THE HOLISTIC APPROACH TO SPINAL CORD INJURY

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UNTIL a few years ago, it was usual to preface discussion of the treatment of spinal cord injury with a reference to how new was this field of medicine. It was in fact remarkable to reflect that a condition of which first the written description appeared in the *Smith Surgical Papyrus*, probably written during the first half of the third millennium B.C., and therein labelled '... an ailment not to be treated', was still so considered until about 50 years ago. Quoted by Dick in 1969, a medical research council report in 1924 said, 'The paraplegic patient may live for a few years in a state of more or less ill-health'. It was nothing less than a revolution in the approach to these patients that arose from the efforts of a few men, among whom the leaders were Sir Ludwig Guttman and the late Donald Munro. There is no need to attempt to apportion credit between them. Good friends that they were, they share enough to honour both.

Happily, Sir Ludwig is still at work among the goodly company who now carry on the efforts of the pioneers. Great progress has been made and grave problems resolved to a degree few would have thought possible only 40 years ago. As is usually the case, however, new problems have risen, the chief of which is how to make the benefits of vastly increased knowledge and skill available to every person in every land, who sustains a spinal cord injury. An increasing number of competent people now make the care of these patients their primary or, at least, a major interest. An expanding literature reflects a considerable body of knowledge, and active research, both basic and clinical, is underway in many parts of the world.

But as one who has been observing these developments for many years and participating in them to the best of his ability, who has had the privilege of friendship and cooperation with both Munro and Guttman, I find it a matter of concern that this important branch of medicine has not yet been integrated into its main structure. Even in countries where the treatment of spinal cord injury patients is well organised, it retains an esoteric character and, at best, among the mass of practitioners it is considered sufficient to know enough to send a patient as expeditiously as possible to the nearest centre. This is not enough. For one thing, it will not adequately serve the patient's needs after his discharge from the centre. No matter how elaborate a follow-up system is maintained, it cannot operate to full advantage without the informed cooperation of the medical community. Whether before, during or after the patient's treatment there, a highly specialised facility does not and cannot exist in a vacuum. It cannot function as an élitist enclave isolated from the general professional population, but must be in constant contact and communication with the medical community at large, from which it draws its basic knowledge and strength and to which, in turn, it owes a special enlightenment.

Within the structure of the centre itself, it is essential to guard against centrifugal forces in a group necessarily made up of individual experts in a number of disciplines. There are probably institutions where this tendency is not evident, but in many more it is an ever-present danger, enhanced by the very expansion of knowledge. The more thoroughly one becomes master of and skilled in a particular

aspect of the problem, the more inclined he is to consider it the most important, and the more difficult to have to reconcile his efforts with those of others who feel the same way. To offset this demands strong leadership and skilful organisation. The concept of unified treatment, of the need for orchestrated effort must be the guiding principle of those who work within spinal cord injury centres and their constant example to those outside.

It may seem a far cry from literary criticism of the nineteenth century to the practice of medicine today, but the following excerpt from one of Schlegel's many discerning comments on Shakespeare may be appropriate here. He wrote: 'The separate parts of a work of art . . . must not be taken in by the eye and ear alone; but also comprehended by the understanding. Collectively, however, they are all subservient to one common aim, namely to produce a joint impression on the mind.'

At the time I encountered this I was reading simply for diversion but the subject of this paper was not too far in the back of my mind and kept me alert for a chance to find something better said than I could say it myself. This brief passage emphasised three ideas which qualified it to serve in this context.

First, although it dealt specifically with art, its emphasis on the significance of considering the work as a whole coincided so precisely with my thinking of the treatment of an ailing human as to remind me of the unity of impulse that seems to subserve all human activities—in art or in science or in the peculiar combination of the two that the practice of healing requires. Critics of the period when Schlegel wrote—and for centuries before although far less since—were much exercised over what they called the unities, particularly in dramatic literature. Schlegel recognised that true unity was a matter of the spirit rather than of physical details, that Hamlet's dilemma, for instance, was a valid unit of human experience, whatever diffusion over time and space its dramatic exposition required. So too, the care of a patient must be considered as a unit of experience, however long the period over which it extends, however complex and varied its several aspects may be, whatever diversity of skills it may require. Because my only credential is my concern with the care of patients with spinal cord injury, I shall use them as an example of the need for what may be called the holistic approach to treatment. The multiplicity of their problems makes the paradigm apt. But, in the larger sense of our responsibility as physicians, any patient, whatever his ailment, might serve.

Let us turn to the second of the three ideas, that although there may be many parts, they are all 'subservient to one common aim . . . to produce a joint impression'. So with the patient whose care we are discussing, we may not for one moment, however specialised and discrete each undertaking may seem, think of removing a calculus or repairing a pressure ulcer or alleviating spasm as a solitary objective in itself, but as part of the whole effort. Moreover, this interrelationship cannot be simply a matter of casual belief; it must be conscious and deliberate and, as a concept, capable of surviving the rivalries of professional disciplines or administrative classifications.

The third and perhaps most important idea embedded in the passage is Schlegel's demand that the work must be 'comprehended by the understanding'. These few words, snatched though they may have been from their context, seem to me to concentrate the essence of the many thousands that have been written about the patient-physician relationship. Again, let us consider the predicament of the spinal cord injury patient. Facing a lifetime disability of catastrophic proportions, he must also face a host of other threats—many of them of similar magnitude—to his comfort, his health and his life. All this must be 'comprehended by the

understanding' of those who attend him. We may think here of 'comprehending' in one of its dictionary meanings of 'including'. Someone must take it all in on the patient's behalf. Someone—and preferably more than one of those whose particular skills may be drafted—must see it all and see it whole. For that is the way it bears upon the patient. He is not just a bladder problem or a skin problem or a vocational problem. He is all of these and more. Having turned once to the dictionary for aid, let me do so again, for this is a useful way to discipline our thoughts—by making us mind our words. My reference to a holistic approach precisely follows the concise Oxford Dictionary's definition of 'holism' as 'the tendency in nature to form wholes that are more than the sum of the parts by creative evolution'.

Emerson, who deserves more reading than he gets today, refers to '... one of those fables, which, out of an unknown antiquity, convey an unlooked-for wisdom, that the gods, in the beginning, divided Man into men, that he might be more helpful to himself; ... The old fable covers a doctrine ... that there is One Man ... and that you must take the whole society to find the whole man ... But unfortunately, this original unit, this fountain of power, has been so distributed to multitudes, has been so minutely subdivided and peddled out, that it is spilled into drops and cannot be gathered. The state of society is one in which the members have suffered amputation from the trunk and strut about, so many walking monsters—a good finger, a neck, a stomach, an elbow, but never a man.'

This is the pitfall into which we as doctors are in great danger of slipping or, as many would have it, have already slipped. The unbelievable proliferation of medical knowledge and skills has made specialisation necessary if it is to be implemented for the benefit of the patient. But it has brought with it a corollary obligation to remember always—consciously and deliberately—that we are not treating a finger, a neck, a stomach or an elbow, but always a man. And turning once more to Emerson, may his shade forgive my adaptation of his noble concept of the scholar that 'in the right state he is Man thinking'; so we must consider, for instance, the function of micturition as man voiding.

Keeping in mind the danger, long recognised, that the cost of specialisation in modern medicine may be losing sight of the patient as a whole, let me suggest that the spinal cord injury patient dramatises this danger with a paradox—he needs a great deal of highly specialised care, but his general care remains of primary importance. The whole is, in fact, greater than the sum of its parts. To bring all the parts together effectively may require a new specialty in which a number of disciplines are combined to be used in a common cause. Whether this will invariably be necessary, I am not yet certain, but we must surely develop a new and specialised orientation.

In spite of the advances that have been made so far, there is no occasion for complacency. In many parts of the world the treatment of spinal cord injury is still unsatisfactory and in some it is appalling. Even where it is generally good, there remain too many examples of ignorance and ineptitude. Sadly, these may occur in communities in which the general level of medical practice is high, mostly because there is still not an adequate awareness of what these patients need and how their needs can be met.

A two-fold obligation rests upon those who have made this work their own and are concerned that it may continue to go forward. First, we must be sure that our own houses are in order, that fragmentation of care, whether resulting from administrative inadequacies or staff imbalance, may never occur. Second, the medical profession must be brought up to date. It seems to me that in many instances, the lay community is better informed than the medical in respect to the

potential for the rehabilitation of these patients. Only a few physicians may choose to devote themselves to this work, but every doctor should know what can and must be done for these patients. To use a Churchillian expression, we have come to the end of the beginning. It is time to start to consolidate our gains and bring the message to our colleagues.