Keynote Address*
by
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I am very much pleased to address a group of twentieth century pioneers. Ours is a time dominated by the space beyond the globe and the space within the atom. The dull, prosaic middleground in which we live tends to be forgotten.

Yet for me the real drama lies precisely in that middleground. The real story of our time is the betterment of the condition of man. Every hour in your daily work you face countdowns in the lives of individual men and women and children. You reach a quiet, unspectacular moment of truth which makes the difference between a productive life and a twilight life.

Thanks to your dedicated efforts, and the tools and techniques with which modern science has armed you, your triumphs far outnumber your failures--among those you reach. There must be a profound sense of inner satisfaction for you in every individual victory, in every life restored. Yet you must also experience the depth of frustration when you consider the millions who remain untouched, millions who slip gradually into permanent, irreversible disability because you cannot serve them.

All of you are familiar with the statistics that demonstrate the magnitude of the need for your services. Some 70 million people--more than one-third of a nation--suffer from some form of chronic disease.

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Twelve million of them are impaired to some degree in carrying on their normal activities. Five million of them are limited in their mobility. At least a million are confined to their homes

Projected against this enormous backdrop of need, the resources at your disposal for rehabilitation may appear to cast a pathetically small shadow.

Yet I suggest that we are allowing ourselves to be overwhelmed by the dimensions of the need. I suggest that we are considering the problem broadly, but viewing our resources narrowly.

I know that the interest and coverage of your organization spans services in the medical, social, psychological and educational fields. I am concerned with the paradox that the medical aspect presents. Although it is one on the most basic of the elements of the rehabilitation spectrum, it is, nonetheless, one of the weakest of the links.

For the challenge of disability confronts every physician--not just those chosen few who have specialized in restorative medicine. It confronts members of all the health professions--not just those whose specialties are obviously and directly related to rehabilitation. It confronts voluntary organizations of many kinds and governments at every level. I am keenly aware that it confronts legislators.

Every keynote speaker should have a keynote, and this is mine: We shall meet the challenge of disability only when restorative medicine is joined to the mainstream of our national health effort.

And to this proposition I would add two corollaries:

First, that rehabilitation can no longer be considered a stepchild by the medical profession in general;

And second, that rehabilitation agencies can no longer afford the luxury of fragmentary, uncoordinated services.

Lately there has been a great deal of talk about comprehensive health services, about continuity of care, about coordination of community resources. These words have been passed back and forth across countlees conference tables, and incorporated in endless reports. Everybody agrees that they are highly desirable goals.

But lip-service isn't health service. Where is the action?

Let us consider for a moment the relationship between rehabilitation and continuity of care.

Disability is a medical problem first and foremost. The success of an attack on disability depends first on the alertness of each physician. The medical solution begins the moment a physician sees a patient whose condition may potentially lead to disability. The medical solution of disability continues as long as the patient needs medical services to sustain his highest potential of active life.

Moreover, delay in instituting restorative services often means waiting until he has become permanently disabled. Take, for example, the initial heart attack. Thanks to modern medical science, the patient is likely to survive. The attack becomes the first of a series of espisdoes. Will this man become another "heart cripple", needlessly retired from active life? Or will the physician act to prevent disability at the earliest possible moment?

Or consider the stroke patient. Untold numbers of them now survive in a tragic sort of half-life. Yet most of them-perhaps 80 percent--could recover function within a short length of time, provided the right services are furnished at the right itme.

In cases such as these, which number countless thousands every year, where are the boundary lines that separate preventive medicine from curative medicine, and curative medicine from restorative medicine? Where does rehabilitation begin?

The point is that we do not know how to prevent or cure many of the chronic diseases such as stroke or arthritis. but we do know how to prevent much of the disability due to these specific diseases. Often the disability is due more to the immobilization of the patient than to the disease itself. And frequently the remedy can be built into the treatment itself.

These facts and their implications are widely known. Yet we find too many rehabilitation services planned around the problems of patients with static conditions--the paralytic, the amputee, the blind. We find too many existing in isolation, serving only the specific categorical group to which they are dedicated.

And most tragically of all, we find medical schools woefully lacking in attention to the entire area of restorative medicine. Only about half of our medical schools have rehabilitation training programs. Most of these devote virtually no time at all to rehabilitation in their general curriculum--an average of something like 14 hours, as compared with 400 hours for obstetrics. Perhaps 10 medical schools in the nation have adequate departments of rehabilitation medicine. It has been estimated that a medical student's chances of studying under an inspiring professor of rehabilitation--the kind of professor that shapes a young man's career-are about 40 times less than his chances of meeting a similarly outstanding surgeon.

With these odds, what price would you quote on recruitment of specialized physicians to meet an overwhelming need?

Clearly, the basic answer here lies in the development of strong departments of medical rehabilitation in medical schools. These can serve as the fountainhead for the improvement and expansion of graduate and undergraduate physician training as well as those of the nurses, the physical and occupational therapists, the speech and hearing therapists, the medical social workers and homemakers, who are all part of the team that is needed to solve this problem.

According to a recent estimate, there are about 7,000 physicial therapists and about 6,000 occupational therapists available in the nation to serve our millions of disabled citizens. We would need 7 times as many in each category to give just ten hours of service to every person who might benefit from their skills.

Wherever we turn, the story is the same. We must augment our supply of manpower. And we must make the very best use of the manpower we have by creating competence in rehabilitation among those already practicing.

In the area of facilities and services, important gains have been made in recent years, in large measure through funds administered by the Office of Vocational Rehabilitation and the Hill-Burton program of the Public Health Service. I believe that the Community Health Services and Facilities Act of 1961 offers new opportunities for rehabilitation in several ways.

As you know, the program now developing under this legislation emphasizes out-of-hospital services, particularly for the chronically ill and aged. During the first six months of 1962, grants totalling more than $2 million were awarded for experimental projects in this area. Among the kinds of projects being assisted are those assisting the development of comprehensive home care programs which involve a coordinated community-wide approach to such key programs as home nursing, physical therapy and other rehabilitation services, nutrition, homemaker services, and others. In addition, there are valuable projects which focus on only one or a combination of these activities.

The Community Health Services and Facilities Act also made an important change of special interest to your group. Formerly, under the Hill-Burton program, Federal funds were available only to centers which

offered medical psychological, social and vocational services. Now any center may apply for construction funds if it offers medical plus one of the other services. All told, more than $48 million in Federal funds have been granted for the construction of 236 rehabilitation projects throughout the country.

Here again we find an impressive beginning. I believe that the Community Health Services and Facilities Act can be a real milestone in the delivery of health services. But the impetus must come from you who work on the firing-line. The situation is ready for more truly creative ideas, more promising new avenues for bringing care to those who need it.

With respect to the Community Health Services and Facilities Act, an additional point is important. Although the primary purpose of this legislation is to provide better care for our people, I believe it is important to remember that better care--improved and more efficient care and facilities--also means more efficient care and more efficient methods of providing care. And efficiency also frequently results in economy. Even though we are just in the infancy of real progress under this program it has already been evident that in many individual cases improved care can be obtained at a lower cost. For example, one of the primary objectives of the program is to find methods to enable us to move hospital patients--as soon as they are medically ready--out of the expensive hospital bed into nursing homes or organized home care programs where costs are less, if we can assure that proper care is available. One study has already shown that in a situation where the same care was available for patients moving from intensive hospital care into nursing homes facilities in the majority of cases the cost was cut by two thirds. Ths same holds true with chronically ill

people who can be given medical rehabilitation treatment to the point that they are no longer dependent on others for care. In one study in this area it was shown that a third of the patients could be rehabilitated to the point of becoming self-sustaining.

But however hard we try, I suspect that our supply of manpower and facilities will never catch up with the demand in so vast a field as rehabilitation. But I am convinced that we can stride forward by using what we have to the utmost.

During this past year my own State of Rhode Island has made a heartening advance in coordinating the attack on disability. A year ago this week, a conference was held in Providence which brought together Federal, State and local health officials, representatives of the health professions, and others interested in disability problems in the Northeastern part of the U.S. The conference itself brought a valuable exchange of ideas. But more significantly, it led directly to action.

Following the meeting, 87 different agencies in the Providence area, all involved directly or indirectly in rehabilitation, got together to map out a program that would combine their knowledge and skills. The number of agencies is significant in itself. Of special interest to me is the fact that this newly established Rehabilitation Council has as its Chariman a prominent physician who had been head of a hospital and very active in civic affairs, and that among its most active supporters and participants are representatives of the Academy of General Practice and other professional medical groups.

This is one instance, with which I happen to be personnally familiar, of the integration of rehabilitation with the mainstream of community health services. I am sure there are many others. And I am

sure that wherever this is happening, rehabilitation facilities are making fuller use of their capabilities and rehabilitation personnel are helping more of the people who are in desperate need of their services. Certainly such coordination should eliminate the tragic fact that some facilities are operating below capacity despite the general need.

Actually, rehabilitation stands at the point where the three broad currents of health, education, and welfare come together. It shares elements of all three, and should draw strength from all.

The new emphasis on retraining in welfare offers new challenges for rehabilitation skills. The steadily growing numbers of persons who are successfully competing on the job market despite impairments represent an inspiring achievement of vocational rehabilitation.

The central facts of the future are self-evident. So are the questions.

As medical knowledge advances, more lives will be prolonged. For what? Rehabilitation must provide the answer.

More and more older people, and also more children, will need restorative medicine--not for employment, as such, but for a satisfying life. How well will they be served?

Increasingly we shall be able to prevent disability even where we cannot cure the disease. Will our health services be sufficiently alert and imaginative to do the job?

More and more emphasis will be placed upon those two dark shadows on our national scene--mental illness and mental retardation. What can our rehabilitation resources do to meet this challlnge?

More tools and techniques, most of them expensive and complex, will be available to us as research advances in such swiftly growing fields as biomedical engineering. Can we make sure that they are effectively applied.

Finally, it is evident that rehabilitation will become still more expensive as our knowledge grows. I know that facilities like yours are costly to operate now, and will grow more so as you have still more to offer. Often community planning for facilities construction is much better than for ongoing support. This problem of the methods of financing rehabilitation services needs more attention.

This last question is very close to my heart. I have heard it said in all seriousness that restorative medicine may be too expensive for the community to afford. In other words, that we can do more for people than the budget will bear.

Are we ready to say that the richest nation on earth is too poor to pay for the health of its people? Are we ready to say that we can afford billions for medical discoveries which then are permitted to gather dust?

Of course not. Our nation is bult on its concern for the individual man, woman and child. Every life lost that could have been saved, and every half-life endured that could have been restored, is a reproach to us. We can and we shall pay the price for rehabilitation.

But we can't apply the results of first-class research with second-class services. The sweep and daring of scientific thinking in recent years has commanded our respect and our support. We look to you for the imagination, for the creative dreams that will bridge the gap from knowledge to action.

You who are the pioneers and the front-line soldiers in the rehabilitation campaign should be doing more than reacting to legialation. You should be proposing it. You should be doing more than "the best you can" within the existing framework; you should be building a bigger framework.

The horizons of rehabilitation are unlimited. But it takes a broad, clear vision to scan them. I know that when there is a genuine breakthourgh in planning for the deliver of health services, society will rise up to support it.