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The spinal cord injury primary physician. One riot—one ranger

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Paraplegia, the International Journal of the Spinal Cord, formerly the *Journal of the International Medical Society of Paraplegia* will enter its thirthieth year of publication in 1992. The inaugural issue provided the occasion for one of my favorite anecdotes.

It was in the spring of 1962 that I made my first hegira to the hallowed halls and tar-paper wards of Stoke Mandeville Regional Spinal Cord Injury Centre to meet with Sir Ludwig Guttmann. It began a long and cherished association with that dynamic mentor. It could have been a disaster.

Sir Ludwig gave graciously and generously of his time and knowledge to those who came to learn his spinal cord injury treatment philosophy and methods. He was constantly searching for proselytes. I eagerly accepted the role.

We were seated in his office following ward rounds and talked of spinal man and his optimal care. Mostly I listened.

During the conversation, I noticed a strange journal on his desk. It was green. With difficulty, I read the upside down words, 'Journal of Paraplegia'. I was a bit perplexed. I thought I was reasonably familiar with the spinal cord literature; yet here was a journal that I had never seen before devoted to the subject. For an instant I was tempted to cover my ignorance by saying, 'I see you have *Paraplegia*. It is my favorite publication.'

Sir Ludwig, noticing my interest in the journal said enthusiastically, 'Look at my new journal'. (He tended to use the first person possessive.) 'This just came off the presses—Volume 1, Number I.'

If I had made my untruthful remark, Sir Ludwig would have categorized me as a complete phoney. I would have been shunned for life.

The journal has flourished over the past 30 years under the editorial guidance of Sir Ludwig Guttmann and Mr Phillip Harris. This year, it will become a monthly scientific medical journal devoted to all aspects and ramifications of spinal cord injury. I am honored to be a small contributor to the 1992 special number.

With apologies, since I have nothing new to present, I have resurrected a favorite editorial that I wrote in the *Digest*, published by the Spinal Cord Injury Data Research Center.[1] In my opinion, it is a sound concept that is still timely.

One riot—one ranger

A formidable bronze statue once dominated the central lobby of the old Love Field Air Terminal in Dallas. For all I know, it may still be there. It commemorated the legendary Texas Rangers. One story has it that the mayor of a small west Texas town wired the governor in panic. 'The town is rioting. Send the rangers!' The next day, a lone ranger rode into town and was met in the littered main street by the distraught mayor. 'There's a riot going on here. Where are the rangers?' 'How many riots ya got?' questioned the ranger. 'Only one—the whole town is rioting,' screamed the frantic mayor. The laconic reply became legend, 'One riot—one ranger.'

The spinal cord injured person, overwhelmed by a bewildering array of medical, surgical and allied health specialists needs a 'ranger'. He needs a doc! Someone to look after his medical problems and orchestrate the activities of all those involved in his daily care. Someone who can explain the whole bewildering process. What happened to me? What's going on? Where do I go from here? He needs a physician who is a specialist in spinal cord injury; someone who can relate on a peer level with the surgical and medical specialists that may be necessary to manage the multiple system problems endemic to

spinal cord injury; someone to communicate with and direct the team of nurses, therapists, social workers, psychologists, orthotists and others who are active throughout sequential phases of his initial treatment and subsequent medical management.

The need for a categorical approach to spinal cord injury care was described by Dr J Paul Thomas in his recent lecture to the American Spinal Injury Association honoring Dr G Heiner Sell:

'Medicine has been traditionally organized around organs and body systems. There are cardiologists, urologists, endrocrinologists, etc. This situation has been complicated by the large body of knowledge and new technical skills resulting from the explosion of scientific discovery over the past 50 years.

There are some clinical entities, however, that are so complex as to not lend themselves to single specialty medical management. These entities, usually affecting multiple body systems, require the coordinated skills and knowledge of many different specialists working as a team to provide an effective and coordinated continuum of care—spinal cord injury is such an entity. While great medical gains have been made, unfortunately the typical management has consisted of an intense initial interest in the orthopedic injury and the resultant neurological damage.

The "acute phase" was then belatedly followed by "rehabilitation". The drama of the trauma eclipsed the urgent need to begin preparing the injured individual for lifelong existence as a paralyzed person. Bones heal and neurological recovery may or may not occur, but in the interim, disastrous complications arise which jeopardize the patient's ability to function within his residual neurological limitations. In the typical fragmented approach these complications are treated in succession by a cadre of specialists. The patient goes from one specialist to another usually for resolution of a never ending set of complications.'

A partial solution to the problem has been the categorical approach to the spinal cord injured person and his multiple needs. Such an approach requires a leader, a physician who specializes in spinal cord injury. He should have the medical skills necessary to treat the routine but frequently unique medical problems associated with spinal cord injury and the judgment as to when to call for assistance from consulting medical and surgical specialists. He must have the 'people skills' to orchestrate and conduct the activities of the other members of the treatment team, respecting their professional skills, but at the same time demanding excellence and precision in the execution of their contributions to the overall effort. An orchestra with a conductor makes music—without one it makes noise.

The question arises, what should be the medical or surgical specialty of this physician who functions in the dual role of primary physician and team leader? Historically, outstanding SCI clinicians have developed out of several specialties such as neurosurgery, orthopedics, urology, rehabilitation and general practice. Logically, the spinal cord injury specialist should be trained and qualified in one of the specialties which play a major role in the medical management of the spinal cord injured. Beyond that, he should have specialized training in SCI care in a center which has a volume of such patients sufficient to develop expertise. Spinal man is different. After managing 100 cases the SCI specialist begins to feel comfortable with the many unique ramifications of their care.

Regardless of his specialty background, once the physician accepts the role as primary SCI physician, he must become a generalist in their care, subjugating his initial specialty interests to the broad concepts of comprehensive treatment.

It is unlikely that an individual physician can become qualified and motivated to serve as the primary physician in both the early trauma phase of treatment and throughout the lifelong period of subsequent medical management. Renaissance men are hard to come by these days.

For practical reasons, initial primary care is best the responsibility of the neurological and/or orthopedic surgeon supported by an organized team of physicians such as pulmonary specialists, neuroanesthesiologists, neuroradiologists and the SCI specialist. The setting for this initial care should be a tertiary center located in a major medical complex. After the brief, critical trauma phase, primary care responsibility should be given to the SCI specialist and the patient transferred to the specialized environment

of the spinal cord injury center. Such a system will provide an uninterrupted continuity of care. The essential element for putting it all together is the SCI specialist physician.

Yes, the SCI patient needs a doc, and a very special one indeed. One riot—one ranger!

References

1 Young JS (1982) *Model systems. SCI Digest* **4**(2): 2.