Clinician's Commentary on Napier et al.¹

Physiotherapists' role in the orthopaedic spectrum of care in Canada has expanded greatly over the past decade. In their study, Napier and colleagues¹ describe physiotherapy triage of knee and shoulder referrals to an orthopaedic surgeon, evaluating recommendations of "surgical," "not surgical," or "needs further investigation" as well as patient satisfaction and the surgical conversion rate, that is, the proportion of those referred to the surgeon who actually require surgery. They find a high rate of concordance on surgical recommendations between the physiotherapist and the orthopaedic surgeon; high patient satisfaction; and a much higher surgical conversion rate for patients referred by physiotherapy than for those referred by family or emergency physicians. These are all positive findings and speak well of this triage role for physiotherapists,² which in orthopaedics has the potential to reduce wait times—provided that enough physiotherapists are available to do the work, and want to do the work, and that they do not create new wait times.

Our team conducted a similar study also in Canada in 2008.³ We looked at patients with shoulder and knee diagnoses referred to two orthopaedic surgeons; comparing diagnoses between the physiotherapist and an orthopaedic surgeon, we also found high agreement on the actual diagnoses made ($\kappa = 80\%$ for knee diagnoses, $\kappa = 100\%$ for shoulder diagnoses). We then compared those who went on to receive a definitive diagnosis through MRI, diagnostic ultrasound, or surgery to these clinical diagnoses, and found that 75% diagnostic accuracy for both physiotherapists and orthopaedic surgeons; we also found high levels of patient satisfaction. What was extremely interesting was that for each patient, the physiotherapist made additional recommendations for potential treatment course, whereas the surgeon did not. This finding suggests the value of having a physiotherapist in this role, not just for triage but to actually offer patients more conservative clinical options.

Along with adding to the Canadian context of physiotherapists working in a triage role in orthopaedics, Napier and colleagues make a new and exciting addition to the literature by addressing the concept of the surgical conversion rate (SCR).¹ As physiotherapists, we can indeed provide more appropriate referrals for surgery, because we are the experts in conservative management of orthopaedic conditions; if a condition is deemed "non-surgical," we have a full repertoire of choices for conservative management. We have also found that when triaging for patients to see orthopaedic surgeons, physiotherapists tend to be more cautious about referring,⁴ and may therefore decide that someone should see a surgeon even though the surgeon may not agree. This caution is important, since the alternative—failing to refer a patient who should see the surgeon—does not bode well for the physiotherapy triage model.

Interestingly, Napier and colleagues¹ found that physiotherapists can have a direct impact on "Wait Time 1," that is, the time from referral to being seen by the surgeon (or, in a triage model, by the physiotherapist); this impact indirectly affects "Wait Time 2," the time from being seen by the surgeon to undergoing surgery. If more appropriate referrals are going

forward to the surgeon, as the higher SCR suggests, presumably surgeons can spend less time in clinic and more time treating patients. However, for this benefit to be realized, significant changes need to be made in the health system. First, provincial governments currently track Wait Time 1 only if the patient is seen by a surgeon; introducing a physiotherapist, while effective, cannot be recognized by provincial statistics as changing Wait Time 1. Further, for Wait Time 2 to be affected, we would have to assume that surgeons who spend less time on their clinic responsibilities are allocated more time in the OR by their hospitals, which may or may not be the case. Both of these systemic changes would have to take place in order for the physiotherapy triage model to have full effect. It is only through ongoing publication of work of this nature that any systemic change can happen.

Second, it is not clear whether we have the health human resources (HHR) in the system to do implement the physiotherapy triage model more broadly. In one orthopaedic screening model in Canada, all orthopaedic surgical referrals first go to the physiotherapist for triage; this is an excellent model, but there is only one physiotherapist, and the wait time to see the physiotherapist is creeping up. If we are to implement models like this, we must ensure that we have the appropriate HHR to make them effective and efficient. Again, this may require changes to the system. By continuing to examine and publish our findings on models of care such as the one described by Napier and colleagues,¹ we can make an effective argument for expanding our role in the orthopaedic spectrum of care.

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