1968 Presidential Address

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Those of us who have the privilege of assembling here this week mark the forty-fifth time that members of the American Physical Therapy Association have met in Annual Conference. I use the word “privilege” because we are free to meet, we are free to decide for ourselves what we shall say, do, and hear this week, and we are free to take action which will contribute to improved patient care and to the future of our profession, our Association, and the very society in which we live.

This week is an occasion for many things: we have come here to share and to gain new knowledge, to exchange ideas, to make decisions and take action, to visit with friends, and to renew our vigor and dedication. Like the annual journey upstream for salmon, this trip is necessary for the preservation of our species and we must never forget that.

We come here in trying times. Our journey, both in society and in the world of health care, is beset with difficulties—with wrangling, haranguing, and with conflict between forces.

I was here in Chicago during the first weekend of April this year. You may not recall the date, but I don’t imagine that you have forgotten the headlines. Chicago was burning that weekend. Two weeks ago I was in Baltimore, Maryland. Some of the streets were very quiet —too quiet. Block after block of empty, boarded-up, charred brick monuments gave testimony to the convulsion that had occurred there.

We know that these were not isolated instances. Broken glass and charred wood may still be found in many of our communities. Riot in our cities has become more than a mere historic event. It has become a process, a phenomenon of the times capable of being repeated. And we do see its methods repeated in some rather surprising, ivy-covered places.

AUTHORITY IN A CHANGING SOCIETY

And there are other changes taking place. Legitimate authority finds itself without the popular support from which its very legitimacy springs. The power to act, impatient to be exercised, assumes its own legitimacy and authority. The “establishment,” whatever it is and wherever it is, is challenged daily. Sit-ins, be-ins, love-ins, walk-ins, and walk-outs give evidence that postural and locomotor forms of expression may be replacing the more human, more intellectual mode of verbal expression.

The hierarchy of values under which many of us have lived, studied, and worked suffers under the scorn of disbelief and nonacceptance. Long-accepted customs, moral codes, standards, and allegiances seek in vain for inheritors. People chafe under both real and imagined restrictions placed upon them by others. In seeking change, the patience, time, and skill needed to use existing mechanisms are frequently discarded in favor of what are hoped to be more direct and immediate methods. Instant demonstration and instant action have joined with instant foods, instant beverages, instant-on television, and instant communication to replace motherhood, love of God and country, and apple pie as symbols of our current culture.

The changes, the disruption of due process, and the violence that are part of the daily scene have produced an abundance of social diagnosticians. We are exposed daily to arguments and counterarguments over whether ours is a sick society or a violent culture.

The cultural pathologists, not to be outdone by the social diagnosticians, assume the disease and speculate on the causes. Some of the proposed causes are mentioned so frequently as to become slogans and rallying cries for action. Some are unique, even if their accuracy may be questionable. We have long prided ourselves on being the “melting pot” of the
world. Dr. David Abrahamsen, of the Lemberg Center for the Study of Violence, Brandeis University, has said that we are not a melting pot but a “damned pressure cooker.”

Is our society, along with our health care system as some believe, sick and distinTEGRATING? Is the “pressure cooker” about to blow? Is this the kind of change we should anticipate and for which we should prepare ourselves, our profession, our Association, our students—and, yes—our children?

We can take some consolation from history that the end may not be in sight. The theme has occurred before. A man once said:

I hope I am not over wary, but if I am not, there is, even now, something of ill-omen amongst us. I mean the increasing disregard for law which pervades the country, the growing disposition to substitute the wild and furious passions... this disposition is awfully fearful in any community; and that it now exists in ours, though grating to our feelings to admit, it would be a violation of truth and an insult to our intelligence to deny.

The year was 1837. Twenty-eight years later, this same man delivered his second Presidential Inaugural Address. In that address he called upon the people of this land to have malice toward none, to have charity for all, and to get on with the business of binding up the nation’s wounds.

RESOLUTION OF DIFFERENCES

Some of the old wounds and scars are still with us, and we have new ones which also demand our attention. Men still have their differences, and they still do resort to inflicting punishment upon each other and upon themselves in their attempts to eradicate, rather than resolve, those differences.

Having differences is not necessarily symptomatic of disease. It can lead to a search for a new equilibrium—a new homeostasis—for it is the nature of the living to make changes, to adjust, and to adapt. The temporary illness—the upset—may lie in the way in which people attempt to bring these changes about.

Eric Hoffer, that grand old philosopher of the San Francisco waterfront, has made a few pithy remarks about the current state of affairs:

To me... one of the striking characteristics of the 20th Century is its juvenility.

Everywhere you look you see young and senile juveniles raising hell... [Juveniles] have a vivid awareness of the possibility of a new beginning—of a sudden, drastic, miraculous change... To the juvenile mentality continuity and gradualness are equivalent to stagnation, while drastic change is a mark of dynamism, vigor and freedom... To a mature person drastic change is not only something unpleasant, but he denies its reality. He sees drastic change, even when it seems a leap forward, as a falling on the face. When we get up we are back where we started, plus bruises and dishevelment.

Whether we choose to call this basic split “juvenility versus maturity,” “liberalism versus conservatism,” or “outs versus ins” matters little. What does matter is that people hold differences not just over basic issues but over how to differ. This is why we sometimes see infractions of the rules for seeking change. This is why we are sometimes startled to see certain individuals bolt from their old ties and create new forces for change.

Man, who by his very nature is rarely satisfied with his lot in life, is suddenly and impatiently seeking more effective ways of express-
ing himself and changing that lot. When he succeeds, and we must be optimistic and assume that he will, his value system and methods may be unlike those which we have known. But there will be a value system, and there will be certain rules of the game for living together and for resolving differences. And people will abide by these—at least for a time—as they have in the past. The entire process is not unlike an agonizing revision of one’s bylaws or code of ethics.

But now, why do these changes come upon us in our lifetime? And what importance do they hold for us as physical therapists and as members of the American Physical Therapy Association? There is some historical evidence for one possible answer.

In the days of ancient Egypt, the most highly educated, the most knowledgeable, the most literate were the royalty and nobility, the priests and priest-physicians, and the legal class. Many centuries later, after some diffusion of education, and some turmoil, in Athens, Rome, the Arabian Empire, and then Western Christendom, this hierarchy had changed but little. The lawmakers, the clergy, and the physicians continued to comprise the top of the educated hierarchy practically into the Twentieth Century. These were the times of “wise men”—when few knew much and many knew little.

THE KNOWLEDGE EXPLOSION

Then, along came mass education—the concept of which has expanded ever higher, until today posthigh school education is viewed as an essential need and as a societal obligation. The explosion of knowledge and technology turned the old intellectual hierarchy over on its side, where it took root and grew along its entire length. There are, today, more people who are knowledgeable and literate—and knowledgeable people have a way of transforming obedient belief and acceptance into question, skepticism, and sometimes rejection as they struggle for a new order of wisdom.

In this climate, wise men have given way to experts. New professions have grown, old and new ones have subdivided within and among themselves and have given birth to still more professions. There are those who shake their heads and speak in worried tones about “fragmentation” and “specialization.” Well, fragmentation and specialization happen to be the peculiar properties of cell division, and for some little time now cell division has been recognized as a necessary condition for growth. I don’t think any of us should fear growth and the changes it brings.

Of course, the growth of which I speak concerns people who cluster together into specially trained groups and erect high, surrounding fences with warning signs that say, “Special Functions—KEEP OUT.” Each group tills its own little patch of soil—digging up facts, growing theories, and cultivating its own special role.

This works well for a while—but then the inevitable happens. Some of the adjacent groups find that, fences or no fences, they have been digging for facts in the same common soil. They find that the roots of their theories, being oblivious to fences as roots are, have intertwined and grown together. It is no wonder, then, that they find their well-cultivated roles overlapping and their “KEEP OUT” signs difficult to maintain.

And so, today, in our neighborhood of health care, we find medical specialties and specialties in the other health professions without mutually exclusive roles and functions, despite titles, traditions, pronouncements, policy statements, and sometimes even licenses. The physician, like the theologian, finds that he is no longer the sole decision-maker in his particular neighborhood. He finds, as we all do, that for patient care to be effective and of high quality, the power to act in certain circumstances must be delegated and entrusted to others. And this is where we as physical therapists come in, for we are among those others.

As Lincoln said so eloquently, “it would be a violation of truth and an insult to our intelligence to deny” that we have some differences with our associates in medicine, because our roles—both of our roles—are changing.

RELATIONS WITH MEDICINE

I would say at the outset that we recognize and respect the physician’s responsibility for ultimate authority in the care of patients. This has been our tradition, and for the sake of coordinated, integrated patient care this should probably not change. At the same time, we and the physician must not close our eyes to the fact that this is a shared responsibility, for we, along with other professional persons, share
with him in the legal and moral responsibilities of good patient care.

**Diagnosis and Evaluation**

I do not think that we, as physical therapists, should question the physician's legal and professional right to diagnose human ills. As a matter of fact, we depend upon him for an accurate diagnosis and for a clear statement of contraindications and precautions. However, physical therapy and medicine do need to sit down and mutually explore just what is meant by the term “diagnosis,” and how and when it differs from “evaluation.” There are disturbances of some human functions which the skilled physical therapist can evaluate more competently than the physician. If we look closely, we see that the scientific determination of the nature of symptoms underlies both the physician’s “diagnosis” and the physical therapist’s “evaluation.” Mutual exploration and discussion might help dispel some of the accusations and conflicts which arise from time to time.

**The Prescription**

If we move on to consider the term “prescription,” we find ourselves in rather murky water. “To prescribe” means to tell another any one, or usually more than one, or sometimes all of the following: what to do, when to do it, how to do it, how frequently to do it, and how long to do it. We recognize that there may be occasions when specific treatments, per se, should perhaps be prescribed. But we must recognize, also, that the concept of what constitutes “a treatment” is changing, that many of the things physical therapists do today cannot be equated with applied remedies which are passively received by the patient, that “treatments,” in the narrow sense of that word, constitute a small segment of the present-day practice of physical therapy, and, finally, that “treatments” rarely comprise the total physical therapy program of any one patient.

In any event, with the present state of affairs—as the practices of physical therapy and medicine co-operatively relate to one another, the physical therapy prescription is something of an anachronism. It logically implies overlooking several important elements in good quality physical therapy: the need to teach and train patients, as well as treat them; the need to plan a physical therapy program on the findings of the physician’s diagnosis and the physical therapist’s evaluation; and the need for flexibility to modify the physical therapy program in accordance with the patient’s responses, his performance, and the social and cultural factors of which he is a part. The physical therapy prescription, in its most rigorous sense, flies in the face of present-day knowledge of learning theory, probability theory, information theory, and individual psychology. It is conducive to a “cookbook” approach to the care of human patients, and is reminiscent of years ago when “remedies” were in vogue.

We must assure each and every physician that we now provide our services to patients only upon referral by a physician, and that we have every intention of continuing that relationship with all of medicine. We must also assure each and every physician, whatever his specialty or area of practice, that we respect and prize his medical knowledge and guidance—much as we respect and prize our own physical therapy knowledge and guidance. We need, we want, and we accept medical direction and authorization in providing physical therapy services to patients, but we must reject out of hand the attempt of any one specialty group in medicine to interpose itself between us and the rest of medicine in order to play the role of “sole prescriber.”

For the sake of those patients who receive our services, we have a professional and moral responsibility to insist upon a major role in co-operatively planning the physical therapy programs we provide, and to demonstrate—without question—without exception—that we can fulfill that role in a professional manner.

If the consideration of “prescription” takes us into murky water, we come next to an area which, by comparison, is a tangle of thorny brier. I refer, of course, to those two relational terms which frequently emit great quantities of smoke and heat, but very little light: “supervision” and “direction.”

**Supervision and Direction**

There is not unanimous agreement among physical therapists over just what “supervision” and “direction” mean, let alone agreement between physical therapists and physicians. This should not be too surprising because these terms are used differently in different contexts. What they mean in the physical therapist-physician relationship may be far different from what they mean in the physical therapist-assistant-aide relationship. I shall confine myself to the former.
"To supervise" means literally "to oversee." At least one implication is that of observing and correcting the performance of others. Logically, this means that the one who supervises, who observes and corrects, must have a required amount of training, education, experience, and expertise in the things that others do. It means that the supervisor must be able to teach and instruct in what to do and how to do it. Neither the physician nor the physical therapist has the required training, education, experience, and expertise for the one to cross over the interprofessional boundary and supervise the other.

Within the context of how medicine and physical therapy relate to one another, and within the context of the respective professions, it is fitting and proper for physicians to supervise physicians and for physical therapists to supervise physical therapists. Within the physician-physical therapist relationship there is no logical supervisory relationship that I can see.

"To direct" means to aim or point toward some definite end; it can also mean to instruct in how to proceed toward that end.

We acknowledge the physician's responsibility in directing the patient's total care toward some definite end. We also acknowledge the responsibility of the physical therapist, the patient, the patient's family, and other professional personnel to participate in determining, achieving, and, if necessary, modifying that end. In this process we value the medical direction of the physician.

Within the physical therapy service, it is the responsibility of the physical therapist in charge to direct that service toward its definite ends—the most important of which is high quality physical therapy care. It is his or her responsibility to direct others within that service in how to proceed toward the end established for each patient referred to the service—and toward the end established for the service itself. In brief, it is this person—this physical therapist—who is responsible for physical therapy direction and for being equipped to uphold that responsibility or lose it by default.

I have chosen to speak about these matters of practice because of our changing roles in health care. I have not discussed some others, primarily related to education, which also need to be squarely faced and resolved. There is a certain degree of correspondence between these matters and the events going on in society which I mentioned earlier. Role changes have a way of leading to expressions of differences, to conflict which is often unnecessary, and to accusations which are frequently unwarranted. Current changes in patterns of paying for and providing health services are acting as a catalyst to accelerate these role changes. One cannot help but comment that these are indeed times that try men's roles.

Resolving the differences that do exist will not come about by unilateral action—unless one side or the other picks up its marbles and goes home, and the probability of that happening is just about point-zero-zero. Nor does the resolution of these differences lie in conflict or name-calling. Flight and fight are two psychologically potent emotions to which we must not succumb because they do inhibit the intellect—and we need every bit of intellect we have to work for the changes that must be made.

**BILATERAL CO-OPERATION**

The solution must come through a joint process involving both physical therapy and medicine. It will mean sitting down as adults for frank, well-informed, intelligent dialogue in which areas of agreement and disagreement can be mutually explored. It will mean doing this at all levels, so it will mean involving yourself as well as those of us who are your elected representatives—for the practice of physical therapy is just as broad as what all of us do, and just as deep as what each of us does.

If we are to help guide change, there are several things we must do to fortify ourselves and our position.

**The Physical Therapist's Responsibility**

There are certain signs of professional maturity we must acquire and retain. We must be rational not emotional, convincing not demanding, understanding not vitriolic, and we must be willing to work for change rather than hoping to suddenly create it. We must say what we honestly think and we must listen honestly when others say what they think. We must clarify what we mean and we must seek clarification of what others mean—especially if we are to operate above the level of slogans. We must be ever ready to consider and to propose alternatives. We must promise only what we can deliver and we must deliver what we promise. We must trust others, with full reali-
zation that trust does not obligate agreement. And finally, but most importantly, we must develop and keep a sense of humor. We must be and do all these things to others, both within and outside our profession, and we must expect no less in return.

As a profession, we need to improve our posture and add one cubit to our stature by tending to some of our own deficiencies. We need to define standards of good physical therapy care and then see to it that the physical therapy provided in these United States measures up to those standards. We need to explore ways of assuring society that once a person has been judged competent for the practice of physical therapy, he or she maintains competency in the practice of physical therapy. We must provide education for our own people to equip them for increasing responsibilities in supervision, direction, and management. Finally, we must see to it that we as physical therapists do more clinical research and better clinical research. Simple, straightforward, well-designed studies of some of our most basic premises and methods do not exist. There are many important reasons why we should make a massive effort in this direction. Perhaps the most critical, the most important, is that we as physical therapists have got to know more about physical therapy than anyone else. We say we do, and we try to persuade others that we do, but we must convince them by demonstrating that we do—and the convincing does not simply lie in showing that we know how to do physical therapy.

I can assure you that measures are either being planned or will be planned to correct these deficiencies and to strengthen ourselves professionally. As for the signs of professional maturity, these cannot be generated by a committee, legislated by our House of Delegates, or financed and carried out by some program. They are a matter for our collective and individual consciences. We shall have to practice them in the conduct of our day-to-day affairs, as well as in the conduct of our Association affairs. Their successful achievement will depend upon each of us because, as a group, we can only be as professionally mature as the most immature among us.

CONCLUSION

Last year our House of Delegates concerned itself, and rightly so, with a socioeconomic security program. If you wish a slogan under which to place the things I am talking about, so be it. My concern in this address has been with a “professional security” program.

The matters I have discussed—the differences that exist and the changes taking place both in society and in the world of health care—will have tremendous impact on physical therapy. The nature of that impact will be determined by the ways in which we go about resolving those differences and guiding those changes. We cannot expect to do these things alone or in a capricious manner, and we must not permit others to think that they can. The things we can do alone are to strengthen ourselves professionally and to move ourselves along to the next level of professional maturity. Then, when we do sit down with others, we can command the respect and attention which physical therapy deserves.

On a day-to-day basis, the changes will be neither dramatic nor sudden. Their impact will be historical, not contemporary. They will come in bits and pieces, but they will come if we exercise the kind of wisdom, prolonged effort, and patience that go with looking ahead to what the profession and the Association will be ten years, or even another forty-five years from now. We must work diligently and honestly for what many of us may not live to see. Perhaps this is all any man can really mean when he says, “I have a dream . . .”

REFERENCES

4. Martin Luther King.