A more perfect union: Reports from an interdisciplinary primary care clinic for patients with spinal cord injury

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The literature suggests that patients with spinal cord injury may have limited physical access to health care, receive fewer preventive services than able-bodied patients, and rely on physiatrists to provide primary care services. In this essay, the authors – an internist and a physiatrist – reflect on a year-long experience of cooperatively caring for patients with spinal cord injury in an interdisciplinary setting.

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Until last year, my interest in spinal cord injury (SCI) was longstanding though pedestrian. As my life partner is a physiatrist specializing in SCI, I would absorb drips of his work through dinnertime conversations, yet had never seriously considered helping care for his patients.

I had inklings over the years that an internist could be of use to people with SCI, particularly when our SCI friends would struggle to get good medical care. Several physicians told my partner and me that their primary care offices were inaccessible – a tale borne out in the literature^{1,2} – and that their medical teams did not adequately understand their disabilities. Many felt they were not receiving appropriate routine and preventive care – another well-described problem³ – so we would occasionally make lists of recommendations for their physicians.

This past year – supported by our chairs of internal medicine and neurosurgery – my partner and I started a primary care clinic for people with SCI. The sessions are held in our outpatient rehabilitation medicine space – which is fully accessible and whose staff is accustomed to caring for SCI patients – and although I am the attending physician of record, my partner books

patients at the same time so we can co-manage more complicated issues.

In formally working together, we have both improved our clinical skills. I have been able to provide my partner with “curb side” medical consultations, saving our patients return trips to the clinic, and he has begun the tedious work of teaching me SCI medicine, offering counsel as I struggle with dysreflexia, neurogenic bladder, and recalcitrant spasticity.

Our collaboration has also spawned clinical questions, which are as maddening as they are promising. We wish we knew how best to screen our SCI patients for diabetes or whether we ought to treat them as “coronary artery disease equivalents”, but we hope our inability to answer to even these basic concerns will propel a new wave of research, and that our patient care will soon be rooted in data rather than suspicion.

Finally, our patients seem pleased, as many claim never to have received thorough and coordinated medical care. A young woman we recently examined reported that no physician had transferred her from her chair, offered her a gown, or performed a skin check on her since her accident 12 years ago. Another patient told us that no one had drawn “routine” labs on him – including kidney function and a lipid profile – since he had been injured, and that his prior physicians had never informed him of his test results.

One year into our collaboration, we feel it makes sense for rehabilitation facilities to offer on-site

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primary care to patients with chronic disabilities. Many medical offices in this country remain inaccessible, and while we hope that will change, we at least know that our patients can be weighed, be safely transferred to appropriate examination tables, use our restrooms, and work with a competent staff.

We are also convinced that internists must more deeply involve themselves in the care of people with SCI. Most SCI patients turn to physiatrists for primary care,⁴ yet physiatrists feel unqualified to provide these services.⁵ As people with SCI live longer and shoulder greater burdens of chronic disease,⁶ internists' input will help them to maintain independence and quality of life.

Last, internists and physiatrists must cooperate in research. While the physiatric literature describes cardio-metabolic complications of SCI such as glucose intolerance, coronary artery disease, and obstructive sleep apnea, it simply lacks depth, and primary and secondary prevention are rarely discussed. We believe that an investigative marriage of physiatrists and internists – melding our unique strengths in the pathophysiology of SCI and in the diagnosis and management of chronic disease – will improve both outcomes research and patient care.

My partner and I are encouraged by our year-long collaboration. Our co-management model seems to yield accessible, high-quality, comprehensive care that may be easily reproduced at other sites, and the gaps in our knowledge may stimulate clinical investigations that may significantly improve the care of our SCI patients. We hope that other interdisciplinary teams will join us in our work.

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