New roles in health care: what are the key questions?

Kathryn M McPherson and Duncan A Reid

Outcomes for patients must be a core variable in this complex research

The report by Oldmeadow and colleagues (*page 625*) in this issue of the Journal details an evaluation of assessment by physiotherapists as an alternative to orthopaedic surgeon management of patients referred by general practitioners for musculoskeletal conditions.[1] The authors describe a service funded by the "Better Skills, Best Care" initiative of the Victorian Department of Human Services, whereby two highly qualified physiotherapists screened patients with uncomplicated conditions before parallel assessment by a surgeon. Their conclusions were that the service was beneficial (reduced waiting lists), acceptable (with good levels of satisfaction among all stakeholders) and of high quality (most physiotherapist management decisions were in accord with those of the surgeon).

Oldmeadow and colleagues directly address a topic of real importance, as highlighted by the July 2006 issue of the Journal, devoted to task transfer.[2] Their findings support what is happening in other countries, particularly the United Kingdom, where the practice of substituting physiotherapists and other allied health professionals (AHPs) for medical personnel has increased over the past 5 years. These changes are taking place largely in response to: increased waiting lists; shortage of medical staff in specific disciplines; AHP aspirations; and, indeed, politics, with efforts to modernise the National Health Service.[3] A number of studies have now shown that nurses,[4] AHPs,[5] and staff specifically trained as physician assistants[6] can take on a number of tasks and roles usually performed by doctors. Perhaps the fact that different health care staff are clearly able to learn and apply new skills and techniques should no longer be surprising.

While welcoming evaluation of new approaches to care when translated from one environment to another, this report and other research about new roles prompts some key questions, including:

- Are the right people with musculoskeletal pain on tertiary care waiting lists?
- When is the physiotherapist the best person to see patients with musculoskeletal pain?
- Does "impact" mean the same thing in workforce research as it does in other clinical research?

As waiting lists for hospital treatment in most countries grow, it is paramount to find the best ways of minimising the number getting onto those lists in the first place. Speedy exit from the list certainly reduces waiting lists, and increased resource allocation to tertiary services currently seems a central strategy, with reports of waiting list difficulties being rare in countries with comparatively greater expenditure on health.[7]

Without additional resource allocation into health, it would seem sensible to *maximise* referral of those who have potential to gain from surgical opinion (ie, appropriate targeting) and *minimise* referral of those who actually have little to gain. It has been noted that in the management by GPs of hip and knee pain in over 300 000 British patients over the age of 65, only 2% were referred to physiotherapy at the initial consultations, increasing to 11% if the patients had been seen again within 12 months, and to 17% if they were seen again within 36 months.[8] As the patients in this study had a high proportion of degenerative joint disease, they would arguably benefit from highly skilled physiotherapy rather than referral for orthopaedic assessment, given that physiotherapy has been shown to be effective at reducing pain and medication use[9-11] and improving function[10,12] in patients with degenerative joint disease of the knee.

In many developed countries, clinical guidelines have been developed to guide GPs and other health professionals as to when referral to an orthopaedic surgeon is required and appropriate.[13,14] Given the high numbers of people on waiting lists, maybe more needs to be done to increase the usability and use of, and reward for using, such guidelines. There must also be some surety of access to physiotherapy, in view of warnings about a serious shortage of therapists by the Australian Physiotherapy Association.[15] If the whole workforce system is not considered, we may simply find excessive waiting lists for surgical review are replaced by excessive waiting lists for physiotherapists.

At the heart of any question about patient management should be: "What is the best treatment for this particular patient at this point in time?" If we forget this, we may actually fail to use and develop our workforce in the most effective and cost-efficient way. While having very experienced physiotherapists working as "consultant" practitioners makes sense, is having them predominantly perform duties as an alternative to consultant physicians or surgeons the best approach?

While Oldmeadow et al restricted their sample to uncomplicated musculoskeletal pain, and excluded patients with psychosocial issues that contribute to symptom chronicity, we suggest that those with psychosocial issues may be one of the very groups who could benefit most from an enhanced physiotherapy intervention. The enhanced scope here would go beyond advanced skills in assessing joint impairment and function. Rather, the physical and technical skills would be augmented by the knowledge, ability and confidence to consider the psychosocial factors that frequently perpetuate painful conditions and lead to enduring disability. A novel intervention was recently described, in which AHPs (including physiotherapists) were trained to deliver a brief psychosocial intervention to complement the usual scope of physical therapy in patients with musculoskeletal pain.[16] While this sample was different from that in the report by Oldmeadow et al (the patients were not on waiting lists for surgery, having either had surgery, or having been assessed as not requiring surgery), the rate of return to work for those with the expanded scope treatment was 25% better than for those with usual physical therapy alone. This indicates a different motivation for, and approach to, task substitution or role replacement, and one that seems to achieve good outcomes for patients.

Oldmeadow et al aimed to evaluate the "impact, quality and acceptability" of the intervention and concluded that physiotherapists were competent and safe in this intervention. While it certainly appears that all the stakeholders involved found the service accept-

able (with the caveat that satisfaction is a particularly tricky area to measure well), evidence about impact, quality, safety and competence are complex, and may require more complex methods of assessment to be persuasive. Shorter waiting lists are indeed one effect of an intervention, but without knowing eventual outcomes for patients, that effect may be of dubious relevance. If the dominant approach to evaluation in task substitution/enhancement research remains predominantly to do with output (such as waiting list reduction), we will really have little idea of which approach to the development of new roles is most likely to be beneficial.

We agree with Oldmeadow et al that more research into new roles is required. Definitive answers to important questions are needed, and it is important that the complexity involved in this type of research is not overlooked.[17] In particular, patient health outcomes must be a core variable in that mix of complexity if we are to make persuasive statements about impact, quality, safety and competence.

Competing interests

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Author details

Kathryn M McPherson, PhD, Professor of Rehabilitation (Laura Fergusson Chair)
Duncan A Reid, MHSc(Hons), PgDipHSc, DipPhys, Head
Division of Rehabilitation and Occupation Studies, Auckland University of Technology, Auckland, New Zealand.
Correspondence: kathryn.mcpherson@aut.ac.nz

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