We Are What We Do

Anthony Delitto

Dr Delitto is well known for his many outstanding accomplishments and contributions to the physical therapy profession. In practice and research, he has represented APTA on practice guidelines initiatives from federal and professional societies, including the Decade of the Bone and Joint initiative. He has been an invited scientific and professional speaker at numerous national and international professional conferences and meetings. In addition, he has published more than 70 articles in refereed journals and 15 in nonrefereed journals.

He has served at both the component and national levels of the Association throughout the more than 30 years he has been an APTA member. He has held leadership positions in the New York, Missouri, Illinois, and Pennsylvania chapters and in the Research, Clinical Electrophysiology and Wound Management, and Orthopaedics sections of APTA. He has served on the Editorial Board of Physical Therapy and currently is a reviewer and chair of the Steering Committee. He served nationally as a commissioner on the Commission on Accreditation in Physical Therapy Education (CAPTE). Dr Delitto has served on numerous APTA Board of Directors’ appointed committees and task forces, including the Advisory Panel on Practice and the committee to revise the Clinical Performance Instruments for physical therapists and physical therapist assistants. He currently serves on the Doctoral Research Awards Committee and the Scientific Review Committee for the Foundation for Physical Therapy.

Dr Delitto has been honored with APTA’s Jules M Rothstein Golden Pen Award for Scientific Writing, the Marian Williams Award for Research in Physical Therapy, the Lucy Blair Service Award, and the John HP Maley Lectureship Award and was elected a Catherine Worthingham Fellow in 2000. The APTA Orthopaedics Section has honored him on 6 occasions with the Steven J Rose Award.
After being asked to deliver this most prestigious lecture-ship (Figure), one of the first things I did was look at the list of previous Mary McMillan Lecturers. Looking at the cast that preceded me, I was nothing short of awestruck. I graduated from my entry-level [professional] physical therapy training in 1979 and attended my first APTA annual conference in 1980. I vividly remember attending Florence Kendall’s Mary McMillan address. I have not missed many McMillan Lectures since then. In fact, I can count on one hand those I have missed. My fondest memories of these lectures involve the highly spirited debate about some of the more pressing issues of our time.

Suffice it to say that you [McMillan Lecturers] did not always agree about these issues. Why should we be surprised that this group would have differences of opinion?

On one issue, however, all previous lecturers were in agreement. The word “honored” came up in virtually every lecturer’s first or second lines. So, like my predecessors, I cannot begin to tell you how honored I am to be the 39th Mary McMillan Lecturer and to be included in the list of previous lecturers, many of whom I consider to be mentors and, most of all, friends. To all of the previous McMillan Lecturers present, I would like you all to know that I have the utmost respect for each of you, and I am humbled to have your name included with yours in the same breath. I would like to begin this talk by paying homage to each and every one of you.

Allow me a few words about my title, “We Are What We Do.” If you remember the movie Forrest Gump, you surely remember Forrest’s mother, played wonderfully by Sally Field, when she would repeatedly remind the slow-witted Forrest, “Stupid is as stupid does.” My first impression was that she was rather cold-hearted, at times almost mean. But the beauty of her approach was that she was preparing her child for a world where she knew he was going to face challenges that in many ways appeared to be insurmountable. Most of all, she was instilling in this child that it was what he did with his life (as opposed to his potential) that was of paramount importance to his success.

Now, I am probably the only person in the entire world who would turn a statement from the movie Forrest Gump into an evidence-based practice lesson. For those of us in the health care field, Sally Field’s words clearly delineate the difference between competence and performance, and they remind us that actual performance is the key to success in anything. I have chosen my title, “We Are What We Do,” to make the case that, as opposed to potential, it is performance, or what we do, that will ultimately determine our profession’s future success. “We Are What We Do” was the best I could come up with for a title, and, besides, I could not title my lecture, “Stupid Is as Stupid Does.”

I welcome the recent talk in the American Physical Therapy Association’s (APTA) Strategic Thinking and Planning Initiative about how critical it is for our field to demonstrate “value”—value to the health care system as well as to the public in general. How will we demonstrate our value in the most convincing manner? One approach that comes to mind immediately is public relations, where I see an overall strategy of telling everyone that our profession’s knowledge base and skill set match up very well with many of the ills of the American public, including diabetes, cardiac problems, obesity, and so on.

Trying to get our audience to focus on our potential role in health care may be a successful strategy in some instances, and I am not opposed to PR. However, I am proposing that our message is much more convincing to our potential audience if we can also demonstrate that—with adequate access to patients—we are not only effective, but cost-effective. This performance-based approach requires data to support our claim of adding value.

In order for us to improve our performance, we first need to have some idea of how we are performing. My goal in this lecture is to begin to characterize ways to assess our performance as a profession.

I was told that, in some way, I am supposed to relate my experiences in the field of physical therapy to this talk. I have always felt uncomfortable talking about myself, but I love to talk about the people who have been very influential in my life. One of my favorite memories as a physical therapist dates back to my fledgling years as a physical therapist student and as a newly minted physical therapist working with my mentor, Dr Steven J Rose. Shortly after graduating from my profes-
sional training, Steve asked me to join him in St Louis, where I began my career and where I remained for the next 11 years. I like to say I did most of my professional “growing up” in St Louis. It was there that I not only learned about the tripartite mission of academia—research, practice, and education—but also got to actually see it role modeled on an everyday basis in the first half of my career, and I have strive to continue to emphasize each element of this model in the latter half of my career at the University of Pittsburgh. I would like to think that I remained in contact and engaged with each of these areas throughout my career.

Going back to my theme, namely performance assessment, I would like to spend a little time talking about performance in research, practice, and education—a sort of “How Are We Doing in Research, Practice, and Education” according to me.

In assessing research, much depends on how we characterize our performance. One of the most compelling benchmarks in research is performance related to National Institutes of Health (NIH) funding. If NIH is our profession’s benchmark, we certainly have much to brag about. Recent estimates by APTA staff indicate that physical therapists account for 25% of the funding for what NIH characterizes as “rehabilitation research” (Justin Moore, PT, DPT, Senior Director, Federal Congressional Affairs, APTA; personal communication). Although the exact percentage is elusive, suffice it to say that this estimate is a conservative one and probably an underestimate. From a performance-based perspective, our stature at NIH is corroborated by other actions taken at the NIH level, including inclusion of physical therapists at study section, council, and advisory board levels.

Most importantly from the standpoint of research performance, we have witnessed a spectacular model of investment and return on investment through the Foundation for Physical Therapy. We can trace most of our NIH-funded investigators, including myself, back to Foundation for Physical Therapy support through doctoral and research grant support. An extremely effective measure of performance is the amount of money “invested” by the Foundation in new investigators compared with the eventual NIH-level money. Our Foundation President tells me that the latest figures in this area are for a $15 million investment from the Foundation for research; we have seen more than $115 million return in the form of NIH dollars (Richard Shields, PT, PhD, FAPTA, President, Foundation for Physical Therapy; personal communication). It is entirely appropriate to take a moment to express our profession’s gratitude to those responsible for forming the Foundation for Physical Therapy as well as those who have maintained it, sometimes through some very rough waters.

Yes, there is much to brag about when it comes to research, if our performance standard is the amount of NIH money our researchers are able to generate. Certainly, in the world of academia, NIH grants have become the key benchmark and the ultimate endorsement of anyone’s research portfolio.

But is NIH fund procurement our profession’s “gold standard” of research performance? I would think that some in this audience, especially clinicians, would like to expand our gold standard to include something about exactly how this newfound research is having an impact on the day-to-day practice of physical therapy. You would think that our research accomplishments, most of which have occurred in the past 10 to 15 years, would have radically transformed areas of physical therapist practice.

Put simply, has our newly minted research transformed practice in any area in any significant way? Quite candidly, no—at least not to a great extent. When we look at clinical performance, we are still not far removed from an observation made by Steve Rose back in the mid-1980s: “Our practice needs more research and our research needs more practice” (Steven J Rose, PT, PhD, FAPTA; personal communication).

Like many other health fields, there is a great disparity between what we know from research findings and what we do in everyday practice. Like many other health fields, our inability to implement research findings into practice would appear to place the blame on practice, with statements that I commonly hear from the research community that go something like, “The practitioners just do not follow the evidence.” There is an equal amount of “blame” targeting the researcher, and it goes something like, “Much of the research being produced is just not applicable to practice.”

Unfortunately, there is merit in both statements when you look at this from a performance standpoint. When a patient seeks care in our health care system, best evidence tells us that 50% of the time he or she will receive care consistent with best practice.

I will take my own area of interest, low back pain, and use 2 sources of data that justify my claim that we...
underutilize procedures that have been shown to be beneficial and that we overutilize interventions that have little proven benefit. For example, the overwhelmingly positive attitude toward the use of physical agents coupled with actual clinical performance data demonstrate a clear overutilization of these procedures. Coupled with profound underutilization of known effective interventions, such as thrust manipulation procedures, our clinical performance in this area may cause an unbiased, outside observer to wonder exactly what evidence we will use to make the claim that a physical therapist should be the practitioner of choice for this highly prevalent and very costly condition. To add insult to injury, much of the evidence supporting the use of thrust manipulation for low back pain has been produced by physical therapists!

How do we justify our claim to adding value when our audience has access to data that clearly demonstrate that we commonly do not practice in ways consistent with evidence?

Certainly, there is room for improvement in our clinical performance data. I believe that if we are to make the claim to be evidence-based practitioners, then adhering to best practice standards should not be a nice thing to do but rather a necessary thing to do.

To the practitioners in the room who have repeatedly stated that much of what researchers produce has little relevance to their practice, let me state unequivocally that I believe strongly that you have a case. Allow me to digress and once more talk about my past. After graduating in 1979, I spent 4 years practicing full time, teaching a few courses, and earning a postprofessional master’s degree. I reached a crossroads in my life where I had to make a decision: stay in academia, or go into private practice. To stay in academia, it was made clear to me that I needed to earn a PhD degree. My initial interest was in the neuroscience area: namely, doing single-unit recording in the basal ganglia of behaving monkeys before and after being made parkinsonian. I began the process of applying to a doctoral program in neuroscience, which at the time would have been a significant commitment of time and money. More than the time and money, I was looking “downstream” and realizing that the path was leading me further and further away from the practice of physical therapy. Now, I know that many out there would argue that neuroscience is certainly a part of physical therapy. However, I did not want to become a neuroscientist who happened to be a physical therapist.

I believe this path represented many of my generation who pursued doctoral research degrees in basic areas and who then turned to the Foundation for Physical Therapy for support. As I stated earlier, the Foundation funded a great number of fledgling researchers, and a substantial number of these researchers went on to become independent investigators with funding from NIH. Although we are quick to applaud these accomplishments, I can certainly see why people in the trenches of clinical care cannot appreciate the connection between basic or bench research and the problems faced by clinicians on an everyday basis. I, myself, have a hard time and must admit that some of the research that has been done by physical therapists is at such a basic level and so far removed from practice that it would take a giant leap of faith to make the connection.

At this point in time, it is very tempting to make some profound statement such as “Our research and practice communities need to build bridges” or “The need for better understanding between the researcher and the practitioner was never more crucial.” By the way, variations of these statements can be found all the way back to the second Mary McMillan Lecture as Catherine Worthingham strived to bring to our collective consciousness the criteria that needed to be met before we considered ourselves a profession.

Instead, my statement is: “Our profession needs to develop strategies designed to stop digging trenches between our practice and research communities.”

The fact of the matter is that there is plenty of blame to go around with regard to the disparity seen between what we know and what we do. In the words of Dustin Hoffman, though, “Blame is for God and small children” (from the Allied Artists Pictures movie Papillon). As researchers and practitioners, we can continue to point our fingers at each other in blame—and believe me, we have. When it is all said and done, we will still be left with the same problems.

Perhaps we need to look no further than at what is happening in the rest of health care and the very well-documented problems with the overall ill health of our health care industry despite the enormous amount of money being spent on research, especially by the NIH. In any regard, disparities and inequities continue to exist despite their long-standing recognition, outcomes vary, and treatments are not provided equally. Health care is an industry that has become a high-volume, low-margin business riddled with inefficiencies, outrageous costs, and outmoded technology. The result: in the United States, health care now accounts for a record 16% of the nation’s gross domestic product. Medical spending continues to skyrocket, with this figure expected to reach 20% in the next 5 years. We have a health care system that is
getting increasingly worse despite an enormous amount of money being spent at NIH. Presumably, this money is being spent at NIH searching for cutting-edge therapies and breakthroughs with regard to management of conditions that negatively affect Americans. But based on numerous performance measures, the benchmarks associated with our health care system do not “measure up.” It’s no secret that the United States lags behind European countries in [reduction of] infant mortality, the 5-year survival rate for cervical cancer or breast cancer, and so on. In very short order, we will be told by one party that we have the best health care system in the world, but the data simply do not support such a statement. In fact, the United States is currently 37th in the World Health Organization’s ranking of the world’s health systems. Can’t we do better?

Knowing how badly our health care system performs and how it does not appear that there is universal agreement that we are getting our “bang for the buck,” it would be very easy for us to sit back and be satisfied with the status quo. That is, we can continue to pat ourselves on the back about our NIH procurement prowess and dismiss our inability to translate our findings to practice by simply stating, “Well, no other health care profession seems to be able to do it, either.” Alternatively, we can set our sights much higher. Guess in which direction I propose we go?

The NIH has certainly recognized this disparity between what we know and what we do, and has responded with the Clinical and Translational Science Awards (CTSA) programs. The CTSA programs have defined 3 categories of translational research: (1) type 1—translational research often is described as moving bench or basic science discoveries into preclinical or animal tests, (2) type 2—translational research is best known as moving controlled observational study findings or phase-3 clinical trials into larger groups of patients and testing interventions in observational studies or survey research, and (3) type 3—translational research is recognized as the dissemination and implementation of research where known interventions and practices can be used in an attempt to make an impact through improved health policy. 6

Although the details of translational research are not critical to this discussion, the basic tenet—catalyzing the application of new knowledge and techniques to clinical practice at the front lines of patient care—should ring a bell with both our research and our practice communities. I would emphasize that initiatives in translational research can arise from any of the 3 types of research: type 1, type 2, or type 3. However, to realize the total impact of any research initiative, the potential of the research in all 3 types needs to be fully explored as this relates to the profession of physical therapy. If a researcher is interested in type 1 research, the question of potential impact on the field of physical therapy can be explored by fully discussing how this work can be translated to type 2 research and further discussion of the potential impact of this research on health policy. These discussions occur in the planning stages prior to the initiation of the research. I am sure that everyone out there recognizes that the area of type 3 research and health policy also includes a path to the magic word for practice: reimbursement.

To best take advantage of this initiative, I believe that our profession needs to expand our research funding initiatives to include a prioritization of research areas. We should base our prioritization, at least in part, on models consistent with NIH initiatives such as the CTSA program initiatives, especially when we consider: (1) our success at the NIH level and (2) despite budgetary cuts of late, NIH remains a deep pocket. Not only will this very pragmatic approach have the potential for a deep-pocketed funding partner, but I see another, more compelling reason to consider this approach: if we carry this out properly, we will eliminate the need to “bridge the gap” between practice and research, because practice and research will be working together in the formulation of the research priorities. In other words, there is no need to build a bridge if you do not dig the trench.

I would like to focus on type 3 translational research and policy issues in particular, especially those related to reimbursement for our services. There is not a single person in this audience who has not been directly affected by the decrease in reimbursement for our services. We have always acknowledged that we are low on the food chain when it comes to health care expenditures. We have all seen the pie charts that illustrate the disproportionate amount of expenditures that hospitals, nursing homes, and physicians receive (up to 66% of the health care dollar) while physical therapy is listed in “other professional” for a combined total of 8% of expenditures. To make matters worse, we have seen this very small proportion of the health care dollar shrink further over the past few years in what we all know as reimbursement rate declines.

Most practices have continued to come to grips with decreased collections. But as a profession, we are now beginning to recognize the profound rippling effect of decreased reimbursement rates. In the past 10 years, salaries for physical therapists have stagnated. When compared with the increasing price of physical therapist education, the disparity be-
tween the cost of education and entry-level salary has increased to a point where it has most definitely infringed on the applicant pool. When you couple this with the attractiveness of programs where students need to make a similar academic investment but receive much higher entry-level salaries, such as PharmD, along with those programs that require much less academic investment and afford greater salaries, such as physician assistant), it does not bode well for the health of our applicant pool.

A strong applicant pool has been the lifeblood of our educational institutions. For years we have taken for granted the popularity of our profession, which translated to healthy applicant pools throughout the 1990s. We have seen an applicant pool decline lately that I believe is related to the cost of education and stagnant salaries. I cannot believe that we will not see continued competition for high-quality applicants as we make education more and more expensive while entry-level salaries remain stagnant.

Considering the latter, what is the cause of stagnant entry-level salaries? Although our profession has never been dominated by independent practitioners, the delivery of physical therapy services was always profitable to someone. Even when profit was distributed to hospitals, rehabilitation companies, or private practice entrepreneurs, there still remained enough resources to adequately respond to increased salaries as the market dictated. Now, I am told by those I trust, dwindling reimbursement rates do not allow for such modifications.

There are not many solutions to problems if we cannot solve dwindling reimbursement rates and increasing tuition debt loads. Although I have listened to success stories in alternative practice environments, I am not sure that we are ready as a profession to convert our practice to cash-only businesses. I am not ready to give up on strategies to address the reimbursement rates, and I am certainly not ready to stop exploring more-efficient ways to educate our professional physical therapist students. It is in these areas that I would like to briefly address my remaining comments and focus on opportunities.

I would like to go back to the reimbursement food chain. Although I agree that our profession is commonly an afterthought when it comes to calculating reimbursement rates, I wonder if we should be reconsidering our strategies. In the past, we have been reactionary to reimbursement cuts that have been more or less arbitrarily imposed on our profession. Consider the $1,500 Medicare cap. Where did the “$1,500” arise? More recently in the United States, one of our largest private insurers decreed that a physical therapy visit is worth $40. If these numbers are not arbitrary, I am sure they are not based on the potential need for care in the Medicare case or the costs associated with providing a physical therapy service. In truth, these arbitrary decisions are not based on any data. They are simply put in place without any sound rationale.

Not only is our response reactionary, but we typically take our argument to the person at the other end of the food chain who is interested only in how much less he or she can offer for our services. Even if we made the argument of positive impact and cost-effectiveness with the benefit of data, I doubt our demand for greater reimbursement would be received favorably. We are taking our case to the level of the food chain that has a boundary. No matter how artificial, we are unlikely to see a substantive move past that boundary and in the direction of increased reimbursement.

I would propose 2 important steps to take in order to have a better chance at improving our ability to seek fairer payment for our services. First, we need to identify those areas where we have substantive proof that we can have a positive impact on the cost-effectiveness of care. By substantive proof, we should be prepared to document the cost savings of using physical therapists as providers of services in certain areas. The bigger the cost savings, coupled with effectiveness to the patient, the better case we can make for our services. Second, we need to take our argument to the right level of the food chain. Our credibility in this endeavor is greatly enhanced with the benefit of data.

To take on the first task, I would like you to imagine me throwing a basketful of $100 bills and a basketful of $1 bills on the floor. If I gave you 30 seconds to pick up as much money as you could, which basketful would you target? Now, I would like us to consider physical therapy’s impact on the health care system in certain areas of care. Impact is defined as cost-effectiveness. We should compare our cost with our overall effectiveness. Include in the cost not only the cost of physical therapy services, but also cost savings that using physical therapy services might entail. What are the areas of care that correspond to the $100 bills for physical therapy?

For example, consider managing low back pain. There was a recent publication in the Wall Street Journal that documented the cost savings of early utilization of physical therapy in the management of low back pain.8 Early physical therapy utilization was compared with a previously used method where the initial contact was with physicians. In the latter case, patients waited long periods of time for a physician appointment, unnecessary ancillary tests were or-
ordered (including expensive imaging), and prescription drugs were administered. The average cost of care with a physician-driven approach was more than $2,000. When compared with an approach where physical therapists were used initially, the cost savings per episode of care was around 50%, or $1,000. Physical therapists were ecstatic with such data and the fact that it was published in such a reputable news source as the Wall Street Journal. Certainly, rational people will see our positive impact and consider reimbursing us appropriately for the cost savings that can directly be attributable to our intervention. As physical therapists, we should be able to see that this scenario, based in Washington, is only scratching the surface of potential cost-effectiveness when you consider: (1) the literature that tells us that the physical therapists were probably delivering care consistent with evidence about 50% of the time, and (2) the study was conducted in a state that does not allow physical therapists to use thrust manipulation, an intervention that we know is effective in a large proportion of the patients studied.

Next, let’s consider to whom we take this argument. Shall we take the argument to the insurer? How are we to be certain that an insurer will not respond by simply taking the cost savings as part of their profit? After all, Aetna is a for-profit company with a responsibility to its shareholders. After APTA’s House of Delegates meeting this week, many of us have to agree with our colleagues from New York that we are skeptical of having a trusted partner in many of our third-party payers.

Now, consider another payer of health care costs, namely the employer. I would argue that the employer is the most important payer of health care services and the payer that is most interested in cost-effectiveness. This is the constituent that is really footing the bill for the exorbitant costs of managing low back pain, whether it be in their workers’ compensation business or with their commercially insured employees and families. I have no doubt that information about our cost-effectiveness to this particular consumer not only would be favorably received but would more likely to lead to demands for better reimbursement for our services. The takeaway message that is missed in the Wall Street Journal publication is the fact that the employers—Starbucks, Boeing—demanded that the insurer—Aetna—provide greater reimbursement to the provider of health care in the form of higher reimbursement for physical therapy services.

Improving reimbursement or payment for services will have a profound effect on our profession across the board, and I hope it trickles down to better salaries for our entry-level practitioners. Better salaries are only one half of the equation to enhance our applicant pool. We must discuss strategies to at least contain and hopefully decrease the cost of education. With our move to the postbaccalaureate professional level, the cost of physical therapist education has increased substantially. Coupled with tuition hikes that I would describe as unconscionable, the debt load for our students has become a deterrent to prospective applicants, especially when coupled with stagnant salaries. The situation begs for strategies to make the education of our next generation of physical therapists more affordable.

In terms of making education cheaper, my comments will be focused once more on pragmatics and low-hanging fruit with regard to professional physical therapist education. I believe it is past time for this profession to begin looking at the manner in which we go about the clinical education component of our professional education.

I have been on record on numerous occasions stating that the most vulnerable component of our educational system is the clinical education of our students. In short, it is an eyesore. The programmatic variability alone, where terminal internships range from 17 to 52 weeks, is indefensible in a profession that calls itself self-doctoring. The lack of control over what happens in the clinical environment and the economic vulnerability of a system that relies totally on volunteerism should be the subject of sleepless nights among all of my compatriots. Present Medicare reimbursement regulations have placed a barrier between our students and hands-on exposure to older individuals in outpatient settings, and I am told that it is highly likely that this will carry over to inpatient settings as well. Although we can discuss ways around these regulations, suffice it to say that none of the strategies will likely address both the desired level of exposure for our students and the lack of cost-effectiveness overall from the clinical environment’s perspective.

Some say that we should lobby the Centers for Medicare and Medicaid Services in an effort to change the regulations and allow students to bill under supervision of a licensed therapist. I must tell you that if I remove my physical therapist’s hat, I would first want to know why I should pay the going rate for physical therapy services provided by a person who has not met minimal standards as documented by licensure. I would hope that government officials would be asking for a data-based argument that supports this request. We know there are no such data.

I put my academic chair’s hat on to ask my compatriots, “How long will we continue to bury our heads in
the sand and ignore this white elephant in the room?” Clinical education has now been singled out in major initiatives, including the education agenda and APTA’s Strategic Thinking and Planning Initiative. As a profession, we are increasingly recognizing that we have a problem, which is good news, in that our lack of acknowledgment in the past was our major impediment to solving the issue. Even if you believe that your program does not have a problem, at least look at the profession as a whole, and acknowledge that the majority believe the problem exists and is severe enough to warrant action. If you need prodding, imagine for a moment the very real possibility that reimbursement regulations such as those imposed by Medicare will cascade to other payers and result in observation-only experiences for our students.

To move forward at an expedited pace, we must first acknowledge the problem and identify barriers. To complete our transition to a doctoring profession, I urge us to at least consider postprofessional, entry-level residencies as a clinical education model. I would propose that we graduate our students prior to the terminal internship, let them sit for licensure, and then place them in long-term entry-level residencies. It is a model that has worked for other professions, does not require licensure law changes, solves the growing problem of Medicare regulations, and reduces the cost of education by eliminating tuition during the year that students are in the residency.

Imagine: solve some real issues in clinical education while decreasing the cost of education as a whole! Although some may look at the establishment of residencies as a barrier, it is not an insurmountable barrier when considering the fact that such models are already in place for specialty residencies and that many clinical directors believe such arrangements can indeed be cost-effective. Finally, a bold move such as this will allow our profession to move toward a more standardized approach to clinical education and, if such residencies go through a credentialing process, a much more credible approach. The effort will be worth it.

Among the many gifts I have received, one of my favorites sits on my desk. It’s a rock with a quote that was given to me by the Editor in Chief Emeritus of Physical Therapy, the late Jules M Rothstein. He gave it to me shortly after I became Chair of Physical Therapy at the University of Pittsburgh. On this rock is a quote from Albert Einstein: “In difficult times lies opportunity.” I do not think for 1 minute that Jules was trying to scare me away from the job of chair. Nor was he warning me to watch for the difficult times that almost assuredly awaited me as chair. I prefer to believe that he was reminding me to look for the opportunities that sometimes lurk somewhere behind challenges and to appropriately and decisively react to these opportunities. To react appropriately to an opportunity, I had to thoughtfully and without bias consider the situation, preferably with the benefit of data as opposed to emotions. Once the situation was accurately assessed, decisiveness was never a problem.

So, where are our opportunities? Thomas Edison stated, “Opportunity is missed by most people because it is dressed in overalls and looks like work.”9 I would like to close by reminding ourselves that, collectively, we are the stewards of our profession. Our collective stewardship of this profession will be documented not by our words lauding our potential, but rather by our accomplishments. Our accomplishments in research need to continue to grow and become more translatable to the everyday practitioner by communicating with the practice community and articulating exactly how our work will eventually be relevant to the practice of physical therapy. Our accomplishments in practice will relate to our ability to implement relevant research findings to our everyday practice and inform the research community about potential areas of practice that are in dire need of investigatory activity. If we address anything in our collective careers regarding education, it must be to solve the clinical education problem as it exists now. I would love for a future McMillan lecturer not to be able to point toward the need for “bridges” between education, research, and practice. We must all remember that the need for a bridge is a sign of failure in our planning process. Education, research, and practice are not, by definition, separate entities that can exist on their own without regard for one another. A bridge is necessary only because of our own man-made trenches that we encourage by not adequately dialoguing with one another at the planning stages.

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