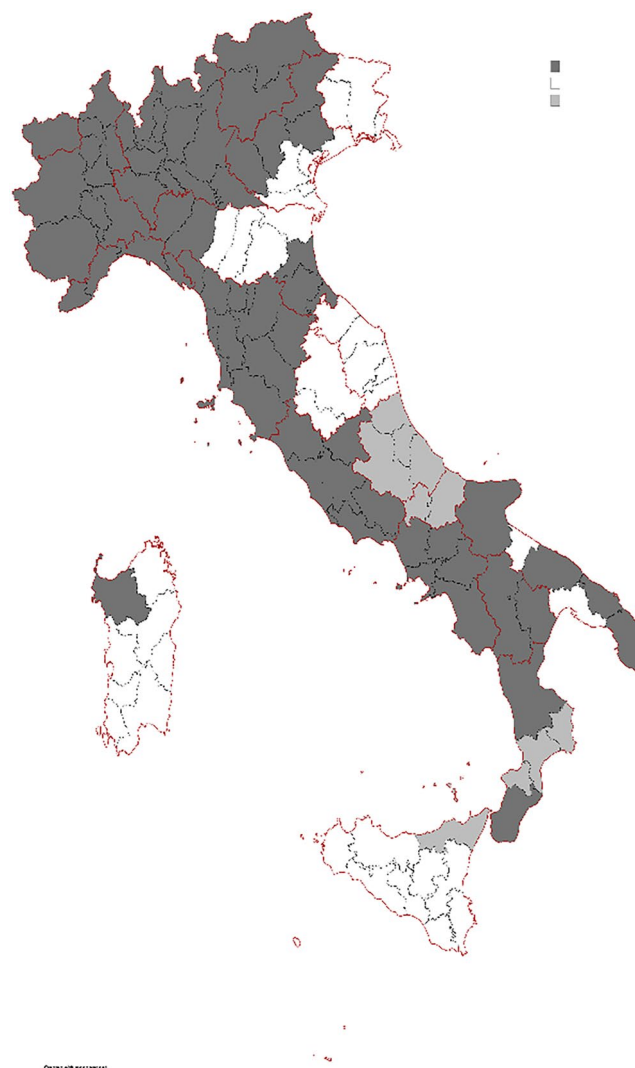


Figure 1. Geographic distribution of responses from the 38 local orders. In dark grey: Orders that provided suggestions for changes to the current Code of Ethics. In light grey: Orders that replied but did not provide suggestions. In white: Orders that did not respond or declined to participate (Created with mapchart.net).

Physiotherapy in 2023 (Policy statement: Ethical principles and the responsibilities of physiotherapists and member organisations. London, UK: World Physiotherapy; 2023. Available from: <https://world.physio/policy/ps-ethical-responsibilities-and-principles>, accessed: May 5 2025) and the Costituzione Etica published by FNO TSRM e PSTRP in 2024 [16].

The literature search provided 53 articles, 14 of which were selected by the working group as relevant for the purpose of the process and addressed the following main themes: factors influencing ethical decision-making [17], ethical and moral sensitivity [18], core ethical values [19], ethics in the clinical [19,20], ethical reasoning [21], issues and implications of new technologies [22].

The comparative analysis of the ethical codes of healthcare professionals in Italy reveals a common foundation of fundamental principles, such as respect for the dignity and autonomy of the person receiving care, the protection of health as a fundamental right, professional confidentiality, and the obligation to undertake continuing professional development. Codes of ethics from other countries share universal ethical principles; they are strongly influenced by their respective healthcare and professional regulatory systems. They often have a structure more oriented towards 'standards' and 'outcomes' (expected results), in line with a culture of performance evaluation. Table 2 summarise the main themes emerged by institutional consultation, literature review, and comparative analysis of existing ethical codes.

Table 2. Themes emerged by sources.

Institutional consultation	Literature review	Comparative analysis of existing ethical codes
- Integration of AI, digital tools, robotics, and tele-assistance in clinical practice - Centrality of shared care planning, informed consent (including digital), and dedicated listening time - Whistleblowing, combating inequalities, managing conflicts of interest, and professional secrecy - Specific attention to minors, the person with disabilities, the elderly, those in "healthcare poverty," and multicultural contexts - Regulation of social media use, information systems, and informational accuracy - Promoting ecological behaviours, equitable resource allocation, and protecting the professional's well-being.	- Ethical decision-making - Ethical and moral sensitivity - Core ethical values - Ethics in the clinical relationship - Ethical reasoning - Implications of new technologies	- Person-centeredness and linguistic agility - Emphasis on accountability (United Kingdom, United States), vulnerability and documentation - Performance standards and expected outcomes - Relationship as a therapeutic tool and ethical transparency towards the citizen - Professional autonomy and modern challenges like pandemics and human enhancement

Table 3. Survey response rate by Italian region.

Region	Responders	Members	Response rate (percentage)
Abruzzo	186	2335	8.0
Basilicata	35	779	4.5
Calabria	175	1912	9.2
Campania	440	6348	6.9
Emilia-Romagna	650	5365	12.1
Friuli-Venezia Giulia	204	1695	12.0
Lazio	829	10461	7.9
Liguria	223	2185	10.2
Lombardia	1571	12300	12.8
Marche	163	2021	8.1
Molise	51	469	10.9
Piemonte Valle d'Aosta	463	4419	10.5
Puglia	389	5165	7.5
Sardegna	186	1929	9.6
Sicilia	281	5004	5.6
Toscana	449	4296	10.5
Trentino-Alto Adige	149	1609	9.3
Umbria	104	983	10.6
Veneto	529	5126	10.3
Total	7077	74401	9.5

The items of the questionnaire explored 6 areas: rights and self-determination; specific care contexts; digital technologies and innovation; communication and professional image; training and professional responsibility; environment, justice and working conditions. The pilot study included 26 responses; the questionnaire was reported to be clear, simple, with a completion time of 7.5 ± 2.8 min. The survey was sent to 74,401 physiotherapists and 7077 responded (response rate 9.5%). The response rate among Italian regions ranged between 4.5% and 12.8% (Table 3).

Two domains achieved their highest response frequency in the 'extremely relevant' category: the enhancement of the physiotherapist's autonomy within multidisciplinary teams and shared responsibility (54.41%) and ethical guidelines concerning teaching activities for non-qualified professionals (38.37%).

The remaining ten items were most frequently rated as 'very relevant'. Within this group, the highest frequencies were recorded for the management of professional errors (44.79%), the handling of complex situations involving vulnerability (43.84%), and shared care planning in accordance with Law 219/2017 (42.46%). Themes related to the integration of emerging technologies (32.18%) and communication through social media (35.50%) showed the lowest relative percentages for the highest relevance category.

Finally, all participants in the four focus groups were invited to discuss and share their contributions on the previously identified topics, taking into account the following aspects for each topic: fundamental human rights, principles of professional practice, professional relationships, ethics, sanctions and continuing education. Each focus group included 9 to 11 participants from 25 territorial orders, while additional eight territorial orders participated by mandate (Figure 2).

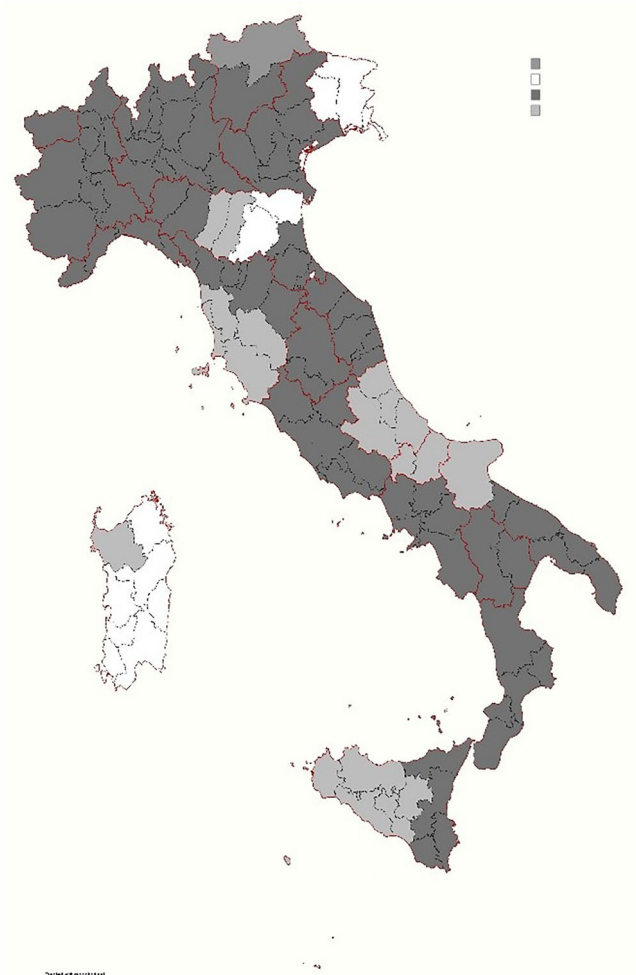


Figure 2. Geographic distribution of participation from the territorial orders (in dark grey), and by mandate (in light grey) (Created with mapchart.net).

The focus group analysis identified several key thematic areas for the revision of the Deontological Code. Methodologically, participants proposed a systematic four-year review cycle and the establishment of uniform national sanctions by the FNOFI to ensure professional equity. Regarding clinical practice, the findings emphasised patient empowerment and the formalisation of 'screening for referral' to ensure appropriate care pathways. Ethical concerns focused on protecting professional dignity by banning treatment 'packages' and regulating social media use, including explicit consent for patient imagery. Finally, a significant shift towards 'professional autonomy' over 'freedom' was advocated to better define the physiotherapist's independent scope of practice.

Discussion

The development process of a code of ethics is understudied [9] and there is no consensus on the processes to develop, or update, a Codes of Ethics.

Updating the Code of Ethics for physiotherapists is a necessary step, more than 10 years after the publication of the current version. As this statement applies to all professionals, it is essential to engage with all stakeholders to promote greater awareness and adherence. For this reason, a long and complex 'listening' phase was designed and implemented to support the development of the updated version of the code. Similar participatory approaches have been implemented in other contexts, such as nursing and pharmacy [8,10], confirming that inclusive and transparent methodologies foster adherence and shared ownership. This representation highlights the broad geographic representativeness and active participation achieved across Italian regions during the consultation phase.

The American Physical Therapy Association revised their code of ethics in 2009, by appointing a task force to review the previous document taking into account core ethics documents and the ethical codes of other health care professions; then, the revisions were submitted to a sample of various stakeholders, including physiotherapists, through a survey [11].

The New Zealand physiotherapists association (Physiotherapy New Zealand) describes the process of rewriting the code of ethics, where a focus groups based methodology were used to discuss more relevant themes [12].

In order to ensure the widest possible participation and a comprehensive basis for the discussion, all professionals were involved as end users, a wide range of sources were consulted (e.g. the current Code of Ethics, relevant literature and other codes of ethics) and a mixed methodology, including both survey and discussion within focus groups have been chosen to.

In fact, as there is no consensus on the development process for a code of ethics, a benchmarking strategy that takes into account different perspectives can provide a basis for a more comprehensive view and discussion.

Four territorial Orders formally declined to provide comments or additions to the current Code of Ethics. Although the reasons were not always explicitly stated, possible explanations may include time constraints, internal organisational priorities, or differing perceptions regarding the need to revise the existing document. These non-responses, while limited in number, highlight the importance of maintaining ongoing communication and shared understanding within professional bodies when promoting participatory processes.

The uneven distribution of responses across regions could have influenced the perceived representativeness of the national sample. However, the proportion of Orders actively contributing suggestions (25 out of 39, corresponding to 64%) is consistent with participation levels reported in similar national professional surveys. Otherwise, the response rate related to the survey is lower (i.e. less than 10%), but the responses obtained can be still considered broadly indicative of national trends, although not fully representative, as the sample is large and homogeneous across the country. In any case, the potential bias has a low impact, since results might not be affected by nonresponses. In fact, the most likely risk could be the overestimation of the relevance of the issues and this can be considered advantageous for the purposes of the survey, as the aim is to gather as many suggestions as possible. In addition, themes are not interpreted alone, but as a part of a larger process including a wide range of sources and steps [23]. Despite these variations, the geographic distribution of both survey respondents and focus group participants supports the interpretation that the consultation process achieved national representativeness.

In addition, the response pattern may reflect varying levels of ethical awareness and familiarity with deontological frameworks across the profession. This reinforces the importance of strengthening ethics education within undergraduate and postgraduate training pathways, as evidence suggests that structured exposure to ethical reflection enhances engagement, sensitivity, and participation in professional governance processes [9,24].

The working group's main interlocutors were FNOFI and the local orders, because they include all the Italian physiotherapists in addition to being the commissioning body, but the discussion was also extended to scientific societies and academia, in order to include different perspectives. The presence of different areas of expertise, such as communication, ethics and law, within the working group further enhanced the validity of the process [9].

After collecting and analysing the available documentation and engaging with physiotherapists and professional institutions, the following future phases are planned: a) the working group will draft a preliminary text, which will then be approved by the Board of Directors of FNOFI; b) the National Council of FNOFI will review the preliminary text, involving citizen and patient associations, as well as representatives of public and private healthcare institutions and other healthcare professions; c) the Central Committee will develop and approve the final proposal, which will then undergo a final review and vote by the National Council.

The analysis revealed a broad consensus regarding the importance of the ethical domains identified through the participatory process. In particular, themes related to professional autonomy, management of clinical errors, and handling of vulnerability emerged as highly relevant, reflecting core concerns in contemporary physiotherapy practice.

Conversely, themes related to emerging technologies and communication through social media, while still considered relevant, showed comparatively lower prioritisation. This may reflect a transitional phase in the profession, where digital and technological challenges are recognised but not yet fully integrated into ethical awareness and daily practice.

Overall, the convergence of findings across institutional consultation, literature review, survey responses, and focus groups supports the robustness of the identified domains and highlights the added value of a multi-step participatory approach.

The findings represent a shift in the Italian physiotherapist's identity, prioritising professional autonomy (54.41%). This marks a transition from technical execution towards independent clinical decision-making within multidisciplinary teams. While international models, such as those from the United States or the United Kingdom, are often structured around 'standards and outcomes', the Italian update remains rooted in a principles-based tradition, integrating national legislation like Law 219/2017 on informed consent.

Practically, these results mandate the integration of ethics into educational curricula and the establishment of uniform national perspectives on sanctions by the orders. This ensures the code transcends a mere top-down mandate to become a lived professional guide.

Limitations

The voluntary participation of the local Orders and individual professionals may have introduced a self-selection bias, as those more interested in ethical and professional issues were more likely to respond.

The descriptive and methodological nature of this report does not allow for an in-depth interpretation of the content of the responses or focus group discussions, which will be the subject of further analyses. Furthermore, the use of an online questionnaire, although efficient and widely accessible, may have limited participation among professionals less familiar with digital tools or less engaged in institutional communication channels. Additionally, technical issues may have affected the response rate (e.g. messages ending up in spam folders or not reaching their intended recipients).

Another limitation concerns the dynamic context in which the process is being implemented: social, technological, and regulatory changes are continuous and may influence ethical perceptions and professional priorities even during the data-collection period. Finally, while the participatory and co-design approach strengthens the legitimacy and inclusiveness of the final document, it also requires prolonged coordination and consensus-building among multiple stakeholders, which can slow the process and introduce variability in interpretations. However, these limitations do not undermine the methodological coherence of the process, but rather define the appropriate interpretative boundaries for the current stage of analysis.

Conclusions

During the update of the Code of Ethics, all professionals were involved in a mixed methodology linked with different sets of sources. The methodological approach was aimed to be as inclusive as possible, while also taking into account the available evidence and different perspectives. This approach could serve as an example for developing a Code of Ethics through a participatory process and the participatory framework adopted by FNOFI could be replicated by other health professions aiming to update their ethical standards. The participation has been integrated with also theoretical analysis of literature, comparing deontological codes and interdisciplinary discussion among the competencies of the group.

To increase awareness of ethical issues, special attention should be paid to training and education, especially during the degree courses. Finally, the modular structure of the process allows for the development of additional thematic outputs (e.g. survey analysis, focus group results, and educational implications), ensuring scientific continuity and transparency while advancing the cultural and ethical maturity of the profession.

Author contributions

CRedit: **Claudio Ciavatta**: Conceptualization, Project administration, Resources, Writing – review & editing; **Pamela Frigerio**: Data curation, Investigation, Methodology, Writing – original draft; **Laura Palazzani**: Investigation,

Methodology, Writing – review & editing; **Matteo Paci**: Conceptualization, Methodology, Supervision, Visualization, Writing – original draft.

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Appendix A1

Search strategy (PubMed, June 2025) [25].

1	Physical Therapy Modalities
2	Physical Therapy Specialty
3	Rehabilitation
4	Rehabilitation
5	Physiotherap*
6	"Physical therap*"
7	"Physical rehabilitat*"
8	"Rehabilitation therap*"
9	Physiotherapist
10	Physiotherapists
11	"Physical therapist"
12	"Physical therapists"
13	1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12
14	Ethics
15	Ethics Consultation
16	Ethics, Research
17	Codes of Ethics
18	Principle-Based Ethics
19	Ethics, Clinical
20	Ethics, Professional
21	Ethics, Nursing
22	Ethics, Medical
23	Ethical Theory
24	Bioethics
25	Ethics
26	Bioethics
27	"Professional ethics"
28	"Ethical issue*"
29	"Ethical dilemma*"
30	"Ethical principle*"
31	"Moral obligation*"
32	"Moral issue*"
33	"Moral principle*"
34	"Moral dilemma*"
35	"Ethical decision-making"
36	"Moral decision-making"
37	"Ethical consideration*"
38	"Ethical challenge*"
39	"Moral consideration*"
40	"Moral challenge*"
41	"Bioethical issue*"
42	"Bioethical dilemma*"
43	14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32 OR 33 OR 34 OR 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42
44	13 AND 43