settings where there are ‘senior’ or more experienced practitioners, large public hospitals being the most common. With changes to workplace arrangements, these settings are disappearing and so the possibility for development through this type of experience is also disappearing. The other common form of consultation occurs in relation to compensable bodies when it is mandated through legislation that long term cases are reviewed by independent assessors. Often this experience is treated with suspicion by the treating physiotherapist, since there is a possibility the independent assessor may become the treating physiotherapist.

A system of consultation that recognises the role of the expert, and which is sufficiently viable to allow the expert to function within that role, would greatly enhance the services provided by physiotherapy. Such a system would provide graduates with a clear pathway for career development and would allow the profession to demonstrate its considerable expertise in clinical areas that are the province of physiotherapy.

Physiotherapy is a profession that has evolved over time to make significant and unique contributions to the area of health care. If the profession is to continue to contribute and have a role in the provision of health care well into the 21st century, there is an urgent need to further evolve the clinical services we offer and how they are to be provided. This will require the co-operative efforts of physiotherapists in all areas of practice to ensure we remain a recognisable and cohesive unit capable of shaping our own destiny.

Louise Wellington
Brisbane


Conclusions of Superthumb study may have clouded the issue of manual handling stress. (Comment on Maher CG et al, Australian Journal of Physiotherapy 48: 25-30.)

I write regarding the article in the Australian Journal of Physiotherapy by Maher et al (2002). I am concerned that the conclusion reached from the research is misleading in two respects.

Firstly, in the conclusion it is stated “the results of our study argue against the use of either tool in their current form” (Maher et al 2002). This hardly appears a valid conclusion from the research in relation to the Superthumb. The Superthumb is clearly a device designed to eliminate the stress placed on the thumb, the information supplied on purchase of this tool only refers to this and doesn’t mention wrist or hand pain.

The common manual techniques involving the greatest stress on the thumb are invariably unilateral mobilisations in the lumbar region. In contrast the most common central PA technique in the lumbar region is delivered with a pisiform grip. Why did the study use a central PA mobilisation of the lumbar spine (my assumption, because this fact was not stated in the article) to determine the clinical justification of a thumb sparing device?

Secondly, it is stated “both tools are significantly less comfortable than the pisiform grip”(Maher et al 2002). If unilateral PA with the therapists’ thumbs had been compared with unilateral PA applied with the Superthumb, a more valid conclusion regarding the therapists’ comfort may have been arrived at. Instead, it was compared with the pisiform grip.

The issue of minimising manual handling stress for therapists is undoubtedly an important one and the conclusions from this article have further clouded this issue rather than helped to solve or direct further research into this problem.

Paul Molnar
Melbourne


Criticism of Superthumb may be invalid. (Comment on Maher CG et al, Australian Journal of Physiotherapy 48: 25-30.)

We commend Maher, Latimer and Starkey (2002) for investigating aspects of the clinical utility of two manual therapy tools designed to reduce the risk of occupational injury in manual therapists.

Superthumb was designed by a small group of musculoskeletal physiotherapists in response to their own thumb pain, and in recognition of a broader need in the manual therapy community. A number of prototypes were trialled over a two year period with the principal design criteria being: the mobilisation force should pass through the broadest cross-sectional area of the hand and wrist to reduce therapist risk, the tool should be capable of being used by therapists of both genders with hands of varying size, the tool should be capable of being used in a variety of mobilisation techniques in a number of areas in the body, there should be minimal attenuation of palpatory information, and the tool should be as comfortable as possible for patient and therapist.

We recognised that Maitland mobilisation techniques using the thumbs appeared to be the most irritating to therapists with thumb pain, based both on anecdotal evidence and on the available empirical evidence. Jensen (1983) found that a significantly greater number of manipulative therapists using Maitland mobilisation techniques had thumb and wrist symptoms compared with manipulative therapists not