# 

INside the OUTcomes: A Rehabilitation Research Podcast

Episode 18: Spinal Cord Injury and Inpatient Rehabilitation   
Released August 13, 2024

SHARON PARMET, HOST:

Welcome to INside the OUTcomes: A Rehabilitation Research Podcast from the Center for Rehabilitation Outcomes Research at Shirley Ryan AbilityLab.

I'm your host, Sharon Parmet, and today, I'm speaking with Mike Whelan about his experience with spinal cord injury, in particular, about his experience with inpatient rehabilitation. This episode is part of a grant to the Center for Rehabilitation Outcomes Research here at Shirley Ryan AbilityLab, funded by the National Institute on Disability, Independent Living and Rehabilitation Research, to investigate how differences in inpatient rehabilitation after spinal cord injury affect outcomes for people from different countries. The grant includes researchers and participants from the United States, the UK, Australia, the Netherlands and Canada.

Mike is a member of the Advisory Council associated with this grant. He's 66 years old, and lives in Naperville, which is about 20, 30 miles outside Chicago, and he's a retired energy researcher who worked in R and D in the oil and gas sector. Before I welcome Mike to the podcast, you'll see how this makes sense later, Mike wants to give a special shout out to Sigma Chi at MIT his fraternity brothers. And with that, welcome to the podcast. Mike.

MIKE WHELAN:  
Sharon, thank you. Glad to be here.

SHARON:  
Mike, can you tell us a little bit more about you, where you live, what you're up to, what's going on right now?

MIKE:

Well, I live actually, in Naperville, which is a western suburb of Chicago, a little over 30 miles as the crow flies. And what I'm up to is we're empty nesters. My wife and I, we have four kids who are off doing their own things, and, as we say, doing what they're supposed to be doing. So all that's good, family wise and in retirement. One of the things I have been doing is actually been active at Shirley Ryan in some clinical trials, along with being on a couple of advisory councils for a couple of different grants that Shirley Ryan has been involved with. And it's interesting the clinical trials, one of them ended about a month ago, but it was a three day a week session for about two, two and a half months. And just the commute, I think, showed my age, 66, I don't know how people do that every day driving.

That's dedication. So I'm showing my age with all that, and it's interesting. I admire the people who can, can, you know, make it to the starting gate every day.

SHARON:  
Wow, yeah, it's, it's hard to imagine, back before Covid, when everybody commuted every day, exactly. Yeah, can you tell us a little bit about how you sustained your spinal cord injury?

MIKE:   
Sure, it was ages ago, back in 1977. Thanksgiving vacation home from college, 2 sets of friends went out one night, actually, night before Thanksgiving, and one didn't make it home. Car accident. So I was the worst off of the four in the car, but that was almost 47 years ago, and you know, fortunately, lived to tell the tale. My injury is at C7, and fortunately for me, it wasn't a complete severing of the cord, but a compression injury, so they were able to decompress in a surgery, and then I laid in bed in the acute care hospital for about a month, little over a month, and then it was transferred to a rehab hospital.

SHARON:  
Let's focus on what happened in that initial inpatient rehabilitation. Can you tell us a little bit about how long you were there and what did the rehab include?

MIKE:  
At the rehab facility? Because the acute care had very little rehab that I recall, other than maybe people flexed my joints or did some basic stretching. Initial inpatient was again a little over a month the rehab facility was about, say, about 65 days. It was right after Christmas to early March. So that seems to be about the timeframe, and that was, you know, a highly focused rehab center, all kinds of people, all kinds of different maladies, and they had a, you know, great deal of spinal cord injury experience.

SHARON:  
Can you talk a little bit about what kind of rehab you engaged in while you were there?

MIKE:  
Well, pretty, pretty intense. Build you up to the most function you could accomplish with your level of injury. Unfortunately, I had a, as I mentioned, a compression injury on the cord. So I had a good amount of function in my arms and hands, which I was pretty lucky at the C7 level. The legs were useless, but I had a great deal of spasticity to deal with. So it was all about assessing what your capabilities are, and then sort of mapping out the plan for what you can accomplish with that, in terms of getting back to a regular life, and, you know, having, you know, become a productive member of society, basically.

SHARON:  
So it sounds like you were very much included in maybe setting the goals for yourself. Is that, is that a correct statement?

MIKE:  
Maybe at a very, very high level, but I certainly didn't know that, like, okay, we're going to get on this mat. We're going to help you get on this mat, because you don't know how to transfer yet. So, you know, once we show you how to transfer, you get on this mat. And today we're going to work on rolling over. So you have to be taught how to roll over, and you know all the little tricks and techniques for how to do that given a level of injury and given an amount of an extent of spasticity. So you learn how to roll over. You learn how to position yourself in bed. You learn how to course transfer. And transfers are really important, and I have a great deal of hand and wrist arthritis right now that has really slowed me down, and I attribute some of that to not properly transferring or using incorrect hand positioning for transferring for a long time, till that finally caught up with me. And you know, I relate that to all my clinicians now, and they say, yeah, you shouldn't have done it that way. You should never have transferred with your flat palms down from one surface to another. You should always use closed fists. And I say, Well, I didn't buy the extended warranty on my hands and wrists, so now I'm paying the price. And I sure wish somebody told me that, you know, almost 47 years ago, that this is how you should transfer.

SHARON:  
So back then, that wasn't the best practice, the gold standard of transferring?

MIKE:  
Yeah, that never came up. And that was okay, hard lesson learned. You know, when I was in my probably early 50s, late 40s, early 50s, like, Hmm, maybe I shouldn't do it this way anymore. So, yeah, that's one. If anybody gets anything out of this podcast who is just starting out learning how to transfer, please take that to heart. Transfer with closed fists, if at all possible.

SHARON:  
How many hours a day of rehab did you have? Do you remember?

MIKE:  
I think there was an am session, and a pm session, and it was an hour and a half to two hours in each. And I remember that I was really tired, and they would have to wake me up from a nap after lunch in the afternoon to get me out. And I've never been a big napper. I'm still not a big napper. People tell me, you should take a nap. It's great. Well, I don't really wake up after naps very well. Never have. And I do remember they had trouble waking me up for my naps back then and rehab, but it was two, twice a day for, you know, an extended period, and that seems to be the standard now too.

A couple years ago, I tore up a triceps tendon on my left arm, and had to have surgery and left that arm out of commission for quite a while, and I was back in Shirley Ryan for rehab for that, and that was their protocol as well, at least an hour and a half a day, excuse me, at least an hour and a half twice a day with PT and OT. So it seems like that sort of level of intensity has carried forward over the decades.

SHARON:  
And then when you were in inpatient rehab, did you have any psychological therapy or talk with a social worker, anything like that?

MIKE:  
I'm sure a social worker came in, and I'm sure we had some kind of discussion, but I don't really recall that as a seminal point or a fork in the road or anything like that. I mean, I was, I was young, and I kind of, the way I kind of framed it was okay, you just really screwed up. Now you gotta figure out how to get on with your life and put the pieces back together. And, you know, just figure it out now, from a different angle, from a different height. You're going to be, you know, foot and a half, two feet shorter than everybody. It's going to be harder to get around. But you are who you are, so just be very practical about it.

SHARON:  
And do you feel that the inpatient rehab experience prepared you to go home and do kind of the basics of what you needed to do to get on with things?

MIKE:  
Very much so because, again, and, you know, I didn't know how to roll over, I didn't know how to transfer. I certainly didn't know how to move a wheelchair around. But, you know, the wheelchair, in some respects, is like when people get into a bumper car at the carnival and, you know, they start spinning that wheel around, and the car kind of response, and it kind of doesn't and, you know, you only have semi control over it. And, you know, wheelchairs kind of like that. The first time you're in it, when you're totally dependent on it, you kind of got to figure it out. But once you do, and it's necessary that you do, you know, obviously you can do a great many things within it becomes really essential to how independent you can be and how productive you can be.

SHARON:  
Is there anything you wanted more of or less of in that initial inpatient rehabilitation?

MIKE:  
Probably, and I don't, I didn't come out of it thinking that there was any meaningful deficiency. One thing might have helped me is if they had perhaps more of an emphasis on, I'm just going to call it bodybuilding, but weightlifting or maintaining strength. You know, I was young, so I didn't have any muscle weakness. I was thinner, thinner than I am now. So, you know, a young kid in good shape, it should be easy to stay in shape, but they didn't emphasize that like I hope they would now. You know, over time, you get, you know, it's not unique to SCI but everybody kind of falls out of shape, and it becomes harder to maintain that musculature, and that's what I need to do right now. You know, working around arthritis, working around that bad arm, still in partial recovery, I really do need to emphasize maintaining upper body strength so that transfers are safe and that I'm not, you know, finding myself on sidewalk and that I can still navigate that wheelchair properly.

SHARON:  
So it sounds like when you were in inpatient rehab, that there wasn't a lot of discussion about looking forward over the decades and things that you need to keep in mind to stay healthy going forward. Is that an accurate statement?

MIKE:  
That's probably correct? Yeah. I mean, there was no, back then in the 70s, you know, there was no emphasis on diet. There was no emphasis on, of course, you know, I can start smoking now. And I joke, well, I need a I need a hobby, so maybe I should start smoking. But no, general health wasn't the focal point of discussions like it is now. So less of that. And what I was trying to think through, and of course, it was quite a while ago, is how much of my time in the rehab hospital was spent with the physical therapist versus the occupational therapist, who have quite different disciplines and skill sets. And, you know, PT gets your body ready for whatever you think your body needs to do. And the OTs help you navigate the world. You know, they teach you how to get dressed. They teach you how to kind of navigate through the kitchen, in the bathroom and in and out of the car and all those sorts of practical things, where the PT works more with body mechanics and level of coordination and whatever strengths you still do have, but I don't remember precisely the distinction between the two. I know when I was in Shirley Ryan a couple years ago, there was an awful lot of OT and probably, probably 60/40, 60% OT, 40% PT.

SHARON:  
After inpatient rehab, did you go into a day rehabilitation program?

MIKE:  
No, they didn't have such things at the time that I recall, but it didn't seem to be an option, because my main focus was just getting home and getting acclimated enough that I could, you know, kind of pass the test for independence to be able to get back to school. And as a sophomore, when that happened, and I missed, obviously, the rest of that semester, and I missed the spring semester, so I was at home and again, just kind of getting my bearings, again with a completely different body, and figuring out how to maneuver through the world. So that was really what was in my head is, was I going to be able to handle myself independently back at school?

And I lived in a fraternity, a big old, 100-year-old, five story brownstone, which was completely inaccessible. So how did that work? Well, fortunately, there was a dumb waiter. There, it served as an elevator for hauling freight up and down in the back stairwell, and it was usually for garbage or cases of coke and cases of beer and stuff like that. It wasn't very wide, but back at the time, back at that time, I had a wheelchair. My first wheelchairs were all Everest & Jennings models, which is kind of a defunct brand now, but it had a device where you could actually put a little crank on the armrests that fit into the frame, and you could rotate this crank, and it would actually fold the chair up partially. It’s a brilliant invention. It worked very well. And we all call it the “Get Small Machine.” So the little crank, so I line it up with the elevator, and I'd start to, you know, twirl this little crank, and the chair would start to fold and with me in it, and it would fold enough to where I could push back into the dumb waiter. The dumb waiter, though, was not electrically actuated. It was ropes. Oh, my God, big, long, like a like a nautical rope, and it was a five story shaft, so we had to figure out how to work the break and do this thing and that thing with so that wouldn't kill myself and just, you know, go screaming down five stories to my death. So there was a counterweight system. So we figured out how to balance that. And it all worked out, and it, and that's how I got around for the next, I guess, two and a half years in the fraternity house, the whole time up and down in that thing.

SHARON:  
So were you able to operate it on your own, or did you need your fraternity brothers to help out?

MIKE:  
No, I was. I was able to pull myself up and down. Oh my gosh, we had things counterweighted such that it wasn't just a pure deadlift, a little bit of help going up with the counterweight, but I had to pull a lot.

So I would I went back for reunions every five years, you know, post-graduation, and the first reunion or two, I could pull myself up, but then, oh, my God, maybe they changed the counter weight and didn't tell me, but I basically almost killed myself. How in the world did I ever do this for the couple, couple and a half years that I did? But that's also testament to how quickly your body can fall apart if you're not, you know, really working it all the time. Because, of course, once I left there, I didn't have any dumb waiters, I had to pull myself up and down in and, you know, the musculature goes away quickly if it's not used like that.

SHARON:  
So then, did you go right to work? Or was there grad school after that?

MIKE:  
I went to grad school, actually, out here in Chicago, and then after that, you know, went to the working world.

SHARON:  
And where did you work? You worked at one place for a long time, right?

MIKE:  
Well, I, my initial job was in Pittsburgh. I worked there for a couple years, and they transferred me down to Houston, and I was there for about a year, and then I started looking for other opportunities and situations, and found one that was up here in Chicago, and moved up here and have been here ever since.

SHARON:  
What was the company?

MIKE:  
The company where I started with, it was PPG Industries in Pittsburgh. People might know that as Pittsburgh Paints, but I was in their chemical division, which makes a bunch of nasty things you put in tank cars that you don’t want to be anywhere near. And my degrees in chemical engineering, so that all kind of kind of hung together, made sense.

SHARON:  
And do you do any rehab today? Or what's your what's your routine today? For keeping up?

MIKE:  
My routine today is to try to work around this arthritis and continue to recover from that triceps tendon rupture, and I was really towards the tail end of recovery from that, when the arthritis flared up. So one thing leads to another to another, and now I have a couple things to do to strengthen shoulders and posture, and my upper back and all those things to avoid what I call, well, I referred to the other day as the something slouch, like the monster slouch, or something like that. But you know how old people all kind of tip forward, and some of them, terribly. Well, that happens to people in wheelchairs, too. And you find yourself leaning forward when you don't want to be you got to press back on your arms. And when you do too much pressing back in your arms, and your arms start to hurt. So you got to get that whole back set of extensor muscles back in gear so you can sit up straight. And, you know, not everything falls apart. So that's what I'm kind of focusing on, and all that is really essential for the active activities of daily living. You know, washing, dressing, clothing, all the basics, transfers. I'm very careful with transfers. They're all planned out, and have to get pretty close to my target destination when I hop into something. But you know, you can work through that. The sum total of all that is really slows me down. So if somebody saw me hopping around 20 years ago, they'd say, wow, you're the same guy. 20 years later, you really slowed down. But it is what it is, and fortunately, I am still able to get around.

SHARON:  
To wrap up, is there anything that you would say to someone who's just entering inpatient rehabilitation right now?

MIKE:  
I would say, listen to your therapist, because despite what you might think, they know a lot more about your condition and what your possible endpoints are than you do. So trust in your therapist and don't whine about being tired or time for a nap or fatigue, because it's really is good for you. And try to push yourself, because it will pay off.

And when they give you a set of exercises to do, either in your free time or at home afterwards, you better do them, because you'll lose that function, especially as it comes back to core strength. Believe it or not, there is core strength of SCI patients. You might not realize you have it, but it's really essential for balance and stability and all kinds of things. And many of the things that therapists point you to have a core strength aspect to it, which isn't appreciated, but follow their instructions and really stick to the stick to the grind, because it'll really pay off.

SHARON:  
Mike, you are a veteran advisory council member, and you are on the advisory council for our grant that we kind of refer to it as the International Length of Stay grant, and it's a NIDILRR funded grant that is going to examine how differences in inpatient rehabilitation length of stay, so how long you're there, and what happens when you're there, how those differences affect outcomes in people with spinal cord injury. So we have researchers and collaborators from different countries. Can you talk a little bit about your participation on that advisory council?

MIKE:  
Sure. The council is set up, I think, with the NIDILRR request that members of the SCI community participate as advisors to the council. And of course, I think what's behind that is they would like some first-hand experiences and indications of what works or doesn't work or stands out in their rehab journey. And it's been a productive interaction, because I think the researchers and the overall project setup is pretty responsive to what individuals have said about some of the nuances of things that they should consider when they're putting their surveys together and cutting through the data. So it's been a productive situation. And again, I think the researchers are very responsive to the inputs, and that's reflected in how they're progressing with the study.

SHARON:  
Thanks so much, Mike, it's been a pleasure talking to you and learning more about you and your experience.

MIKE:  
Thanks much, Sharon, you did a great job. I appreciate it.

SHARON:  
This has been INside the OUTcomes: A Rehabilitation Research Podcast. I'm your host, Sharon Parmet, signing off.