Tenth Mary McMillan Lecture

The Not-So-Impossible Dream

My overriding dream is that physical therapy shall achieve greatness as a profession.

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Since the inauguration of this lecture a dozen years ago, there have been scholarly critiques of physical therapy history, philosophy, education, and therapeutics.

The lecturers have been physical therapists who have placed their indelible mark on this profession—those who have proudly received the torch passed on by Mary McMillan and kept its flame burning brightly for the future.

Thus, I am filled with gratitude, responsibility, and humility. If you insist I find a word for it, I can—paralysis. But I am fortified also by this challenge, this opportunity, and this honor.

I accepted the challenge because of the debt I owe to this Association for the fullness of life it has given me, and in respect and honor to you, my associates, who handed me the torch.

In selecting the title for this address, “The Not-So-Impossible Dream,” I reflected on a vision I have for a great profession—one unified by shared values, shared beliefs, and shared attitudes. These shared experiences and dreams are what give a profession its tone, its fiber, its moral style, its determination to exist, and its capacity to endure.

Thomas Jefferson said, “Every man should have a dream. Every dream should have a purpose.”

My purpose in sharing a dream with you is to be found in these paraphrased words of Pericles speaking to the Athenians:

Fix your eyes on the greatness of your profession as you have it before you day by day; fall in love with her; and when you feel her great, remember that her greatness was won by people with courage, with knowledge of their duty, and with a vision that all things are possible.

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IDENTITY CRISIS

Physical therapy today is in the midst of a crisis of identity; it is, indeed, a profession in search of an identity. During fifty years, we have passed quickly through an age of tolerance, to a golden age, and most recently to an age of survival. Despite all our recognition, despite all our acceptance, despite all our disclaimers, we have not arrived and our survival is not assured.

Physical therapy needs to appreciate how essential distinction is to survival. Over five generations, we seem to have forgotten why our founders sought recognition. A society, a profession without a sense of the past for which it has respect, lacks identity and regard for the future.

This, of all times in our history, is a time for strong identification. We must ask ourselves if in our attempt to develop in multiple directions we have assumed a cloak of unidentifiability; if in our rhetoric we have transmogrified our ideals; and if in our desire for acceptance we have become victims of self-made delusion.

Who, my friends, if not we ourselves, is to speak for the spirit and essence of physical therapy? Establishing a strong identity is not a question of restriction. Rather, it is a matter of who is to say what we can do, what we will do, and what we must do.

The intellect is vagabond and our present condition fosters restlessness. We neglect the history of ideas and the need for identity at our peril. If we deny them, we may be ingenious technocrats, but we are also ingenious Philistines and guilty of intellectual treason.

I hope you will pardon me if I bear down hard on the adrenal glands of this profession, but we have something worth fighting for and I hope to stir up your concern. The generation growing up in physical therapy needs some of the spirit and spunk of Mary McMillan.

There are outside forces which are working to retard our progress, even toward our destruction, but these external forces have little penetration power in themselves. It is our internal fragility, our laxness, that establishes our vulnerability. In the words of Pogo, "We have met the enemy, and they is us."

The reason for physical therapy's vulnerability is that it is relatively defenseless against the leviathan of modern science. Physical therapy has a soft underbelly because its science is in disarray. This disarray leaves it open to attacks against its inadequacies—attacks from medicine, attacks from government, challenges from fiscal agencies, and questions from the consuming public.

But, most of all, physical therapy is vulnerable because somewhere along the way it has lost the sense of its elemental identity.

Physical therapy is on the defensive and it cannot speak with one voice because of the difficulty stemming from its failure to define and agree upon what physical therapy is.

What are the fundamental and unique concepts of this discipline? What are physical therapists? Who are they? What do they do? How do they do it? What results are expected from whatever it is they do?

Physical therapy has yet to document its own conviction about its value to total health care and to demonstrate its commitment to develop, teach, and apply its scientific principles as effectively as possible.

The Genetic Forces of Identity

There are two cardinal forces that create the genetic heritage of a group, that imprint its quintessence in the archives of knowledge—the forces which act ultimately to carve out the identity of the physical therapist.

The first is the centrifugal or outflowing force which arises from the basic motivations and purposes of the group. The centrifugal force in physical therapy springs from a people-helping desire linked with a motivation to manipulate the human body to achieve more acceptable modes of function. The science and humanism we employ to achieve our ends are the vectors of this force, and the magnitude of either vector may be large or small.

But as we attempt to see ourselves, we are at the same time viewed by our fellowman. This gives rise to the centripetal or converging force which arises from the basic motivations and purposes of the group. The centripetal force in physical therapy springs from a people-helping desire linked with a motivation to manipulate the human body to achieve more acceptable modes of function. The science and humanism we employ to achieve our ends are the vectors of this force, and the magnitude of either vector may be large or small.

But we attempt to see ourselves, we are at the same time viewed by our fellowman. This gives rise to the centripetal or converging force that acts upon us. Its vectors are our contributions to the individual patient and to the welfare of man. It arises in the anthropocosmos in which we conduct our affairs and can reflect either warm winds of approbation or shivery blasts of rejection. We cannot escape this centripetal force for it is the respect given by those we serve for that which we are.
We can use these two forces—one which represents the profession and the other the function of the profession—to carve a conceptual framework for physical therapy.

It is time for physical therapy to lay claim to the title of profession. It is time for physical therapy to decide whether it wants to develop to the fullest those distinctive contributions for which it has been recognized or whether to accept secondary status as the ultimate fulfillment of its purposes. To paraphrase Lewis Carroll:

The time has come, it may be said
to dream of P.T.'s role
of life and limbs, and hearts and minds,
of sciences and goals.

I present these views as provisional, as your interpretations should be. Our equity in ideas should be in their continued refreshment and not in their eternal verity. For truth changes as new knowledge sheds light on old shadows.

So we address ourselves to the question, “What is physical therapy?”

WHAT IS PHYSICAL THERAPY?

Physical therapy is knowledge. Physical therapy is clinical science. Physical therapy is the reasoned application of science to warm and needing human beings. Or it is nothing. The precise role of science in physical therapy is not often understood and no coherent philosophical overview exists to guide the growth of the profession. In the spirit of dialecticism, therefore, may I present several premises upon which I believe such a philosophy can be founded.

The basic postulates are these:

1. Pathokinesiology is the distinguishing clinical science of physical therapy. It is the study of anatomy and physiology as they relate to abnormal human movement. It presents a theoretical base broad enough to afford a rational explanation of human motion disorders. Physical therapy in this context contains a body of scientific and empiric thought that can be applied to the treatment of a wide variety of disorders.

2. Physical therapy can claim the unique privilege of placing the role of exercise in health and disease in its proper scientific focus and perspective.

If we view man as a natural system after the manner of Laszlo and others,1-4 we find a hierarchical pattern which can be used to define the science of physical therapy and its application (Fig. 1).

Each of the levels in this hierarchy is a subsystem of the level above, as well as being a system in its own right. Information flows freely up and down the system, and there are simple and complex feedback loops for interlevel and intralevel exchange.

The person level of this hierarchy is of itself a natural system as well as being part of the larger hierarchy. At the person level, man expresses himself in all things from primitive emotions to the most abstract theory with, and through, motion. Without motion there is no communication, no interpersonal reaction, no development of society.

Health may be defined as the smooth functioning of these interrelated systems, whereas disease results from any perturbing force which upsets the balance within one level, or between levels.
Conveniently, each level in the hierarchy coincides with one of the basic biological sciences, which provides a solid foundation for its adaptation in and contribution to physical therapy (Fig. 2).

In applying the principles of motion to this natural system, it becomes obvious that all of the structures express their function in motion (Fig. 3). Some of the more common expressions of this motion would be Brownian movement at the subcellular level, blood flow at the tissue level, reflexes or postural adaptation at the systems level, and purposeful work or play at the person level. When motion is altered at any level, homeostasis is disrupted and adaptations must take place to restore some degree of balance. The alterations in motion may be hyperactive, hypoactive, or externally restrained and static. If the disruption is at the higher levels, signs of disuse or incoordination ensue at lower levels. If motion ceases at lower levels, the result might be destruction of a function or even death of the person. Thus, there are many degrees of perturbation, and subsequent adaptation may be total, partial, or nonexistent.

Motion is a concept that must be viewed beyond the purposeful contractions of skeletal
Fig. 4. The realm where physical therapy is effective in the hierarchy of the human organism occurs between the tissue and person levels.

Fig. 5. Humanism is a correlate that must be considered with the science of physical therapy for the profession to meet its social goals.

Muscle initiated by a complex nervous system. Within this concept of biological motion we can construct a paradigm for physical therapy.

A Model of Physical Therapy

Conceptually, physical therapy by virtue of its heritage, its science, and its available technology is called to intervene when a perturbing force or a potential disturbance manifests itself in a motion disorder that is amenable to externally applied therapy. This externally applied therapy is, for the most part, some form of controlled exercise or stimulus to induce movement; or it may be a means to ease the perturbing force by judicious application of physical agents, such as those which increase blood flow or promote gas and fluid exchange.

The purpose of physical therapy is to restore motion homeostasis to the person or his subsystems or to enhance the adaptive capacities of the organism to permanent impairment or loss. The realm of physical therapy in this hierarchical system is between the motion disruptions that occur at a tissue level and those that manifest themselves in a most complex manner at the person level (Fig. 4).

The physical therapist may have an influence on the family at the upper level and the cells at the lower level, but only through either the person or the tissue—possessing no unique tools for intervention at these levels.

Humanism is an intrinsic attribute of therapy, and as such it is an intrinsic element of physical therapy (Fig. 5). Humaneness places highest value on the person level of the hierarchy, and physical therapists, in common with other health practitioners, must retain a holistic view of the patient, even when their therapeutic efforts are directed at a lower level of the natural system.

Examples of system perturbations, their effect, and the point of therapeutic intervention may be drawn using vectors in one direction to display the forces of disease or injury and vectors in the countervailing direction to display the forces of therapy (Fig. 6). Only the most simple influences are illustrated in the Figure, but one should keep in mind that changes at one level can influence alterations at all levels, and what may be external to the tissue is internal to the organ, and so forth. The perturbing force may be very precise to one hierarchical level, such as a fracture, or it may be very broad, such as the extensive trauma of a motorcycle accident.

A burn is an example of tissue destruction which may have profound effects at all levels (Fig. 6). Wide tissue destruction causes endocrine responses which give rise to such stress signs as gastric ulcers. Interruption of the
normal functioning of the skin leads to scarring, contractures, and body fluid imbalance. At the person level, there will be some decrease or loss of function of the part or of the person as a whole. Emotional responses are reflected at the person level and these, in turn, have a disrupting influence on the dynamics of the family and even beyond.

Intervention by the physical therapist occurs at three specific levels. Debridement and all that goes with it is used to promote healing of tissues. Other than aiding the salutary healing, the therapist has no specific tool to use at the organ level, but he can use techniques for positioning and splinting to reduce the sequelae of contractures and prevent deformity or reduce edema. The application of a variety of forms of active exercise—active implying the person's consent and cooperation and, therefore, involving his conduct—will counteract the effects of immobility, both general and specific.

In the example of a coronary thrombosis (Fig. 7) with its myocardial infarction and decreased cardiac output, the patient suffers from disruption of his normal energy supply and is made further inactive by angina and fear.

Fig. 7. The disrupting force is a coronary thrombosis which causes disruption at four levels. Physical therapy has direct influence only at the person level, but this influence produces beneficial effects at lower levels if patient cooperation is achieved.
Fig. 8. Trauma in the form of a lower limb amputation is an example of a perturbing force at the systems level which is counteracted by prosthetic fitting and gait training.

The only level where the physical therapist has influence is through an exercise program carefully titrated to match the patient's physiologic resources.

An example of perturbation at the systems level would be the loss to the musculoskeletal system of a limb (Fig. 8). The resultant decrease in locomotor ability is managed by limb replacement with a prosthesis and gait training and its accompanying exercise program at the person level.

Physical therapy, then, may be viewed as a pyramidal structure which has its foundations in social and cultural needs (Fig. 9).

The people who are attracted to physical therapy have a deep caring for people and, beyond this, an altruistic drive for service to people.

In common with all health professions, physical therapy also has a scientific foundation which springs from the needs of the sick and the injured. Our particular foundation does not include all of the basic sciences but it does draw significantly from several, including anatomy, physiology, pathology, biochemistry, biophysics, and psychology.

Each health profession came into being to meet a special social need. That need, or the purpose of the professional discipline, should be identified. Physical therapy was founded to provide restorative services to persons who suffer physically handicapping conditions. The wellsprings of our origins are rooted in physical education, for that discipline gave us our founders, and from their knowledge of body movement and exercise grew the applications of exercise to pathological conditions; thus, again, the purpose we serve is to restore motion homeostasis.

So, then, the stage is set to place the science that is physical therapy in our model. We may term this science pathokinesiology to distinguish it from kinesiology, which is the science of normal human motion. The components of the science derive from several anatomical and

![Diagram of physical therapy](image-url)
physiological substrates including pathokinesetics, biomechanics, neuropathology, and exercise physiology.

At the apex of our model is the clinical application of our science—therapeutic exercise. This concept emphasizes our uniqueness and is not intended to encompass more peripheral, but important, contributions to patient care.

By definition, then, physical therapy is a health profession that emphasizes the sciences of pathokinesiology and the application of therapeutic exercise for the prevention, evaluation, and treatment of disorders of human motion.

Fragility of Clinical Science

Where physical therapy is fragile is in lack of precision of its intervention procedures. There are no specific answers to the what, where, when, how much. Basmajian put it succinctly in an article in the June 1975 issue of Physical Therapy when he said science is not the virtue of physical therapy but rather its virtue lies in an intensive interpersonal relationship with individual patients. This, my friends, is not enough for our survival.

After fifty years, the science of physical therapy is entering its infancy. A great difficulty in developing the clinical science of physical therapy is that we treat individual persons, each of whom is made up of situations which are unique and, therefore, appear incompatible with the generalizations demanded by science.

In reality, however, humans have common fundamental traits and they share experiences, values, and life styles which make statistically predictable responses possible. This makes clinical science possible. The time has come to give to the study of the responses of the living human being the same dignity and support now given to the science of parts, animals, and petri dishes.

The determination of the profession to retain a viable place in the health care system with a vigorous economic base compatible with the nation's resources, and to improve the quality of patient care must, for the indefinite future, necessitate a large, continuing research and development enterprise.

This enterprise will not be taken on blind faith. Everything we do, everything we propose will be scrutinized as never before. To convince others of our aptitude, we must prove to ourselves that our methods work. Are our wondrous efforts a result of sound method or do personality and human interaction explain away or create patient improvement?

We are confronted on all sides with therapeutic endeavors which mix scientific fact with quasi-scientific hypothesis. Others have become quick to condemn us—and they have justification because we have not demanded rigorous and careful studies of unorthodox concepts—in fact, we perpetuate the attitude of condemnation because in our naive eagerness, we permit the promulgation of untruths or part truths and confer honor and respect where we admit we do not understand.

I suspect that we cannot continue to count on help from our neighbors in other disciplines. It is going to be up to us to manage this science of ours by exploration and hard thinking.

There are no scholarly professions today which do not have doctoral programs in their own discipline. The time is now to support doctoral education in pathokinesiology or physical therapy. In physical therapy, the advances in our field of endeavor are being made, not by us but by others, and in this state we are reduced to being mental pickpockets simply because we do not have organized programs to develop our own science.

This fact was clearly and succinctly pointed out to us by Worthingham in her study of basic education in physical therapy, 1966 to 1969. That study, which could have had the impact of a latter-day Flexner report, should have sparked an educational revolution in physical therapy. Instead, bits and pieces have at least prodded the forces of slower evolution.

I am an optimist about what all of this means for us. I believe that we have the power to shape the future in ways that will vastly improve our condition. On the other hand, we also have the power to destroy our profession as we know it by wandering without a strong identity.

The value of physical therapy to the total health care of the public can be assessed only within its value system. Only when the science is established and proclaimed will physical therapy cease to be palliative, adjunctive,
elective, or an arena of last resort for the patient.
If we will have the conviction and the courage to proclaim once and for all what physical therapy is and then act on it, the centrifugal forces generated will cast an ever-lengthening shadow across the pages of human history.

The Centripetal Forces of Identity
The centripetal forces which cast the character of physical therapy arise from the value systems of the society we serve. Thus, to assess the value of professional activities, one can propose criteria that arise from outside the profession—that is, from the judgments the public makes regarding a professional discipline. Such external criteria ask of any given professional activity that it have meaning and relevance in three spheres:

1. Scientific merit—which judges the degree to which the discipline understands its role and achieves its purpose
2. Humanistic merit—which judges the relationship between the therapist and the patient
3. Social merit—which judges whether the services provided aid social goals

My dream, simply put, is that physical therapy will merit a secure and valued role in our society when measured against these criteria.

What Must We Do?
1. First we must set up absolute standards of clinical performance rather than remain lost in the morass of relativity. To be sure, such standards are good only for today and not forever, but the whole history of man indicates that when standards of conduct (of any kind) gradually decay, permissiveness leads to total decline.

2. We must produce scholars in human pathokinesiology. Not every therapist can become a scholar in the true sense, but every therapist can be imbued with an understanding of science as it is applied to physical therapy.

If the capacity for logical thought and scientific values is not acquired early, there is little hope such qualities will surface later. This lack already has given rise to serious implications:

- Essential growth dependent upon accurate analysis of patient needs is not occurring.
- The practitioner is more artisan than scientist, and only a scientist can integrate successfully the multiple variables expressed by an impaired human being.

Do not think I am crowning science as the only important value. But, those in physical therapy who do not comprehend the advances of science seem to fall back on the convention that the scientist is incapable of sympathy and compassion—as if scientific accuracy and humanism were mutually exclusive.

Sensitiveness toward people is not blunted by science. Science is not inhumane. The scientist and the humanist must complement each other in the same individual to balance the equation for excellence in care.

To weave a fresh fabric for each new patient with the warp of man's primal empathy and the woof of man's intellectual understanding—this is the final and permanent art of physical therapy—its apotheosis.

3. We must elevate the role of the clinician. Physical therapy in its essence is an interaction between two human beings in a cybernetic loop—physically, physiologically, and psychologically. Success in the clinic depends on constant interaction between therapist, patient, environment, and ever-changing requirements. It depends on the ability of the practitioner to assess the changing requirements and to apply his science, which is exacting and demanding, through meticulous practice and persistent study.

To a clinician, treatment is not only important, it is paramount. The care of the patient is the ultimate, specific act that characterizes a clinician. It differentiates him from all others. Its obligation is transmitted as the heritage of the profession. Its performance is his unique contribution to mankind. If treatment is unimportant or takes a secondary place, a
clinician has no useful purpose for his existence.

Just as the work of talent leads to success, so may success lead away from the endeavor which conferred it. Most clinicians eventually are bogged down with the by-products of their own successes. They are given large departments which must be administered; invitations come for lectures; more and more visitors are received; correspondence grows voluminous; meetings replace care of the patient.

Eventually nothing is left but interruptions.

Clinical skills are fragile and they must be practiced to be preserved. Those clinicians who elect to become involved in other endeavors must exercise great care to avoid entropy else patient care be relegated to a position where the patient becomes the forgotten man.

For the physical therapist who wishes to remain a career clinician there should be incentives, economic and otherwise, to reward his proficiency and contribution to patient care, which is what physical therapy is all about. The advent of the physical therapist assistant to take care of less demanding procedures frees the clinician to direct his attention to the development of our clinical science.

If you want a bee to make honey you do not issue directives and protocols on carbohydrate metabolism and solar navigation. You put him together with other bees. If the air is right, the science will come in its own season, like pure honey.

Clinical Specialization

The momentous and great advances in medical science of recent years have had an impact and have introduced changes that perforce should modify our practice. It is only natural that the explosion of knowledge should outstrip the capacity of any practitioner to encompass the entire field. The need for some kind of specialization is upon us because society has served fair notice that it anticipates more complete and higher quality health services. To respond, physical therapy must come out of its long diastole and recognize new modes and new methods for the practitioner.

It is my dream that this profession embark upon structured programs to train clinical specialists, but with caution and with realization that our world of knowledge is so small in relation to our universe of ignorance. The strength of this innovation will depend upon proof of clinical competence. Specialization should not be a drain from the grass roots of general service. It should transfuse into the commonweal realistic and vital promises of higher quality patient care. The pattern of specialization should encompass broad areas of practice so that knowledge is not partitioned so minutely as to build in myopic views of patient care.

In advocating specialization as an option in clinical practice I am aware of its problems. The major criticism leveled against specialization is that by trying to solve complexity it creates some degree of isolation. The corpus of knowledge keeps breaking in ever smaller subdivisions, each tended by persons who, unless offsetting influences are exerted, may be inarticulate and even unaware of other efforts in their own profession. The wisest specialists will, of course, never lose sight of the bewildering complexity of man. In disease or health, man cannot be understood piecemeal, even if he has to be studied that way.

Specialization is one idea whose time has come for the clinician. The kind of clinical practice I envision for the specialist cannot be ordered or commanded. The best we can do is recognize it and encourage it in the sensitive few—to prevent its inhibition by too much teaching, its submission by too much dogma, its extinction by too much ritual.

The clinical specialist should be the clinical scientist and demonstrate that clinical science and its methods stand successfully over all others in the advancement of knowledge. Indeed, it is my dream that clinical specialists, born in science, nurtured in reason, seasoned in practice, and blended with compassion will begin to deal in physical therapy with questions that long have challenged the human intellect and the human spirit.

Strategy for Survival

The place of physical therapy is in the stream of patient care, not on its banks.

The role of the clinician represents a challenge that will, of necessity, be met in one
fashion or another, and it can be better met if we face it forthrightly. It is old knowledge in Scotland that the sheep who stand on a rise of ground and face into the storm survive, while those which huddle together for warmth in the low places frequently are suffocated in the snowdrifts.

What will happen to us, I wonder, if we deny the value of the primary clinician, if we distort our identification by denying use of skills which take years to accrue through long and intimate contact with patients and countless clinical dilemmas.

Physical therapy is in deeper trouble than most realize, for we have no real strategies for mending our ways, for adapting to change—only tactics aimed at simple survival.

Unless the best trained of our constituency are willing, no, eager, to retain their clinical orientation in direct care of the patient, it is difficult to see from whence the push toward the steady improvement of quality will come. That, indeed, would be the ultimate tragedy, for if our glimpse of the future finds us as powerless as we are today to answer the clinical questions, I'm afraid there will be no future. Only because there is hope for the eventual improvement of quality can we retain optimism for the ultimate effectiveness of physical therapy.

Why will we survive? How will we survive? Just this. By providing a unique and distinct service to the people—service not equaled in its excellence, breadth, or comprehensiveness by any other group.

We have a choice. Either we assume control of the science of physical therapy or we fail to take that responsibility and see our profession become increasingly irrelevant, redundant, and its practices deteriorate.

Perhaps I can best illustrate my remarks by this fable from an unknown source: A cynical man walked up to a wise philosopher one day and said, "You who are so wise, I ask one question. I have a bird in my hand. Tell me, is the bird dead or alive?" The philosopher thought for a moment. "If I say to him that it is dead, the live bird will fly away; but if I say to him that it is alive, he will clench his fist, crush the life from the bird, open his hand and show me a dead bird." So the wise man said to the cynic, "You have a bird in your hand. You ask me is it dead or alive; I answer, it is as you will."

The future of physical therapy is in your hands. To each mind is offered its choice between ideas and somnolence, its choice between questing and resting. Take which you please. You can never have both.

GREATNESS

My overriding dream is that physical therapy shall achieve greatness as a profession. Our aims may be noble, our virtues admirable, our sins minimal, and our practice moral, but without the saving merit of a habitual vision of greatness, its attainment is impossible. If we do not achieve greatness, what we do or what we believe does not matter. We shall be no more noticed than sand dropped and buried with more of its kind at the bottom of the hourglass of time.

Physical therapy stands at what could be the beginning of a new era; an era in which science is our quest and humaneness our expression; an era in which physical therapy can constitute a bridge over which science and man's dignity maintain contact.

The issue is clear: if greatness is a goal, it will take great thinking and consummate honesty to achieve it.

I have spoken to the crisis of identity with which we are afflicted. Now is the time to burst out of our lassitude with an explosive force that others do not credit to us.

Our distinctive recognition as a profession is not the contribution of a single measure but a concept of health care, the touchstone of which is the identifiable clinical science of pathokinesiology.

Physical therapy cannot achieve its best purpose until that clinical science is elevated to preeminence in that purpose. In turn, we must elevate the clinician to a level of primacy. There is no more important task today than to provide him with newer knowledge, newer tools, a strong, defensible identity so that Longfellow's words might describe him fittingly, "Staunch and strong, a goodly vessel that may with wave and whirlwind wrestle."

Our end is our own to be won by our own endeavor and held on our own terms. The reality of our tomorrow will depend very much
upon the quality of what you think on, for as Marcus Aurelius said: the soul of a profession is tinged with the color and complexion of its thought.

Be scientific but not callous
Be humanistic but not soft
Be independent but not isolated
Be professional but not narrow
Be judgmental but not dogmatic
Be vocal but speak with one voice
Be dreamers but not drifters.

For

We are the music makers
and we are the dreamers of dreams...
Yet we are the movers and shakers
of the world forever, it seems.

To dream the impossible dream? To fight the unbeatable foe? No, my friends.

We will be great.
This is the not-so-impossible dream.

REFERENCES