

ensure competition. Physiotherapists who have invested in postgraduate education and continuing professional development to ensure they acquire advanced knowledge and skills need to assess their value in the healthcare market relative to other physiotherapists and other professions. The ACCC enforces legislation that prevents the APA from publishing a schedule of recommended fees. It is up to individual practitioners to set fees that reflect their market value and the costs of maintaining their practice - including education.

Other tangible benefits include recognition – both peer and external. The revised process of specialisation provides two levels of recognition via award of a title for physiotherapists who demonstrate advanced levels of knowledge and skills, for example, “APA Sports Physiotherapist” and “APA Specialist in Sports Physiotherapy”. This provides tangible recognition via a different “brand” to physiotherapists who have not demonstrated advanced levels of knowledge and skills. Already, some external parties including employers and compensable bodies have recognised these titles in the form of increased remuneration for physiotherapy services. Interestingly, peer recognition in the form of referral is poor - again, it is up to individual physiotherapists to embrace the concept of specialisation and incorporate specialist practitioners into the fabric of our profession.

Our profession is imploding. Resistance to change, unwillingness to embrace opportunities to define what makes physiotherapy unique, and continued refusal to acknowledge the highly competitive environment in which our profession is practising threaten to eliminate physiotherapy. Unless individual physiotherapists who collectively form “our profession” recognise the importance of postgraduate education, the fundamental necessity of a career pathway and the vital influence of market forces, our profession will stagnate.

So, the challenges are there. The issues raised most certainly require urgent discussion, but meaningful discussion requires interest, not apathy and resistance to change. All stakeholders must be prepared to tackle these issues now - before physiotherapy in Australia is absorbed by like professions.

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Crosbie J, Gass E, Jull G, Morris M, Rivett D, Ruston S, Sheppard L, Sullivan J, Vujnovich A, Webb G and Wright T (2002): Sustainable undergraduate education and professional competency. *Australian Journal of Physiotherapy* 48: 5-7.

Physiotherapists risk losing their identity. (Comment on Crosbie J et al, *Australian Journal of Physiotherapy* 48: 5-7.)

The Heads of Schools of Australia and New Zealand have challenged the profession to consider how the universities are to continue producing physiotherapists who satisfy the

expectations of the profession in the current health and tertiary education environment (Crosbie et al 2002). Their discussion primarily focuses on undergraduate education and the need to consider a specialisation process. However, the issues raised by the Heads have far greater implications. The Editorial in fact begs the broader question: will the profession of physiotherapy exist in 20 years time and if so, in what form? Will physiotherapists (in particular clinicians) still have a role or will a physiotherapy qualification be the springboard for careers in health management, health research and health promotion?

The APA, as a member-based organisation responsible for the advocacy of physiotherapy, has developed a framework for specialisation which establishes a career path for a graduate physiotherapist to progress to a specialist level of clinical practice. The framework is yet to be fully implemented, however there has been significant progress in defining the expectations for the titled stage of the process. Whilst the framework takes shape as a result of the input from various groups within the profession, the real challenge remains in motivating the profession to recognise and pursue specialisation as a worthy goal.

For a specialisation framework to operate effectively, the profession must be able to appreciate and utilise the knowledge and skills of expert physiotherapists through a system of consultation. There is a tendency within the profession to consider that the undergraduate qualification is sufficient to equip physiotherapists to deal with most clinical situations. This is evidenced by the fact that very few physiotherapists undertake postgraduate studies in clinical specialties. Without the development of knowledge and skills beyond that afforded by the undergraduate qualification, physiotherapists run the risk of losing the ability to distinguish themselves from competitors in the health market. In recent years we have seen “traditional” areas of clinical physiotherapy being taken up by other professions such as nurses, massage therapists, sports trainers, exercise physiologists and rehabilitation specialists of various titles, to name but a few. In an era of “credentialism”, formal postgraduate education is essential if the profession wishes to demonstrate its credibility to a market place that is increasingly competitive and discerning.

Recognising and developing experts is one aspect of specialisation, a system of consultation is the other vital aspect. The profession needs to develop and utilise a system of consultation between practitioners of differing levels of expertise and also between areas of practice (such as musculoskeletal, women’s health, sports, gerontology etc). A formal system which allows experts to provide advice for the ongoing management of complex, multifactorial or specialised cases would greatly enhance the efficacy of physiotherapy and provide a significant competitive edge to our profession.

Physiotherapists have very little experience in seeking or providing advice from other physiotherapists. The most common situation in which physiotherapists can experience a system of consultation is in large clinical

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.

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Crosbie J, Gass E, Jull G, Morris M, Rivett D, Ruston S, Sheppard L, Sullivan J, Vujnovich A, Webb G and Wright T (2002): Sustainable undergraduate education and professional competency. *Australian Journal of Physiotherapy* 48: 5-7.

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.

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Maher CG, Latimer J and Starkey I (2002): An evaluation of Superthumb and the Kneeshaw device as manual therapy tools. *Australian Journal of Physiotherapy* 48: 25-30.

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