

7. Concerted opposition in Australia

The events described in the two preceding chapters—namely, the evolution of Freeman's ideas and practice on domiciliary rehabilitation and the machinations evoked by the availability of a large grant of research funding—occurred against a background of considerable hostility towards those ideas and practices. The extent to which this general hostility fuelled the antagonism expressed in individual situations and happenings is not readily discernible after a quarter-century. Similarly, questions about the relative contributions of various influences to the development and entrenchment of the opposition are not easily resolved. This chapter recounts a sample of the hostile responses from some Australian medical personnel. The next chapter balances this against international support for Freeman's ideas, frequently forthcoming as a reaction to the attacks described below.

At the outset, it appears fairly clear that opposition originated among Freeman's medical colleagues. Expressions of opposition in the context of the health system at large can be traced back, with some confidence, to a relatively small number of members of the medical profession. Opposition to Freeman was not generalised within the profession, but critics were considerably more vocal than supporters. The Australian Medical Association, of which Freeman was a member, was supportive of him. There were clinical leaders within the profession who, while not necessarily endorsing chapter and verse of Freeman's thinking, considered that his clinical observations were potentially of major significance and merited an open-minded assessment.

One issue that was raised in criticisms of Freeman related to the paucity of laboratory data, derived from experimental systems, pointing to some superiority of his active early approach to patient rehabilitation. This argument failed, and continues to fail, to take account of two other issues. The first of these was the almost total lack of hard laboratory data supporting the prevailing approach of non-intervention. The second was the obstinacy implicit in discounting clinical observations that Freeman's approach appeared to help some patients and harmed none.

Following his visit to the United States in 1983, Freeman sought advice from the Director of the John Curtin School of Medical Research at The Australian National University:

Bob Porter had a reputation as an international neuroscientist. I told him about the research on brain injury. I spoke about the nerve cells sprouting like buds on the branch of a tree. He listened for half an hour and suggested that I should not become involved in studying the brain at the cellular level, but should demonstrate what could be done with the patients.

The advice was taken.

As already suggested in discussing the aborted trial at the Westmead Hospital, a factor specific to that episode is likely to have contributed to moves to exclude Freeman from the process. In short, it would require a combination of exceptional naivety and charity not to indict a strong motivation to appropriate the funding offered by the GIO as an important factor in that attempted exclusion.

As to the more general factors fuelling opposition, apprehension about considering therapeutic proposals that were very much at odds with accepted practice was certainly important. A distinction should, however, be drawn between exercising caution about accepting, let alone adopting, practices contrary to established precepts and refusing at least to consider new ideas and give their proponents an uninterrupted hearing. The former is prudent, the latter prejudiced.

Another contributing factor, albeit an unproven one, to opposition to Freeman and his ideas may have been the realisation that any degree of acceptance of them must implicitly be a criticism of the then prevailing management of people with substantial brain injuries. 'Management' is used here in its broadest medical sense. Thus, Freeman persistently challenged *diagnoses* made by his colleagues. He persistently issued *prognoses* that, although heavily guarded, retained possibilities of hopeful outcomes. As a result of his diagnosis and prognosis, he persistently recommended rehabilitation *treatment* that was heavily dependent on contributions from families and communities rather than on professionals.

For all of these reasons, he was condemned by specific groups of colleagues—namely, those whose responsibilities entailed the acute care of individuals with brain injury and those responsible for their rehabilitation. The first group often regarded his intervention at the behest of families as a direct attack on their diagnostic competence. A recovery, even with substantial persisting disability, could be read as such an assertion. The second group, with responsibility for rehabilitation of people with brain injuries, found Freeman's willingness to assist patients who had been categorised as unsuitable for rehabilitation offensive.

Exclusion

Opposition to Freeman on the part of particular colleagues was expressed in many ways. Perhaps the most childish was to restrict his access to patients whom their families had asked him to visit. In some instances, his visit to a hospital was met with studied officiousness. An example of this in a NSW hospital occurred when Freeman, at the request of a patient's wife, and with prior agreement from the neurosurgeon and the hospital, arrived at the hospital: He records:

I was surprised to be asked to go to the office of the Director of Medical Services. I waited outside for an excessively long time before being invited into the room of the director, who asked me to sit down. She questioned me about what I wanted to do at the hospital and then asked me, 'Can you show me your medical registration?' I did so. She asked, 'Can you show me documents that you are in the medical defence?' I did so. She asked, 'Would you show me your driver's licence?' I thought this was a peculiar request but complied. Next she asked to see two credit cards. I produced them. She then asked, 'Would you show me your passport?' I thought this was totally out of order, but replied, 'I do not usually carry my passport with me. Why do you ask?' The director said, 'I will give you permission on this occasion to see the patient, but we do not like having you in this hospital.'

Freeman gave an account of this episode to a colleague, a former federal president of the Australian Medical Association, whose response was 'silly bloody idiot'. Whilst Freeman regarded the director as a particularly rude person, his commitment was to visit the patient, not to argue with the director.

At other times, he was left in no doubt that his future presence was not welcomed. An example of this tactic was the response to Freeman's visit to the patient Donald recounted in Chapter 2. Freeman described the circumstances after he had examined Donald:

The Neurosurgical Registrar, when I had completed my examination, walked to the ward door with me and said, 'I have been told to tell you—we don't want you to come back.' I asked why, but he ignored me.

Sometimes, Freeman was refused any access to a patient despite parental requests. In the case of Louise, a young woman who had suffered a severe brain injury and was likely to be sent to a nursing home, he recalled:

As the hospital authorities were reluctant to allow me entry into the hospital ward, Sister Jeanette Budak arranged for Louise's parents to bring her in a wheelchair into the hospital car park for assessment. A car park is not the best or most private place to assess a patient but at least Louise had remained on hospital premises. Immediately I saw this young lady, I knew that she had awareness.

Following the attack on him in the NSW Parliament, described later in this chapter, exclusion of Freeman from hospitals was directed from levels higher than that of hospital administrators. On one occasion, the parents of a boy with a severe brain injury who had requested the hospital management to permit Freeman to examine their son received a reply from the NSW Department of Health as follows:

Unfortunately as Dr Freeman is not accredited to attend patients at ... Hospital he would not be able to see your son on this basis. As Dr Freeman has a different philosophy for those with traumatic brain injury there have been several occasions where different methods of treatment have caused conflict. I understand your concerns and need to explore every avenue but at this stage it is not feasible to agree to your request.

Another manifestation of opposition was the exclusion of Freeman from presentations and projects concerned with management of brain injury. These exclusions contrast with the invitations which, paradoxically, Freeman was concurrently receiving to participate in international conferences as the sole Australian invitee.

In July 1987, the NSW Government introduced a new transport accident compensation scheme, Transcover. The new scheme was intended to replace the existing arrangement under which the injured person received a single lump-sum compensation payment with ongoing financial support that could fund continuing rehabilitation. To mark this change, a seminar was arranged and, as severe brain injury was the commonest condition requiring prolonged rehabilitation, the seminar was devoted to this subject. Freeman was invited to attend and, given his commitment to continuing rehabilitation, he assumed that he would be programmed as a speaker. He was, however, disabused some weeks before the seminar when visited by the GIO official responsible for organising it. In Freeman's words:

When we sat down over a cup of coffee he said, 'I am sorry, Ted, but you will not be invited to speak.' He appeared to be embarrassed. 'Why not?' I asked. 'Because other speakers will not stand on the same platform if you participate.' I was astonished—in my opinion, this was not an objective scientific attitude in response to a major community health problem—but obviously John felt that he was in an extremely difficult position. He said he could not risk my inclusion because it had been a major effort to push the NSW Government to agree to Transcover.

The speakers at the seminar were to be two persons from a consultancy speaking on the Transcover scheme, two participants from the abandoned Westmead study speaking on research on brain injury rehabilitation and two rehabilitation specialists both of whom had been critics of Freeman's approach.

Abandoned research proposals

In the following year, a leading neurosurgeon in Victoria advised Freeman that he was attempting to initiate a study of coma arousal in that State. He advised

Freeman that he had shown his book on coma to some neurosurgeons and ‘they took exception to the fact that I was encouraging families to “impose” their own ideas on the treatment of their relative’. Freeman’s correspondent continued that, according to the neurosurgeons, ‘the whole thing was hopelessly unscientific’. He concluded: ‘I finally end up with a list of who will cooperate and who won’t. One minute all is sweetness and light, and the next there are innumerable difficulties.’¹ Predictably, the study was abandoned.

History was to repeat itself 10 years later. As mentioned in the preceding chapter, a medical practitioner who was a member of the NSW Parliament proposed to the then health minister that it would be appropriate to undertake a review of Ted Freeman’s work on rehabilitation following brain injury. Coincidentally, research psychologist Dr Ross Harris, an expert in pain management, together with a rehabilitation specialist holding a university appointment who had consistently perceived value in that work, had been preparing, at the request of the National Brain Injury Foundation, a protocol for a research project, tentatively titled the Brain Injury Outcome Study (BIOS).

In order to initiate the BIOS, some means of accessing a historical control group of patients with brain injury who had been treated by ‘conventional’ procedures would provide a baseline. The best source of such data seemed to be the outcomes achieved to that time by the NSW Brain Injury Rehabilitation Program (BIRP). Information from the BIRP units could then provide a baseline for comparison with data relating to community rehabilitation.

As noted in the previous discussion of clinical trials, when a request was made, through a government body, the Motor Accident Authority, for access to the outcome statistics from the BIRP, it emerged that, notwithstanding very adequate funding over a number of years, no statistics had been collected. Apparently, the BIRP units had not been sufficiently concerned with assessing the efficacy of their unchallenged practices to undertake simple statistical collection or evaluation. For example, no information was available as to which forms of therapy had been most successful when provided to different groups of patients with brain injuries. The irony of this was not lost on Ted Freeman:

Over the years of my involvement in the field of brain injury some of the directors of BIRP units, most of whom I had never met, had been highly critical of my approach to the treatment of brain injury, accusing me of having no scientific basis for my work. None had ever corresponded with me about my medical papers, which had been published in refereed international journals, and none had acknowledged or rejected the theories advanced in my book on coma.

1 Keith Henderson, Letter to Freeman, November 1989.

Antagonism to Freeman and his procedures, it turned out, was not a thing of the past, even in 1997. Notwithstanding the lack of records from the preceding decade, the current practice within the BIRP units could have provided control data for a contemporary assessment of Freeman's practices. The research psychologist who was seeking to undertake a comparative assessment of Freeman's ideas and the generally prevailing practices in New South Wales realised that this could only be possible if the BIRP units were participating. Yet antagonism to Freeman remained alive and well. In attempting to secure participation by some BIRP units, the specialist arranged meetings with the directors. It soon became abundantly clear to him that, if Freeman was invited to participate in any of these meetings, the directors would boycott them. The specialist was effectively in a lose-lose situation.

An ideal approach to establishing a comparative study of the efficacy of 'established' and 'Freeman' procedures was envisaged as entering a group of patients, who had already been classified as 'not suitable for rehabilitation' by a BIRP unit, into a community-based rehabilitation program. The most cursory rereading of the patient stories in Chapters 2 and 3 indicates that many of Freeman's patients during the preceding two decades had met this criterion and had indeed been so diagnosed. They had been, in all but formal naming, the 'rejects' of the system. In contrast with this history, when the rehabilitation specialist met with BIRP unit directors, his meeting notes recorded:

[T]here is a difficulty in that no-one will commit to paper that in their opinion a particular patient is 'not suitable for rehabilitation'.

Apart from the resistance of the BIRP unit directors to participation in any study of Freeman's outcomes, the BIOS was doomed by the resource allocation approved by the NSW Government. The arrangement would be that the BIRP units would continue to receive considerable funding, as in the past, to undertake their programs and the university-based BIOS would receive the resources required to undertake the study. In contrast, the patients entered into community-based rehabilitation would be dependent on *minimal guidance and education*.

Freeman interpreted 'minimal guidance and education' as a deliberate attempt to ensure the failure of that part of the research that was supposed to be evaluating the community-based program. Needless to say, the BIOS did not commence.

At this juncture, it should be repeated that opposition to anything connected with Ted Freeman was certainly not universal among the medical community, or even among the specialist neurological and neurosurgical subpopulations within that community. Whilst a number of senior practitioners were prepared to confide to Freeman that they perceived merit, at least partial, in his ideas and their practical application, a much smaller group was prepared to state this

publicly. An even smaller group was prepared to express support for the testing of his practices after initially opposing them. This required an open mind—not necessarily a given within the profession.

Formal opposition

Apart from individual initiatives to exclude Freeman from the medical community as in the examples above, some collective attacks were mounted. In May 1986, the Australian Association of Neurologists (AAN) wrote to the federal health minister to express its concerns in the following terms:²

You may be aware that ‘coma arousal’ is a name given to a very active rehabilitation of head injured patients. A unit has been active in Sydney for some time and those involved with the unit claim that ‘coma arousal’ achieves more than the simple passage of time and traditional physical therapies.

The association asserted that the treatment was costly and, perhaps providing an indication of the motivation underlying the letter (the trial at the Westmead Hospital had lost its GIO funding at the end of the preceding year), continued: ‘there appears to have been a reluctance on the part of those proposing this therapy for it to be submitted to appropriately controlled scientific trials.’

In June 1987, the National Health and Medical Research Council (NHMRC), the premier body charged with overseeing Australian medical research, weighed into the attack. As had been the case with the AAN letter to the minister, no prior attempt was made to consult with the Australian Brain Foundation, a well-credentialed body that had been backing Freeman’s approach to rehabilitation, or with Freeman himself. At the 103rd session of the Council:

Council noted that coma arousal therapy, an as yet unproven therapeutic modality used on severely brain injured persons, continues to be actively promoted. In addition, it was noted that there are considerable psychosocial implications for relatives and close friends of patients for whom this treatment may be suggested.

While the mobilisation of hope is part of such programs they may lead to unrealistic expectations with problems for family functioning, guilt and grief. Thus a thorough evaluation of positive and negative outcomes in a controlled trial is essential.

² Correspondence, Australian Association of Neurologists to the Minister for Health, 20 May 1986.

Council expressed the view that new forms of treatment should not be promoted unless supported by the results of scientifically valid clinical trials.

In the case of coma arousal therapy such a trial should be practically and ethically possible. Council accepted that the rehabilitation of head injured patients is a problem of major concern in our society and expressed the opinion that the development of scientific trials of new treatment modalities in this area is to be strongly encouraged and supported.³

Two points claimed by the NHMRC disclose some ignorance on its part concerning the subject on which it was pontificating. In the first instance, the 'considerable psychological implications' and 'unrealistic explanations' that it cited had already been studied by a Macquarie University research team with results that were entirely favourable to the practice of Freeman's group and quite dismissive of the NHMRC's envisaged concerns. Although that study was funded by the GIO, rather than by the NHMRC itself, it would be entirely reasonable to expect that the council staffer preparing the advice, which was patently based on unpublished opinion, might also have been aware of unpublished research at a major Australian university that contradicted the argument it presented.

A second issue, on which one might have hoped that the council should have been more knowledgeable, relates to the assertion that a trial should be 'practically and ethically possible'. As the Cochrane review of the practicality of similar trials was to discover two decades later, it had not proved possible to complete a statistically acceptable study complying with the generic guidelines for randomised control trials. One of the responsibilities of the NHMRC is that of maintaining ethical overview of all medical research projects in the nation, irrespective of their funding source. Given this, it is rather disappointing that those advising the Council had not been able to discern the massive ethical quandaries inherent in trials of the type of the failed Westmead one. Freeman wrote to the NHMRC Chair with a detailed rebuttal of the claims in the recommendations in September 1987 but failed to receive a reply. Even in 1987, the Australian community was entitled to expect better from its peak medical research body.

A postscript to these events affords an interesting perspective on the manner in which collective mind-sets survive even as history overtakes them. A 1995 request from the NSW branch of the Australian Medical Association to the NHMRC for a meeting to examine Freeman's practices and outcomes brought

³ National Health and Medical Research Council, 103rd Session, June 1987.

the response from the Chairman of the NHMRC that '[t]he position on coma arousal therapy as discussed in June 1987 is still current and there is no plan to review it at present'.

Had the Chairman's mind been sufficiently open to seek some wider advice, he would have found that Freeman was, at the time of the request for an examination of his activities, in London participating in PVS 95, a small, invited group of international specialists examining methods of facilitating rehabilitation after brain injury. Some detail about this meeting will be included in the next chapter, which discusses some international assessments of Freeman's achievements.

Pilloried in Parliament

All of the preceding attacks on Freeman shrank in perspective when he became the victim of a defamatory attack under parliamentary privilege. When placed in historical context, this can be seen as one of the most despicable abuses of privilege in an institution that is no stranger to that practice.

In 1988, Ted Freeman was asked by Gail and Rollyn Graham to meet with their son Jim, who remained severely disabled as a result of a brain injury five years previously. Jim's parents had worked unremittingly over that period attempting to obtain the best possible outcome for him. This had included a period in a US clinic, admissions to a succession of Australian hospitals and an ongoing correspondence with those administering health care, not to mention politicians. Gail has written a book giving an account of the problems that she and Rollyn encountered and this has attracted widespread attention.

After Ted Freeman had been approached to assist Jim, Gail circulated to every member of the NSW Parliament a letter outlining the obstacles that the Graham family had encountered. Recipients included the health minister and his opposition shadow. Whilst many members replied to her letter, this pair failed to do so. Prophetically, Gail wrote about the health minister, Peter Collins, 'he can't ignore us forever'. This proved to be correct. On 9 February 1989, the minister wrote to all Legislative Assembly members acknowledging receipt of the Grahams' representations on the subject, stating that the Health Department had 'reacted appropriately by investigating details of this patient and communicating with his mother. Further assessment of his condition and the need for future treatment has been offered.'

Gail Graham has written of this ministerial action:

We were speechless. Except for one odd phone call, nobody from Mr Collins' department had communicated with either of us. Certainly no

further assessment of Jim's needs had been offered. Nothing whatsoever had been offered. Worst of all Jim's situation had been misrepresented to the only people who were in a position to help us.⁴

Ted Freeman's unpublished account of what eventuated, as communicated by Gail Graham, follows:

Gail and Rollyn were extremely frustrated in their attempts to make contact with Collins so they made huge posters that said 'Why won't you talk to us Mr Collins', and stationed themselves on the footpath outside the NSW Parliament House. Soon a member of staff approached them on the footpath and told them that, if they removed the posters, they could have a meeting with Collins that afternoon. Gail recorded the interview. In it Collins turned his back on her and spoke only to Rollyn. Collins prevented Rollyn from completing his sentences. Collins blamed the Federal Government for Jim's predicament. The meeting finished with Collins saying he would be speaking about the matter in Parliament two weeks later, on 1 March 1989.

Concurrently with the initiatives of Gail and Rollyn Graham, the Brain Injury Division of the Australian Brain Foundation had been preparing a submission to the NSW Health Department requesting funding for a study of coma arousal. Essentially, this proposed that 20 patients who had been diagnosed as 'vegetative' or 'unfit for rehabilitation' in hospitals would be transferred to the Brain Injury Therapy Centre at Eastwood. These patients would be assessed at regular intervals by independent medical examiners. After the proposal was submitted to the Health Department, the Australian Brain Foundation learned that a favourable response was possible and that (coincidentally) the minister would be making a statement on the subject to Parliament on 1 March 1989.

At 2.30 pm on the appointed day, the minister rose from his seat to address the Legislative Assembly. *Hansard* records the following:

Mr Collins: I am concerned that the Grahams have circulated misleading correspondence to many members of Parliament—

(interruption)

Speaker: Order!

Mr Collins: —suggesting that neither Jim's doctors at Mt Wilga, the Department of Health, nor my staff have offered any assistance. This is incorrect.

(interruption)

4 Gail Graham (1995) *Staying Alive*. Angus & Robertson, Sydney.

Speaker: Order! Having had three general calls to order, I call the honourable member for Waverley and ask the Serjeant-at-Arms to remove him. (The honourable member for Waverley, Mr Ernie Page, left the chamber accompanied by the Serjeant-at-Arms.)

Following this diversion, the minister proceeded to read from a document.

Mr Collins: Dr Freeman has over a number of years sought government endorsement for his therapeutic approach—commonly called coma arousal therapy. The Government Insurance Office in a report by Cuff Consultants to the previous Government issued the following advice about Dr Freeman:

This report which I shall later seek to table is dated the 6th March 1987. It continues:

The therapy centre is not legitimate research work.

The therapy centre activity does not constitute rehabilitation of brain injured people and their families.

The therapy centre activity has not improved disability outcomes despite the relatively high cost.

There are questions of medical and professional ethics in regard to the division's activities.

Dr Freeman is not conducting his work within any scientific framework. He does not even try to respond to requests for justification of his concepts or beliefs: he seems totally unconcerned about the rightness or wrongness of his ideas.

The Brain Injury Therapy Centre is not staffed for the rehabilitation of brain injury. Dr Freeman does not assess the patients in the objective manner required by the rehabilitation process to measure both the recovery and the effectiveness of the rehabilitation effort. The medical practices preferred by the Brain Injury Therapy Centre are unacceptable to rehabilitation professionals particularly as they are performed on helpless people unprotected by any legislation.

Continuing to read from the Cuff Report, the minister quoted from the NHMRC recommendation described above and followed with:

In 1984–5 the doctor withdrew from a joint GIO–Westmead Hospital study aimed at assessing coma arousal.

The minister concluded his statement making reference to the Grahams:

The Grahams, like other parents in this heart wrenching position, should take some consolation in that they have done everything possible for their child—so too will health workers in our public health care system who continue caring for young Jim Graham.

Aftermath of the parliamentary attack

Reactions to the Collins statement were profound. Ted Freeman decided to retire, hoping that criticism of him would then have less unfavourable impact on the BITC. He has recalled the time immediately after the minister's statement:

On the afternoon of 1 March 1989, after the Minister for Health, the Hon. Peter Collins, had made his speech in the NSW Legislative Assembly, I left Parliament House and walked down Macquarie Street in a state of shock and bewilderment. This was not the outcome I had expected. I wondered why the proposal to research 20 patients labelled as 'vegetative' or 'unsuitable for rehabilitation' had been rejected. Weighing heavily on my mind was the fact that to be publicly criticised in Parliament by the Minister for Health could ruin the professional reputation of any doctor, and I was aware that now it might be impossible for me to continue my work in the field of brain injury.

The Grahams were very distressed. Gail has written an account in her book:

We were both devastated. In particular Rollyn felt that he had been personally humiliated, because on top of everything else, Peter Collins had publicly rebuked him. He said that now people would think it was his fault that Jim was being denied the treatment he needed. Jim probably thought so too, Rollyn said. This was ridiculous but nothing that I [Gail] or anybody else could say seemed to comfort him. He became convinced that his colleagues and students were talking about him behind his back, laughing at him, holding him in contempt.⁵

Two weeks later, Rollyn committed suicide.

As mentioned above, consternation raged among the families of people under treatment at the Brain Injury Therapy Centre. The Brain Injury Division of the Australian Brain Foundation was disbanded. The BITC administration was reshaped in an attempt to overcome the impact of the statement. With Freeman no longer having any position in the BITC, it was replaced with a more commercially oriented venture, Brain Injury Services Proprietary Limited, led

⁵ Ibid.

by an entrepreneurial executive. Within a year of its formation, this company was liquidated in circumstances characterised by the accountants as entailing 'gross mismanagement, profligate and irrational expenditure and also, it appears, nepotism'. The liquidator concluded that none of the medical staff associated with the BITC had been aware of any financial impropriety or mismanagement.

The Sydney tabloid press on the following day ran headlines drawn from the liquidator's findings, effectively compounding the damage previously done to community perceptions of coma arousal.

The Cuff Report examined

As the devastation of lives following Collins' statement of March 1989 derived from conclusions of the Cuff Report included in that statement, it is appropriate to formulate some assessment of the quality of that report. As the Report became a public document after the statement, this is not difficult. Answers to the questions of why the report was only released two years after its completion, of its location during that interval and of who was pulling the strings to bring it to the minister's attention before any of the people attacked in it were given an opportunity to comment are less easily answered.

The story of the commissioning of the Report is as follows. In 1986, the GIO was preparing for legislative changes to enable the conversion of the existing practice of single compensation payouts into structured settlements whereby the insurance company provided an annuity on a set pay scale for life, depending on the extent of the patient's disability. As a first step, the necessity to determine the extent and cost to the community of severe brain injury was acknowledged. A GIO official wrote a detailed letter in September 1986 outlining the problems to Chris Cuff, of Cuff Management Consultants, with a request: 'What I am now seeking is your assistance in pulling together all these issues and determining strategies for future GIO involvement and for the establishment of a new study on the treatment of the brain injured.'

A report was presented to the GIO Third Party Division on 6 March 1987.⁶

When refereeing an article's suitability for acceptance in a medical publication, one would be provided with some indication of relevant qualifications or professional position held by the author. As the only attribution of authorship disclosed in the Report is 'Cuff Consultants', it is reasonable, given the nature of its content, to assume some expertise on the part of the author(s) and then

⁶ Cuff Consultants (1987) *Report on the Brain Injury Division. Presentation to GIO Third Party Division*, 6 March 1987.

to proceed to review it as one would deal with an article on rehabilitation after brain injury emanating from an appropriately qualified source. The authority which was accorded the Report conferred by its parliamentary release permits of no other conclusion.

The Report contains a number of sections, each of which is headlined with the conclusion derived from it, followed by the information on which that conclusion has been based. In order to provide a basis for its evaluation, each conclusion will be cited. Following this, an abbreviated account of the supporting information contained in the report is provided. A critique of each conclusion and its supporting information, including comments referring to it from several independent healthcare practitioners, follows.

Freeman's theories disparaged

The first two conclusions concern the nature of the theories underlying Freeman's practices, and do not consider the clinical outcomes of those practices.

- Ted Freeman's treatment of severely disabled people seems to be based on a 'triad' of concepts/beliefs about the ability of the brain to regain function; none of these beliefs has the validation of any scientific evidence.
- Specialists in the rehabilitation of brain-injured people have asked Ted Freeman to explain the basis and nature of his ideas.

The three concepts identified in the supporting information attached to the first conclusion relate to the ability of the brain to repair itself or to compensate for loss following injury. They are 'the plasticity of the brain', 'the spare capacity of the brain' and 'canalisation—the inherent fixed pathway of recovery'. In the report's discussion of these, the first two are dismissed as having 'no scientific validation', whilst the third is dismissed as 'pure conjecture'.

No attribution of a credible scientific source for the dismissal of these three theories is provided in the Report. No evidence has been presented in the Report to support these conclusions. The Report will be examined only in the light of what was generally accepted in 1987 and so will not, for example, assess it in the light of the more recent universal acceptance of the reality of neuroplasticity. A commentary informed by some knowledge of the state of experimental neuroscience in 1987 might have concluded that little was known, on the basis of experimentation, *either for or against* the three concepts. They remained to be tested in experimental models; however, given the available clinical observations pointing to them at the time of the report, each constituted a reasonable hypothesis.

The second conclusion is supported by a claim that Freeman had failed to respond to questions about his proposals for rehabilitating patients who remain unconscious following brain injuries. Whilst the Report's conclusion, presented above, refers to 'specialists', the supporting information relates only to input from a single practitioner. This takes the form of a copy of a letter sent to Freeman by the clinical superintendent of an Adelaide clinic undertaking rehabilitation of patients after brain injury. The copied letter has been highlighted in 22 places at each of which its author is said to have directed questions to Freeman. All questions are said to refer to points made by Freeman in his papers, either published or in draft form (it would be unusual for an author to pass the latter to hostile colleagues before publication). As no attempt is made in the supporting information to disguise the existence of an antagonistic relationship between Freeman and the writer of the letter, one might question its objectivity.

Reference to Freeman's publication list reveals that his writings were invariably published in peer-reviewed journals, usually internationally based. Consequently, it is probable that many, if not all, of the points that have been queried by the Adelaide doctor had been accepted and approved as reasonable statements by unbiased overseas professionals qualified in the field of brain injury. If referees had challenged any, Freeman would have been required either to amend them or to justify their inclusion to the satisfaction of the journal editor before acceptance of a manuscript for publication. The scrutiny to which Freeman's presentation of his ideas had been subjected before their acceptance in the scientific literature contrasts with the lack of anything resembling scientific process in the discussion of possible theories in the report.

It may be appropriate to balance the comments of the Adelaide-based practitioner on Freeman's work with the inclusion of those of two extremely well-qualified, senior, Adelaide academic clinicians.

Professor Donald Simpson, Professor of Neurosurgery at the University of Adelaide, wrote in March 1989 after the parliamentary attack on Freeman: 'One of the merits of Freeman's work is that it has stimulated an overall improvement in rehabilitation services and he has played a respectable role in the development of rehabilitation in Australia.'⁷

Dr Roger Rees, Director of the Institutes for Learning Difficulties in Adelaide (subsequently Professor of Disability Studies and Research at Flinders University, Adelaide), wrote, also in March 1989:

The Brain Therapy Centre at Eastwood has undertaken pioneering intervention with some of the most severely brain injured persons in Australia. The team work approach allied to the persistence is unique

⁷ Donald Simpson, Letter to Freeman, March 1989.

and can best occur when the therapy unit also provides a social network which acts as a life-raft for the brain injured and their families. The Brain Injury Therapy Centre at Eastwood provides a state of the art program which meets an important need for long term individual therapy and family support for persons with severe disability.⁸

Freeman's clinical competence attacked

Three of the conclusions in the Report amount to criticisms of Freeman as a clinician. These are considered individually, together with their supporting arguments and an evaluation of each. The first was:

- Rehabilitation specialists take responsibility for prognosis in regard to patients' disabilities and consequent needs: Ted Freeman does not take this responsibility.

In support of this contention, the Cuff Report compares two responses to legal requests on prognosis. Both have been selected from GIO files. One of these is headed as 'typical' while the other response is attributed to Ted Freeman. Whilst this is not explicitly stated, the second response is, presumably, intended to be 'typical' of Freeman. It relates to a request from the GIO to which the report's authors can find no answer in the file.

Any decent assessment of Freeman's response to requests from solicitors should consider factors such as the comparability of the relationship to the specific patient of Freeman and the 'typical' rehabilitation practitioner. For example, had Freeman examined that patient once or twice whilst the 'typical' practitioner had full clinical responsibility for an inpatient on a daily basis? A reasonable comparison would necessarily be based on a comprehensive examination of the records of many patients. The second conclusion of the Report was:

- Ted Freeman does not assess the progress of patients in the objective manner required by the rehabilitation process to measure both recovery and the effectiveness of the rehabilitation process.

This conclusion was supported by a comparison between Freeman's approach to assessment and that undertaken at the Prince Henry Hospital Rehabilitation Unit. As with the preceding comparison, a single 'Freeman' patient is used as an information source. The Prince Henry Hospital assessment method required the allocation of a numerical score to indicate a patient's status as measured for a number of functions. For example, the first two functions to be estimated were 'mental capacity' and 'psychological activities' and the rehabilitation specialist

8 Roger Rees, Letter to Freeman, March 1989.

was required to allocate a score within a range of 1–12 and 1–6 respectively. For comparison, Freeman’s assessment of a specific patient included descriptions, without any attempt at attaching a numerical scale, to categories such as ‘emotion’ and ‘independence of drive’.

Admittedly, the allocation of numbers to a patient’s estimated competence will permit aggregation of results achieved in a group of patients and one can derive means, standard errors, and so on. With great respect to social scientists, however, the question that a more competent report author might have asked is that of whether converting assessment of an entity such as ‘emotion’ to a numerical value actually achieves much other than camouflaging something that is no more than a subjective estimate. Freeman’s description of his patients, I submit, conveys much more information to someone wishing to know about their status. The third conclusion of the Report was:

- Ted Freeman does not have the concern of people with long experience in the rehabilitation of brain-injured people in regard to the needs of families.

This criticism of Freeman’s clinical practice is sourced to three concerned, anonymous commentators who deplore his lack of awareness of the needs of patients’ families.

A quick reread of Chapter 3 containing families’ firsthand accounts of their experiences with Freeman will shed some light on this one. Unfortunately, these letters were not written until the mid 1990s, so could not be seen by the three anonyms. But wait. The Macquarie University study that was concerned precisely with the impact of their association with Freeman on patients’ families had been completed by December 1986 (see Chapter 6). This study was funded by the GIO, so its conclusions—very different from those asserted in the conclusion above—would have been accessible to the Report’s authors. Given the evident access to GIO files provided to Cuff Consultants, it would be surprising if the authors of the Report were unaware of the conclusions of the Macquarie study. These emphatically refuted the opinions of the three individuals, which provided the basis for this third Report conclusion criticising Freeman’s clinical performance.

The Brain Injury Treatment Centre’s practices attacked

Whereas the three critical conclusions discussed above related to Freeman as a person, three other adverse conclusions advanced by Cuff Consultants focused on the structure and operations of the BITC. The first was:

- The rehabilitation of people with brain injury involves skills from many disciplines; the rehabilitation process assists both the person and responsible relatives.

The supporting information accompanying this conclusion outlines the variety of skills and resources available to a young woman who had sustained a brain injury, after she had been admitted to the Coorabel Rehabilitation Hospital (this information was presented preparatory to comparison with those skills and resources provided at the BITC).

The striking difference between this outline and the role of the BITC is that the young woman had been admitted to Coorabel as soon as she was no longer in need of ventilator support, some 20 days after sustaining the brain injury. As the most cursory familiarity with the BITC should have revealed, patients admitted to it were not 'fresh' but had previously spent long periods either with little progress, in 'orthodox' rehabilitation facilities, or stored in some type of prolonged-care facility. To express this more crudely, Freeman's patients were invariably 'rejects' not suitable for any(more) orthodox rehabilitation. They had not been regarded as 'suitable for rehabilitation'. Consequently, they had usually been denied access to 'conventional' programs incorporating the multidisciplinary skills on offer at Coorabel.

In relation to this point, a senior lecturer in neurology at the University of Sydney, Dr Michael Halmagyi, who had visited the centre, wrote of the Report that the critics were not in possession of the facts:

[V]irtually none of the critics have been to the Centre or spoken with any of its patients. If it had not been for Ted Freeman's work, more brain injured people would be warehoused and the brain injury problem would have been largely ignored by the government.⁹

Dr Halmagyi provided an excellent example of a practitioner who was prepared to keep an open mind when confronted with new information that was not readily explained. He had originally been critical of Freeman's approach to rehabilitation, in the course of a radio interview, but had accepted an invitation to visit the centre. Freeman recalled, in relation to the visit, that

as we walked around looking at the family and staff and volunteers working with these most profoundly brain injured patients, I could see that he was moved by their plight and the care and concern with which they were being treated. He came back to my room and said, 'Something must be done to help these people.' He offered his support.

⁹ Michael Halmagyi, Letter cited in press release from Professional Public Relations, 2 March 1989.

A second adverse report conclusion is directed to the purported inadequacies of the BITC:

- The Brain Injury Therapy Centre is not staffed for the rehabilitation of brain injury.

This report conclusion is supported by a comparison of staff profiles at Coorabel and at another head injury rehabilitation institution with those of the BITC. Details of bed capacity for which staff had responsibility at the three institutions were not provided. No indication was given as to the comparability of the patient profile. To attempt any comparison between institutions, information such as time elapsed since injury and preceding management of residents is essential. Whereas both Coorabel and the SA facility had many more specialised paramedical staff, the BITC lists 10 registered nurses and three assistant nurses. Coorabel lists 'nurses' without any numbers. The other facility under comparison does not list any.

Without knowing the needs of typical patients in the facilities, and the aggregate workload that they would generate, it is difficult to derive much from this comparison. As remarked in the preceding critique, Freeman's patients consisted primarily of people who had not made it into the rehabilitation programs to which the cited staffing profiles related. During the interval between discharge from acute care until entry to the BITC, they are unlikely to have been in receipt of the attention provided by 'mainstream' rehabilitation. The third adverse conclusion claimed:

- The medical practices preferred by the Brain Injury Therapy Centre are unacceptable to rehabilitation professionals, particularly as they are performed on helpless people unprotected by any legislation.

This section presents brief descriptions of alleged incorrect/inappropriate procedures undertaken under Ted Freeman's auspices, presumably in the BITC. No attribution of the source(s) of these descriptions was provided.

This conclusion hints at the occurrence of illegal practices of which residents of the BITC were the victims. If improper practices are alleged to have occurred at the BITC, they should have been raised with the authorities responsible for oversight of medical practice, as should similar allegations when they relate to events at 'conventional' rehabilitation centres. In this instance, this could be the NSW Medical Board or the Australian Medical Association.

The Brain Injury Therapy Centre's outcomes attacked

The Report's conclusions considered above attack the theoretical basis of Freeman's approach to rehabilitation, his clinical competence, the facilities

available at the BITC and the practices undertaken there. Three other conclusions consist of criticisms of the value of treatment provided at the BITC. The first is that:

- The therapy provided at the Brain Injury Therapy Centre will not improve the overall degree of disability of the patients.

In the background to this conclusion, some statistics drawn from a paper by Bryan Jennett are cited. The greatest prominence among these is accorded to Jennett's statement that 95 per cent of people reach their final outcome level of recovery after brain injury by 12 months post trauma. This figure is coupled with another—namely, that most patients entered the BITC one to four years after their injury.

Referring to the patient and family stories in Chapters 2 and 3, it will be recalled that people coming to Freeman's attention, either in the BITC or elsewhere, had often been deemed unsuitable for conventional rehabilitation programs during the preceding period. Following rejection from the conventional system, placement in a nursing home or similar institution was common. Freeman had agitated, with uniform lack of success, to have his methods tested on 'early entrants' like the person cited above in the report, who had entered Coorabel Rehabilitation Hospital within weeks of her accident.

The only valid comparison group for assessing whether the BITC had benefited its patients would be people with brain injuries of similar severity who had *not* been retrieved from aged or terminal-care placements. One may assume, with considerable confidence, that no health minister would wish to bring *their* histories into the public domain.

A second of the Report's conclusions was that the treatment offered at the BITC would not assist patient rehabilitation:

- The treatment programs at the Brain Injury Therapy Centre are not regarded as effectual programs for rehabilitation of brain injury.

The information on this page is sourced to BITC 'personal communication'. It describes a number of sets of manoeuvres to be undertaken with a specific patient. This is footnoted with a comment from a leading (as usual, anonymous) rehabilitation specialist: 'As a rehabilitation program for someone four years post-trauma, I have to say that it's simply rubbish.'

The supporting information for this conclusion exemplifies the recurrent features of this Report. First, the opinions relating to Freeman's practices are of anonymous origin. Perhaps this was considered to be essential given the defamatory nature of much of the opinion? Second, the content of the Report is almost invariably based on snippets of patient information without any

indication of context. Contextual background information on patient age, nature of injury and preceding patient experience in more conventional rehabilitation services is invariably lacking. Third, comparisons between the patients who had graduated into a group overseen by the anonymous leading rehabilitation specialist and Freeman's patients who had already emphatically failed that test are meaningless.

The history of this patient of Freeman's during the four years after injury would be quite revealing. One's guess is that he or she is likely to have spent most of that time, after rejection as 'unsuitable for rehabilitation', in a warehousing situation of sensory deprivation. The last two words of the leading specialist's opinion might provide a useful description of much of the Report. Who knows?

A third conclusion offered a view on strategies for rehabilitation:

- Gentle, non-intensive 'coma stimulation' programs for a limited time period are the only kind of coma arousal now practised in orthodox medical centres in the US.

This conclusion is based on opinions expressed by three US rehabilitation specialists and one Australian who had visited the United States. The content of those practitioners' comments includes one that the value of coma arousal is unproven, another that it is very difficult to measure the effectiveness of coma arousal, a third that controlled trials would be very difficult to conduct and finally a comment that coma arousal was being used by the respondent at a low intensity.

The sample size from which opinion has been sought is extremely small. Had Cuff Consultants taken the time to read the 1983 volume of the journal *Physical Therapy* discussed above, they would have been better informed. A conclusion that might equally well be drawn from the 26 lines of supporting information accompanying the conclusion is that coma arousal has not been validated and that, methodologically, it will be difficult to do so. The reference in the Report's conclusion to 'orthodox' centres could hardly be taken as something with which Freeman could disagree. His ideas for brain injury management were certainly not regarded as orthodox in Australia in the 1980s. A third Cuff Report conclusion was that:

Freeman's rehabilitation therapy will cost too much

- The therapy advocated by the Brain Injury Therapy Centre could raise the cost of third party claims.

The final section of the Report suggests that the BITC might increase the cost of third-party insurance claims. It is concluded that 'the therapy is more

labour-intensive than the nursing home level of care normally given to people with an outcome of profoundly severe physical and cognitive disability'. Apart from raising the issue of relative costs of the BITC and nursing homes, the Report floats the possibility that there may not be sufficient numbers of people with profound physical and cognitive disability to fill it 'at a desirable capacity'. A concluding point raised in the Report is that the BITC does not have sufficient of the right mix of staffing.

When the Report draws attention to the differences between the BITC and what is 'normally' done in nursing homes, I can at last agree, with the proviso that 'usually' be substituted for 'normally'. One might suspect that the Report conclusion that the BITC might increase costs took account of views expressed by its commissioning personnel.

The original decision of the GIO to fund Freeman's work on behalf of people with severe brain injuries could be seen as substantially humanitarian. One might speculate that, reflecting personnel changes within the organisation, recognition dawned that humanitarian considerations come at a cost. If so, perhaps it became necessary for humanitarian considerations to become more subsidiary to financial ones. When one recalls the enthusiastic response of all participants, including the GIO, to the improvised facilities when the centre opened, the report's identification of the architectural inadequacy of the buildings—potentially, another looming expense for the GIO if the operation were to continue—is consistent with the speculation above.

Specialists implicated in preparation of the Cuff Report

The final page of the Report is headed 'Specialists'. It lists 19 individuals, five of whom are identified by name at various places in the body of the Report. It would be reasonable to infer that all of those listed had been consulted during preparation of the Report, however, it is clear that this certainly was not the case. Freeman's inquiries of two of the named specialists—Professor Sheldon Berrol, Head of Rehabilitation Medicine at the San Francisco General Hospital, and James Lance, Professor of Neurology at the University of New South Wales—determined that they had not been contacted and could not therefore have commented on the report, whilst a third, Bernard Amos, Director General of Health for New South Wales, had met Cuff but had not had any discussion about the BITC with him.

Assessing the Cuff Report

What, then is one to make of the Cuff report? It consistently fails to grasp the concept of testing evidence in a scientific manner. It could be read as an array of opinions justifying the withdrawal of funding support to the BITC. Certainly, staffing changes at the GIO around the time of commissioning the Report resulted in a change of personnel overseeing the BITC. As noted in Chapter 6, Freeman considered that the original GIO decision to fund his approach to management of brain injury was not solely a commercial decision but owed something to a genuine humanitarian concern. If so, perhaps commercial imperatives were reasserting their primacy?

Another puzzling aspect surrounding the Report is the two-year gap, almost to the day, between its presentation to the GIO and its public release by Collins in the NSW Parliament. Collins was to maintain in later years that he was doing no more than reading out advice received from his department. This does not explain why the Report was withheld from the public for two years. Assuming the GIO accepted the findings of the Report in March 1987, it could be convincingly argued that it was deficient in its disbursement of public money in permitting funding of the BITC to proceed for another two years after this. On the other hand, if the GIO found the Report not to be credible, it might have been expected to file it away permanently and allow the moths to have their way, not to release it to the minister when a GIO executive deemed this to be appropriate. One might speculate that the release of the Report was a made-to-order circuit-breaker to afford an opportunity for curtailment of expenditure.

Two opinions of the Cuff Report's overall scientific veracity might be cited at this point. A neuropsychologist from a major university wrote concerning the Cuff Report:

[T]his report will have to be judged of such appalling standard as to be deemed a parody of professional commentary. I sincerely hope it has never influenced anyone's decision making as such could only be a basis for travesty. The author provides us with no definitions, terms of reference, description of methodology, list of working assumptions, account of his own qualifications or operational model for the evaluation of a therapeutic process. Without these conventional niceties the report is fairly viewed as a political document likely to introduce unspecified biases and proceed by exacerbating existing controversy. This particular report is rather worse than that as it purports to introduce relevant evidence. In so doing the author displays gross ignorance on every technical issue raised and a willingness to construct evidence in such a way that it constitutes a deliberate process of deceit.

It is also my view that before a neutral tribunal a very strong case can be made that any administrative decisions and their consequences based on this report were either based on misadvice or irresponsibly taken. If anyone has been foolish enough to take this report seriously I can see many good grounds for having it exposed to judicial scrutiny. After all Mr Cuff has made a vicious attack on an important practitioner working in an area inevitably steeped in human misery.¹⁰

Another reviewer, an educational psychologist, wrote:

I have examined the 'Report of the Brain Injury Division' prepared by Cuff and Associates (March 1987) and have reached the conclusion that this document can in no way be described as a research report.

Summary: This report which roundly criticises Dr Freeman for his lack of research basis, is itself totally without a solid research basis ... Its conclusions concerning both the operations of the Brain Injury Therapy Centre and its medical director, Dr Ted Freeman, are in no way justified on the basis of the very slim evidence put forward in this report.¹¹

In the aftermath of the incorporation of the Report into parliamentary proceedings, Freeman has expressed his opinions on the issue of parliamentary privilege as follows:

There are three basic components.

First, every Member of Parliament must act with integrity and ensure that his or her statements are based on knowledge that is honest and accurate.

Second, any person whose reputation is likely to suffer from adverse comments to be made under parliamentary privilege should be made aware of the charges against him or her and be given the opportunity to refute them before they are raised in Parliament.

Third, a mechanism should exist which allows redress in Parliament for incorrect and misleading statements made under parliamentary privilege.

In relation to the minister's speech, he considered, very reasonably:

Collins had made a series of critical thrusts at me and virtually called me an impostor taking advantage of 'helpless people unprotected by any legislation'.

¹⁰ John Masters, Letter to Freeman, 13 June 1990.

¹¹ Cecile Ferguson, Letter to Freeman, June 1990.

Collins had used a document in the House without ensuring its accuracy. This had done enormous damage to people with severe brain injury and to my work and had blocked a new approach to therapy for some of the most disadvantaged people in the country.

Freeman, and others acting on his behalf, attempted over the course of the decade following Collins' statement to obtain redress in the NSW Parliament. He has described one approach:

I found that there was a mechanism known as a Citizen's Right of Reply. I wrote to the Speaker of the Legislative Assembly seeking such a right. I referred to Collins' comments and wrote—

The comments were detrimental to my pioneering work with those who have been severely brain injured. I have adequate medical support from Australian and international sources to refute the claims made.

The Speaker replied: 'Unfortunately, as the proceedings you refer to predate the passage of the Legislative Assembly's resolution on 26th November 1996, regarding a citizen's right of reply, I am unable to consider your request.'

The events that ultimately led the NSW Legislative Assembly to have a correction introduced into *Hansard* were a reflection of the high regard in which Ted Freeman was held by his colleagues, both in Australia and overseas. As such, they can most appropriately be told in the context of medical support for him, which is the subject of the following chapter. Before concluding this account, however, it would be timely to give an indication of the manner in which the Cuff Report and its uncritical promulgation by Collins was to be used to inflict further damage on Freeman.

One of the occasions on which Freeman was denied access to a hospital when families had asked him to assess their inpatient relative occurred in April 1995. In this instance, the ACT Director of Rehabilitation Services had requested the hospital administration to ensure his exclusion. In response to this, Freeman and two friends—a retired ACT Supreme Court judge and myself—found ourselves sitting in the hospital boardroom facing three others: the rehabilitation director, the clinical superintendent and the dean of the local medical school.

It became abundantly clear as the meeting became increasingly combative that the patients' families were not going to have their wishes fulfilled. The *pièce de résistance* came when the dean, in a superbly choreographed performance, read the Collins statement in its entirety as the definitive reason Freeman was not wanted in that hospital.

Parenthetically, it could be noted that the preceding anecdote related to the hospital at which Freeman's exclusion resulted in his examination of Louise in

the hospital car park (see above). Some years later, during a burst of media interest in brain injury, the National Brain Injury Foundation was contacted to ascertain whether a patient who had improved following a very poor prognosis could be located in time for the evening program. Louise immediately came to mind. Unfortunately, the opportunity to secure some viewing time for brain injury was lost. She was competing in track and field at the Athens Paralympics. As a postscript, it can be added that, at the time of writing, she has this week won a silver medal in the shot-put at the London Paralympics.

Conclusion

A number of reasons for the strong opposition directed at Ted Freeman and his clinical practices were advanced during the 1980s and 1990s. For instance, the claims by patients' families, and in some instances, by the patients themselves, that very worthwhile improvement had occurred during the course of a Freeman program were often flatly contradictory of pessimistic prognoses issued by acute-care practitioners. Similarly, when Freeman espoused community-based domiciliary rehabilitation, he was challenging the prerogative of several groups of medical and paramedical practitioners to make all rehabilitation decisions.

Whilst the above reasons are likely to have loomed large in fuelling opposition, the reason most commonly advanced was probably that Freeman had not presented any scientifically validated data to support his contention that active attempts at stimulation would be of more benefit for people remaining unconscious following brain injury than the established practice of 'wait and see'. The irony of this reasoning was that the 'wait and see' approach was itself totally lacking in any scientific validation. The precept underlying it—namely, that the damaged mammalian brain heals better if sensory input is minimised—was longstanding but remained no more than unproven theory.

Although independent scientific evidence supporting the theoretical basis for Freeman's propositions was unavailable at the time when he was putting them into practice, more recent discoveries have provided some strong support. The ongoing refinement of techniques for scanning the human brain in order to detect activity that cannot be observed by clinical observation has yielded new insights relevant to Freeman's clinical management strategies. For example, it has been established that stimuli with strong personal relevance, such as speaking the patient's name, are consistently recognised by some brain injured people, notwithstanding the absence of any response that is clinically apparent. Another observation has been that responses to stimuli during the early stages of awakening from coma may occur only intermittently, a phenomenon originally characterised by Freeman as 'soft signs'.

One of the outcomes of increasing recognition that Freeman's proposals represented an advance on the prevailing attitude towards rehabilitation after brain injury has been their gradual incorporation into the practice of others. Whilst that incorporation has not usually been accompanied by acknowledgment, there have been some notable exceptions. One of these, provided by neurosurgeon Professor Donald Simpson and already cited above, merits repetition: 'Freeman's work has stimulated an overall improvement in rehabilitation services and he has played a respectable role in the development of rehabilitation in Australia.' This appraisal was provided shortly after the 1989 attack in the NSW Parliament and was a response to that attack.

Paradoxically, although Freeman was criticised for not providing firm evidence of the efficacy of his approach, some of his critics who were well placed and resourced to document the results of the conventional approach had failed to make any attempt to do so. I refer to the BIRP units discussed above, which were unable to provide historical information on the outcomes of rehabilitation programs undertaken with brain injured people.

A few general implications of the responses encountered by Freeman are worth noting. Caution about adopting novel therapeutic responses to any medical condition is quite justifiable. The same cannot be said of the mind-set underpinning the opposition, ranging from the petty to the highly destructive, which Freeman experienced. When a practitioner is not prepared to discuss alternative approaches to the treatment of a patient's condition with a fellow practitioner who is advocating change, that refusal says more about the first practitioner than about the colleague. The complete divergence between Australian and leading international practitioners in their appraisal of any form of therapy is both puzzling and disconcerting. It is not necessary that Australian practitioners follow overseas practice without question. It is necessary, surely, that they be aware of differences between practices. Especially disappointing in this context was the inability of the NHMRC, even as late as 1995, to think again about revisiting an earlier pronouncement.

Finally, and of very general significance, Freeman's case adds to a considerable existing body of legitimate concern about parliamentary privilege. When ministers and those supporting them fail to exercise responsibility before issuing statements that are likely to damage others, often irreversibly once the media disseminates them, that represents a blatant abuse of privilege.