Triage of back pain by physiotherapists in orthopaedic clinics

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SUMMARY

In 1994 we described a system whereby certain patients with back pain, on referral to an orthopaedic clinic, were seen first by a physiotherapist who referred on only the problem cases and those in need of surgery ('triage'). This practice has grown rapidly but there have been difficulties. To clarify these we have carried out a postal questionnaire.

The results reveal similar practices in most centres but some discrepancies that are cause for concern. These relate to the workload of the physiotherapist, informed consent, supervision and accountability, the type of cases seen and not least the stresses on the physiotherapist.

We believe the triage system has many benefits, but if it is not to be derailed the issues of concern must be addressed and the posts properly structured.

INTRODUCTION

Back pain makes great demands on orthopaedic outpatient time, and only a small proportion of patients referred eventually need surgery. For these reasons, about five years ago we instituted a system in Exeter whereby, with general practitioner (GP) approval, cases that were apparently straightforward were seen initially by a physiotherapist trained by the surgeon to whom they would otherwise have been referred. The physiotherapist then referred on to the surgeon only problem cases and those potentially in need of surgery. This system reduces the time patients wait to be seen in the clinic, makes better use of surgical skills and develops the role of the physiotherapist.

The growth in such roles for physiotherapists has been phenomenal. When we described the work in 1994[1] we knew of only one or two centres around the country adopting a similar practice. Now 43, to our knowledge, use a system of this kind.

In brief, the physiotherapist takes a careful history, does a physical and radiological examination, and then discusses in resumé all cases with the consultant. The management is then agreed and the GP is informed. As the physiotherapist becomes more experienced, the surgeon, in most cases, finds that he is only sanctioning what has been proposed.

Although we continue to use the system as originally described, and judge it very successful, enquiries from other centres indicated that difficulties have arisen. To clarify these difficulties we undertook a national questionnaire survey. This paper reports the information collected and our recommendations.

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METHODS

On the basis of enquiries made to our own unit, and with information provided by the Extended Scope Practitioners Group from the Chartered Society of Physiotherapy, we found that in 1997 there were 43 centres on the UK mainland using a system to triage patients with back pain. A questionnaire was sent to each and 39 (91%) replied. The questions covered various issues—in particular, clinic organization; the number and ratio of physiotherapists and surgeons involved in back pain review systems; the nature and types of conditions reviewed by the physiotherapists; the investigations that physiotherapists could request, and the interpretation of the results. We also asked about the working relationship between the physiotherapist and the surgeon, including open-ended questions regarding the advantages and disadvantages of such systems, and left space for general comments or recommendations.

RESULTS

Clinic organization

Clinics with a back pain review system had been established for between 5 months and 9 years (mean 2.5 years). In 24 (62%) of the units, one physiotherapist acted on behalf of the clinician; in 5 centres there were two physiotherapists,

in 4 there were three, and in 5 there were four. One centre did not provide this information.

Most physiotherapists saw between 6 and 10 new patients a week (range 1–30). All received referrals from GPs and in 21 (54%) centres they also received referrals from other surgeons.

We asked whether patients were informed that they were seeing a physiotherapist rather than a doctor in the back pain clinic: 32 (82%) said yes, 7 (18%) said no.

In 67% of centres the physiotherapists worked for fewer than 4 surgeons, a one-to-one arrangement being the commonest practice. In 20% they worked for between 4 and 6 surgeons, and one for 10.

Case mix and time allocation

Specific questions were asked to assess the type of cases being reviewed. All physiotherapists saw acute disc problems and chronic degenerative spinal disease. In 32 centres (82%) they saw patients who had had previous spinal surgery, and in 8 (21%) they saw patients suspected of having spinal tumours or infections. In 20 (51%) centres the physiotherapists saw cases of spinal deformity and in 13 (33%) they saw children. The time allotted for each new spinal patient varied between 20 and 90 minutes.

Further investigations

In addition to the clinical examination, 32 (82%) centres authorized the physiotherapist to request straight X-rays, 7 did not. Of those physiotherapists who said that they requested spinal radiography, 59% passed the X-rays either to their consultant surgeon or to a consultant radiologist for reporting, but 41% did not. In 25 centres the physiotherapists could request additional radiological investigations such as magnetic resonance imaging or myelography, though a countersignature by the consultant was usually required. In 30 centres they could request haematological investigations.

Working relationships

We asked whether the physiotherapist discussed every new patient with the surgeon. This happened in only 6 (15%) centres but 33 (85%) discussed problem cases. In 32 (82%) the physiotherapist saw the consultant at least once a week with the others between once a fortnight and 'as required'.

Subsequent referral to the surgeon

In 28 centres (72%) the physiotherapist referred less than a quarter of the patients to the surgeon for further review. A few referred up to half. 3 (8%) did not refer for review: one simply put patients on the surgical waiting list if they were thought to need surgery; the other two discussed cases with the surgeon but, for reasons which were not specified, presumably at the behest of the surgeon, never referred them on.

General comments

In 31 centres (80%) physiotherapists believed that their clinic had reduced the routine waiting list time for an outpatient appointment. This reduction was perceived as a major benefit of the system. Other benefits included professional staff and consultant time being put to better use than previously (13), and the opportunity to increase knowledge and understanding (9). In 17 (44%) the physiotherapists also felt that their role in such orthopaedic clinics had improved communication between departments.

The biggest drawback of the system as practised by respondents was undoubtedly stress, with 74% finding the job stressful all or some of the time. A few (8) felt that some patients were unhappy at not being seen by a doctor, and 9 respondents (23%) were concerned that they might miss a diagnosis, because of lack of medical knowledge. This led some physiotherapists to have medicolegal concerns. A few physiotherapists replied that they found it mentally exhausting seeing chronically depressed chronic back pain patients, and a theme that emerged in the answers was the need for the surgeon and the physiotherapist to maintain mutual support and cooperation for such a post to be viable. The need for a good relationship between doctor and physiotherapist was emphasized. In general, respondents identified a need to improve the quality of referrals from GPs and to educate GPs about the role of the physiotherapist in the orthopaedic clinic.

DISCUSSION

The use of a physiotherapist to see orthopaedic outpatients was first described by Byles and Ling in 1989[2]. In 1994 we reported such a system to triage back pain, and a similar practice for general orthopaedics was reported by Weale and Bannister in 1995[3]. Such a triage system has now been adopted on a national scale. This survey reveals that there is a conformity in the way in which such posts are organized but there are also some striking differences in practice. We canvassed only the members of the Extended Scope Practitioners Group from the Chartered Society of Physiotherapy, and it is possible that not all physiotherapists working in this role belong to this group. There might therefore be interested practitioners whose practice differs from that of our respondents.

The average number of new back pain patients seen per week is 9, although in one centre it was 30. This variation in the number of new patients seen may be explained by the fact that most of the physiotherapists involved in this survey had other physiotherapy commitments, whereas the

therapist dealing with 30 new spinal referrals in the orthopaedic clinic worked solely as an orthopaedic assistant. To maintain high standards, the number of new cases seen each week may have to be limited. The proportion of new cases referred by the physiotherapists to the surgeon remains consistent with our original work, at about 25%.

Although 82% of patients knew they were initially seeing a physiotherapist and not a doctor, 18% did not. We believe it is important to advise all patients and let them make the choice, which for a routine back complaint is likely to be an earlier appointment with the physiotherapist or a later appointment with the consultant. Dowling *et al.*[4] draw attention to the need for patients to be told of the qualification of the practitioner they are seeing. If the patients perceive they are seeing a doctor, then they have the right to a standard of treatment applicable to a doctor. Any misunderstanding on this issue might provide the basis for a future complaint.

We were also concerned at the high number of physiotherapists who were seeing for the first time the more complex spinal problems—patients who had undergone previous spinal surgery (18%), those were suspected of having a tumour or infection (21%), cases of spinal deformity (51%), and children (33%). One of the reasons for the introduction of physiotherapist review was to free the surgeon to see such cases and in so far as this can be followed—accepting that the initial referral is not always explicit—we recommend it be adopted.

Another concern is that 41% of physiotherapists did not have radiographs checked by a doctor. Again this practice could raise medicolegal questions. Although some physiotherapists had attended radiology courses and had the confidence of their consultant in judging the X-rays, one would have to question the view of the law in such a case if, for example, a spinal tumour evident on radiological examination was missed.

As recommended in our original report[1] it is our practice for the physiotherapist to discuss briefly each new spinal patient with the consultant. This is evidently not a universal practice although 85% of those replying did discuss what they saw as problem cases with the consultant.

We think that the stress experienced by three-quarters of physiotherapists is an important issue. The degree of responsibility taken by the physiotherapists in such posts exceeds that which they would normally be expected to carry. Here, back-up by the surgeon is essential to counter isolation of the physiotherapists. In this context certain issues are important. We would emphasize the need for a frequent and regular review of cases jointly by the physiotherapist and the consultant or consultants concerned. The X-rays should always be reviewed by the surgeon or a radiologist. Physiotherapists should not be expected to see children and potentially difficult cases.

The benefits of back-pain triage, to the patient and to staff, are substantial, but unless the referrals are appropriate and the physiotherapist receives support from the surgeon, the patient will not receive the best care and the physiotherapist will find the responsibilities onerous. To maximize the benefits we recommend structuring of such posts along the lines originally proposed[1].

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