

General Discussion to the papers of Dr Cheshire et al; Misses Dingemans and Hawn, and Miss Burnham and Mr Werner

MR P. HARRIS (*G.B.*). I should just like to bring out one point Mr Chairman, it is that I personally feel that this is a very important point. I think that the authors of these papers this afternoon will also probably agree that patients can and will learn a lot from each other, and I wonder if the speakers who have spoken in the last session could tell me if they think this should be done in a positive way to get other patients to help your patients, the patients with particular problems.

DR CHESHIRE (*Chairman*). Well, let's go in the order. How about us having a combined opinion from Craig, and Phoenix will jump in after Craig. I don't imply any order of priority.

DR WERNER (*U.S.A.*). We certainly do agree with you. As a matter of fact one of the priorities at Craig is that we have the physical layouts so that all of the patients can be in contact with one another; a great deal of the adjustment process takes place when the patients are able to get together and to discuss their mutual problems and discover that other people are experiencing some of the same kinds of things. This is a very positive environment that we find contributes positively to the patient's rehabilitation.

DR CHESHIRE. I think there is little more that I can do than to echo Dr Werner. I think that he is totally right. The only thing I would do is perhaps pick up a couple of points that he was prevented from making by the necessity for brevity, and that is that in addition to informal contact, I think there is great value in group counselling sessions, not just about human sexuality but coping with life. In Phoenix we are running two group sessions: one is human sexuality and the other is coping with life in a wheelchair. The next thing is that, in addition to the in-house patients, we have a cadre of graduates upon whom we can call for assistance for anybody who is obviously in need, and I think you are totally and completely right in your statement which must be elevated above hypothesis.

DR MENTER (*U.S.A.*). One point I would like to elaborate briefly on, in response to our people, is that at any given time we have probably a minimum of six to eight respirator-dependent patients in various stages of weaning from a respirator. There is nothing that is more potent as a stimulus to a person who is initially on a respirator, than to see a mobile patient in a chair free and able to go out to social functions with the recreational programme or back in for re-evaluation. So the concept of a respiratory centre, that is one that treats more than just paraplegics and tetraplegics, where there are respiratory cases, has its own group effect. The other thing is that in our Centre we have separate groups where paraplegics have their own counselling sessions within their problem level; we have tetraplegics within their own problem level, and in a certain sense the tetraplegics that are respirator-dependent form their own little niche and the families will go and talk to another family that is in a phase of discharge. They will get a lot of confidence and a lot of reassurance that these people do survive, that they are not fragile, that you can go through the night and get some rest even though they are on a respirator, that there are alarm systems and other things that allow security and that it is not as dreadful an experience as they may initially think.