

8. International support forthcoming

If one is to attempt to form an unbiased assessment of the value of Freeman's work, it is clearly necessary to search beyond the hostile opinions some examples of which were given in the preceding chapter. One possible approach would be to examine the extent to which his proposals for management of people with severe brain injuries have been reflected in clinical practice during the three decades since he began to apply them. Another, more direct, course of action could be to refer to evaluations of the man and his work by others with acknowledged expertise in this field. Both will be considered below.

When seeking to assess the value of a clinician's practices by determining the extent to which the direction of the practice of others subsequently came to resemble them, it is essential to recognise that, with rare exceptions, the evolution of clinical practice and the thinking underlying it are likely to reflect a succession of contributions from many clinicians. That said, the temporal sequence of modifications in practice may be quite informative. If, for instance, advocacy by a clinician of a practice that is not generally accepted is followed, some time later, by the acceptance of that practice as legitimate in 'mainstream' medicine, it is possible that the original advocacy has contributed to its acceptance. In its simplest form, such a contribution might be affirmed by its acknowledgment as a citation in the literature.

If modifications of attitudes and resulting practices have occurred through a gradual series of changes, this is likely to militate against direct linkage of contemporary practice to proposals advanced from a single source several decades earlier. It may not be justified to infer that, because more generalised adoption of a particular approach to therapy followed some time after earlier advocacy for it, that advocacy had caused the adoption. Nevertheless, that adoption certainly supports the value of the modifications that formed the basis of the preceding advocacy.

Taking account of the inevitable limitations to tracing the origin of changes in clinical practice, it is informative to scan the published literature on coma arousal over the 30 years since Freeman's original advocacy for change. At the outset, it is extremely likely that Freeman's ideas, although independently derived, would have been strongly influenced by those of US clinicians responsible for the operation of highly specialised rehabilitation clinics such as that of Danese Malkmus outlined in Chapter 4.

International research and practice

A 1994 paper from an Ohio medical centre in the *Journal of Neurosurgical Nursing*, rather provocatively titled 'Early intervention: coma stimulation in the intensive care ward', presented the case for a greatly expanded role for coma arousal at an earlier time after injury. The ideas presented in this paper could have passed as a summary of Freeman's hopes at the time of the 'Westmead' trial described in an earlier chapter. The abstract merits quoting in full:

Coma stimulation is a technique that has traditionally been reserved for patients in a rehabilitation setting. Information regarding the use of coma stimulation in the intensive care setting is limited. An individualized coma stimulation program in the early stages of recovery from brain injury is paramount in stimulating the reticular activating system and promoting brain reorganization. Coma stimulation program development within the intensive care setting includes the appropriate selection of patients and the utilization of the entire rehabilitation team in devising an approach specific to each patient's needs. Planning should include the family, with consideration given to the prior interests of the patient. Ongoing evaluation of the patient's responses should be considered as well as the ease of performing stimulation within the intensive care environment.¹

Freeman advocated the early implementation of arousal programs but, while a few families undertook these informally in intensive care wards, most of his patients had sustained their injuries months, if not years, before attempts at stimulation. The emphasis on family involvement in stimulation and on exploiting a patient's prior interests in this 1994 paper accord precisely with Freeman's aspirations.

Whilst the 2009 Cochrane review of publications on coma arousal to which reference was made in Chapter 6 covered the period 1996–2002, the paper of Sosnowski and Ustik from Ohio noted above, not being a clinical trial, was not considered in it. All of the publications to be cited below, which reported trials, fell outside the period covered by the review.

In 2003, another article published in the same journal, in this instance from the University of Michigan School of Nursing, reported on a small 'quasi-experimental' study undertaken in an intensive care setting. A group of 12 patients was introduced into a 'structured auditory sensory stimulation program' three days after injury and this was continued for seven days. The outcome

¹ Cheryl Sosnowski & Melissa Ustik (1994) Early intervention: coma stimulation in the intensive care unit. *Journal of Neuroscience Nursing*, 26, 336.

in this small group suggested that the program may have promoted arousal. Perhaps more importantly, taking account of criticism of Freeman on the basis of potential harmful effects of stimulation, no adverse effects on parameters of patients' brain status were observed notwithstanding the very early stage of this intervention.²

Also in 2003, two members of the Faculty of Nursing at the University of Calgary published an article described as 'a conceptual analysis', which discusses the comparative merits of coma arousal, based on the provision of high degrees of stimulation and a 'sensory regulation' approach. The latter was described as comprising 'information processing and mediation of reaction to sensory information with emphasis on enhancing selective attention by regulating the environment'. Aside from the comparison, it was noted that both approaches have in common

the belief that the person in a persistent vegetative state may, at some level, be able to perceive and begin to process information and that external stimulation may enhance that process. Nurses interacting with persons in persistent vegetative state are encouraged to think about how they can regulate sensory input to enhance meaning and facilitate information processing for these patients.³

In 2004, another report, in this instance from the Shanghai Second Medical University, examined 175 patients who had been comatose for periods of at least one month. The arousal procedures that were tested included exposure to hyperbaric oxygen, physical therapy and arousal drugs. The frequency of regaining consciousness decreased with the length of the period in coma. Nevertheless, the authors concluded that 'the application of appropriate arousal procedures improves recovery of consciousness in patients with prolonged coma'.⁴

A review from the intensive care unit of a San Diego hospital published in *Critical Care Nursing Quarterly* in 2005 canvassed the question of the adequacy of existing management of comatose patients in the following terms:

Today, healthcare professionals are being encouraged to research and explore the possibility of implementing structured coma stimulation programs as early as 72 hours postinjury in the intensive care unit.

2 Alice E. Davis & Ana Gimenez (2003) Cognitive-behavioral recovery in comatose patients following auditory sensory stimulation. *Journal of Neuroscience Nursing*, 35, 202.

3 Patrizia Tolle & Marlene Reimer (2003) Do we need stimulation programs as a part of nursing care for patients in 'persistent vegetative state'? A conceptual analysis. *Axone*, 25, 20.

4 Jy Jiang, Y. H. Bo, Y. H. Yin, Y. H. Pan, Y. M. Liang & Q. Z. Luo (2004) Effect of arousal methods for 175 cases of prolonged coma after severe traumatic brain injury and its related factors. *Chinese Journal of Traumatology*, 7, 341–3.

Starting early is of paramount importance to a patient's survival, quality of life and overall long-term prognosis. The goal of this article is to educate healthcare professionals (in the hospital setting) about managing and implementing structured sensory stimulation sessions.⁵

A 2010 Chinese report of attempts to arouse comatose patients utilised an approach reflecting its source. The aim of this study was '[t]o observe the therapeutic effect of continuous electroacupuncture for arousing consciousness of comatose patients with severe craniocerebral trauma'. An interesting reflection on the investigators' perspective was their description of the control group as receiving 'traditional western medicine'—namely, nothing more than nursing care. Of 56 entering subjects, all with a Glasgow Coma Scale score lower than 8, half were randomly selected into the acupuncture group. The arousal rate after both one and three months was significantly higher in the group receiving the experimental treatment.⁶

Whether any of the preceding reports owed something to Freeman's publications cannot be determined. What they do demonstrate is that ideas very similar to those espoused by him in the 1980s have been expressed in the 2000s by healthcare professionals working in high-quality facilities. The implementation of arousal programs in an intensive care ward was something to which he had aspired but which had never been possible in the environment within which he was working. All of these papers expressed the premise that patients remaining in coma might have retained some level of awareness without the capacity to indicate this to others. Notable similarities between the approaches described in these reports and that of Freeman, apart from the repeated advocacy and practice of very early intervention, included the importance of family involvement and the value of introducing environmental cues with which patients had been familiar before brain injury. The leading role envisaged for nurses, rather than medical practitioners, evidenced in the authorship of these reports, is also strongly in accord with his beliefs.

The methods suggested to facilitate arousal varied with the institution—strategies varied between structured stimulation and sensory regulation—reflecting local practices, for example, the use of acupuncture in one of the Chinese studies. The description cited above, by Chinese authors, of the 'non-intervention' approach as 'traditional western medicine' provokes reflection on its scientific origins (or on the lack thereof).

5 Carolyn S. Gerber (2005) Understanding and managing coma stimulation: are we doing everything we can? *Critical Care Nursing Quarterly*, 28, 94.

6 Fan Peng, Ze-qi Chen & Jie-kun Luo (2010) Clinical observation on continuous electroacupuncture at Neiguan (PC 6) for arousing consciousness of comatose patients with severe craniocerebral trauma. *Zhongguo Zhen Jiu [Chinese Acupuncture and Moxibustion]*, 30, 465.

None of the reports cited above was contributed by Australian sources. A search of the US National Institutes of Health 'PubMed' web site failed to uncover any Australian papers either promoting or rejecting coma arousal procedures apart from Freeman's publications and one paper from a Westmead Hospital group relating to the abandoned trial. Freeman published a response to this report in the same journal. The absence of local publications with relevance to coma arousal is not particularly informative as, in the absence of novel information, there may be little impetus for practitioners to publish or for editors to accede to that impetus. That said, it hardly suggests the existence of a vigorous culture of research among Australian rehabilitation practitioners.

Evolution of Australian practice in management of prolonged coma

Finding documentation of Australian management practice of people who remain unconscious following brain injury is difficult given the apparent absence of any publications in peer-reviewed journals. One interesting exception has been provided by the minutes of a meeting between the Board of the National Brain Injury Foundation and a rehabilitation specialist from the University of Sydney, Professor Denis Smith. This meeting occurred on 11 June 1993 at the Royal Rehabilitation Centre, Ryde. Denis Smith is reported as saying that '[t]here is now a belief that many of the things Dr Freeman has been saying over the years are true, that is, if you stimulate people at a critical time in their recovery, the prognosis might well be better'.

The minutes continue:

Professor Smith went on to say that institutional services need to be far better than they are, and it is important that they learn from Dr Freeman and others the nature and best type of service that should be provided to people in the community. He added the reason he attended the meeting was that he believes that for a significant number of people Dr Freeman's program is better than the alternative.

Professor Smith stated that Dr Freeman looks after people from his (Smith's) unit who it was felt would be better treated at home. They are not (officially) referred to Dr Freeman but rather are told, 'You can go and see Dr Freeman'.

In contrast with the negative Australian responses to Freeman's ideas and practice, expressed in several ways, which were recounted in the preceding chapter, he received strongly positive assessments from leading clinicians in the

United States and United Kingdom over an extended period. This took the form of unreserved approbation of his monograph *The Catastrophe of Coma*, and of refinements to practice that he pioneered, most notably his Coma Exit Chart.

Appreciation of his achievements also took the form of invitations to small group meetings of leading international practitioners in the field of brain injury. This contrasted with his simultaneous Australian experience of exclusion from participation in meetings of rehabilitation practitioners for the reason, repeatedly given, that others would not participate if he were to be invited. This contrast in assessment of Freeman's work raises questions about some aspects of Australian medical practice that should be concerning. These are briefly examined in the conclusion to Chapter 7. Finally, and most emphatically, his international standing was unequivocally affirmed by letters of support in response to his efforts to have his reputation reinstated in Australia after it was besmirched under parliamentary privilege. These letters are considered below.

International appraisal of Freeman's publications

It will be recalled from the preceding chapter that the attack on Freeman in the NSW Legislative Assembly, which effectively destroyed his efforts to assist people who had not been helped by traditional rehabilitation methods, occurred in 1989. The Australian edition of his first book, *The Catastrophe of Coma*, was published in 1987. The US edition was published in 1989. Responses to it from clinicians who were, arguably, much better qualified to assess rehabilitation after brain injury than any contemporary Australian rehabilitation practitioners provide stark contrasts with the frequently anonymous opinions cited in the Cuff Report.

For example, the foreword to the US edition of *The Catastrophe of Coma* was contributed by Professor Henry Stonnington, Director of the Research and Training Center for the Severely Head Injured at the Medical College of Virginia, Virginia Commonwealth University, Richmond, and Professor of Rehabilitation Medicine at the university. Stonnington was also the Editor-in-Chief of the international journal *Brain Injury*. He wrote:

Dr Ted Freeman is a pioneer. Like many pioneers he does what he thinks is right. He knows that coma patients can improve when handled in certain ways. He has confidence that something can be done in many cases. He has devised a coma care delivery system which relies heavily on family involvement. Who better to help the victim than the family?

The book is not only a must for all the families and friends of brain injury victims but also for the professionals who treat them. Here we have a method of management which is not only sound—even if not proved scientifically—but also one which is fiscally responsible and can be afforded by everyone whether living in a large town or a small rural community.

Congratulations to Dr Freeman for his innovative approach and for all the hope he gives to victims, friends and families.

A number of points raised in this foreword merit emphasis. Apart from his very positive endorsement of Freeman's strategy of working through the agency of the family, Stonnington suggests that the book will be a 'must' for rehabilitation clinicians. Contrast this with the apparently organised attacks on Freeman by a section of the Australian rehabilitation profession, specialty groups such as the Australian Association of Neurologists and a national regulatory body, the NHMRC. Stonnington has explicitly made the point that the absence of 'scientific' proof of a method that has been shown to be clinically sound should not preclude its adoption.

Reflecting on the events surrounding the abortive Westmead trial described in Chapter 6, it would not be unduly difficult to interpret the abandonment of a trial as more of an excuse than a reason for resistance to Freeman's approach. Finally, Stonnington has credited the strategy described in the book with being 'fiscally responsible'. This contrasts with the condemnation of Freeman's approach in the Cuff Report on the grounds of its inferred expense.

A transatlantic appreciation of *The Catastrophe of Coma*, also written in 1989, was provided by Dr Keith Andrews, the Director of Medical and Research Services at the Royal Hospital for Neurodisability in London. He considered:

It is extremely good though to be quite honest I would be very frightened to give it to relatives of patients in my Unit until after they have left us. To have the relatives pressuring us even more to fit in with your recommendations would I think result in closure of the Unit.⁷

Another strong English endorsement of Freeman's work was provided by Dr Clarke of the British Life Insurance Trust for Health Education:

The Catastrophe of Coma—a Way Back, is a really excellent book and I would like to congratulate everyone involved in its production. We have been raising money to distribute free of charge Coma Stimulation Kits to hospitals. What I would like to do is include the book with the kit.⁸

7 Keith Andrews, Letter to Freeman, 20 March 1989.

8 Donald Clarke, Letter to Michael White, 20 July 1988.

Some time after publication of this book, Freeman met Professor George Zitnay, the President of the International Brain Injury Association and the CEO of the US National Head Injury Foundation. He recalls:

He congratulated me on my book, The Catastrophe of Coma—a Way Back. I asked, 'Would the US National Head Injury Foundation be interested in publishing another edition of my book, as it is now out of print?' 'Yes,' he replied, 'we would be pleased to consider such a proposition.' I then showed him the draft of my new book, Brain Injury and Stroke—a Handbook to Recovery, which recorded my recommendations on the rehabilitation of people with a severe brain injury in their own home. 'Would you be interested in publishing this book as well?' I asked. He replied, 'Yes, we may be interested. Could you let me have a copy?' I was very pleased.

Freeman received a letter from the National Head Injury Foundation:

I would like to inform you that the National Head Injury Foundation [NHIF] endorses your publications: *The Catastrophe of Coma—a Way Back* (1987) and *Brain Injury and Stroke—a Handbook to Recovery* (1995). Indeed we would be pleased to be involved in the publication and dissemination of these remarkable books. We at the NHIF applaud and admire your courageous approach to the cause of individuals with TBI [traumatic brain injury] and wish you all the best in your endeavour to champion this noble cause.⁹

But things did not work out that way. In early 1996, Professor George Zitnay wrote that the legal advisors to the US National Head Injury Association had said that the publication of Freeman's books would jeopardise their non-profit status. Professor Zitnay wrote: 'I regret we are unable to act as publishers. However, the National Head Injury Association would be willing to assist in promoting the book and disseminate it through our Catalogue of Educational Materials.'

The preceding assessments refer to Freeman's achievement in devising his approach to coma management, in applying his ideas in a clinical setting and in presenting them in a form intended for, and accessible to, both families and professionals. In the decade following the publication of his second book, the author conducted what was effectively a mobile solo practice, travelling, as described in Chapter 7, to patients' homes. Nevertheless, the development, refining and testing of his ideas continued. Reference has already been made to his earlier attempts to meet a major need—namely, that of documenting the pace of emergence from coma. This was sometimes slow and irregular and could only be observed inconsistently in its early stages.

⁹ National Head Injury Foundation, Letter to Freeman, 17 April 1995.

International acceptance and adoption of the Coma Exit Chart

A second major achievement, resulting from his years of working with patients and their families, was Freeman's introduction of the Coma Exit Chart, described in Chapter 4. As should be evident from reading the stories of patients and their families in earlier chapters, that emergence from coma, although it tends to be well publicised when it occurs abruptly after a prolonged period of coma, can be much more difficult to detect.

Signs of awakening and awareness may be accessible to eliciting and observable at one time of day but not at another. They may be entirely dependent on individually specific circumstances such as the identity of person(s) attempting to elicit a response and objects or sounds peculiar to the individual. Whilst often difficult to document, especially in the early stages, a patient's responses can be a critical guide to further management and prognosis.

Freeman's description of his Coma Exit Chart was first published in the journal *Brain Injury* in 1996. It has impacted substantially upon the management of comatose patients in some leading overseas clinics. Other charts in use overseas have been based on Freeman's original, not invariably with appropriate attribution.

Two appraisals of Freeman's contribution to detecting awakening were also cited in Chapter 4. To summarise their content, Dr Sarah Wilson, senior lecturer in the Department of Psychological Medicine in the University of Glasgow, indicated that she routinely used the chart and that she considered Freeman's work had generated further research internationally. Keith Andrews of the Royal Hospital for Neurodisability in London considered that Freeman's exit chart filled a primary role in the standard UK procedure for assessment of emergence from coma.

In attempting to assign a level of significance to any piece of research, the opinions of well-qualified and independent peers are invaluable. Perhaps even more important are indications of the extent to which the research under consideration has resulted in changing the thinking, practice or research of the persons responding to requests for an assessment.

The assessments of Wilson and Andrews imply that, at least in the United Kingdom, Freeman's Coma Exit Chart had exerted a major influence on clinical practice. Parenthetically, the date of publication of the first paper in *Brain Injury* describing the chart was 1996. This might be placed alongside the opinions being promulgated at that time in Australia about Freeman—for example, the

official opinion of the NHMRC. Reference to the preceding chapter will again disclose considerable discrepancy between the 'home' and the international scenes.

Invitations to present Freeman's research at international conferences

Another yardstick of the extent to which any researcher's contribution is valued by his or her peers is the occurrence of invitations to contribute to the formulation of 'high-level' recommendations. It will be recalled that Freeman was most emphatically blackballed from several Australian meetings (not especially 'high powered') intended to explore possibilities for research into management of coma. The grounds given for exclusion to those endeavouring to ensure his participation were that, if he was included in the program, other potential participants would withdraw.

Taking note of events in Australia, it may come as a surprise that Freeman was invited to some small group meetings overseas at which the other participants would undoubtedly qualify for description as international leaders in the field. A most significant year for Ted Freeman was 1989, as it was for the implementation of his ideas on management of coma, with the attack on both in the NSW Legislative Assembly on 1 March. Again, the contrast between local and international perceptions of his work came into sharp focus.

He was invited by the International Association for the Study of Traumatic Brain Injury (IASTBI) to present a medical paper on coma arousal therapy at the First World Conference on Traumatic Brain Injury, which was held in San Jose, California, in April 1989. Freeman has summarised his impression of this conference:

It was a relief to be amongst professionals who were seeking ways to improve the care of those who had suffered brain injury. It was also fascinating that while the medical profession had been slow to come to grips with this problem in the United States, the neuropsychologists and psychologists had become interested and were forcing the pace of reform.

In September of the same year, Freeman presented a paper on coma arousal therapy at the International Conference on Brain Injury in London. In the course of discussions with clinicians and researchers from half a dozen countries, a proposal evolved for a multinational research study on coma. The study was

envisaged as a collaborative project jointly based in Glasgow, London and Sydney. Taking account of the events in Sydney during 1989, what followed became predictable. Freeman recalls:

Some months after the conference in London, Dr Woods wrote to me asking 'to know urgently whether you wish to take part in the collaborative study'. I replied that the Brain Injury Therapy Centre could not take part in the study because, following the devastating repercussions of the Cuff Report, I knew that no government support or funding would be available to enable the therapy centre to participate in this groundbreaking venture.

Interest in the possibility of some level of recovery in patients who remained comatose in the longer term continued to increase among clinicians in a number of overseas clinics that specialised in their management. In 1991, Andrews reported in the *British Medical Journal* that 15 per cent of patients in the Royal Hospital for Neurodisability who had been diagnosed as remaining comatose six months after brain injury had subsequently improved significantly.¹⁰ In response to this observation, he set about gathering participants for an international working party on the persistent vegetative state (PVS). This resulted in the mounting of a meeting, 'PVS 95', in London in 1995.

The goal of PVS 95 was spelled out in an article in *Brain Injury*, which reported on its outcomes:

The need for a Working Party on the Management of the Vegetative State was identified when several specialists in neurorehabilitation expressed concern that there were no formal guidelines for the treatment of patients in the vegetative state. There had been several working parties which discussed the ethical issues, but none which had discussed the management of patients, which it was felt was required before ethical decisions such as withdrawal of tube-feeding or resource allocation could be made.¹¹

Participants in PVS 95 were invited from the United Kingdom, the United States, Germany, Sweden, Israel, France, Russia, Japan and Australia. The aim of the meeting was to think beyond the prevailing established beliefs about the nature and outcomes of PVS. Freeman was the only invitee from Australia in a highly selective list of those regarded as being at the cutting edge. The extent of selection may be best conveyed by listing the names and geographical spread of the participants, as listed in Andrews' report of the meeting in *Brain Injury* in 1996.

¹⁰ Keith Andrews (1991) Persistent vegetative state. *British Medical Journal*, 303, 121.

¹¹ Keith Andrews (1996) International working party on the management of the vegetative state. *Brain Injury*, 11, 797.

The working party consisted of specialists in neurological rehabilitation, neurosurgeons, neurologists and neuropsychologists from around the world. They were Dr Keith Andrews (Chairman, UK); Professor Graham Beaumont (UK); Dr Francois Danze (France); Dr Mihai D. Dimancescu (USA); Professor Axel Fugl-Meyer (Sweden); Dr E. Freeman (Australia); Dr Zeev Groswasser (Israel); Professor Bryan Jennett (UK); Dr James Kelly (USA); Professor Jean Francois Mathe (France); Professor Alexander Potapov (Russia); Dr Jay Rosenberg (USA); Professor Dr Med. Paull-Walter Schonle (Germany); Dr Henry H. Stonnington (USA); Dr Francois Tasseau (France); Professor T. Tsubokawa (Japan); Dr Sarah L. Wilson (UK); Dr Roger L. Wood (UK); Dr Nathan D. Zasler (USA); Dr George A. Zitnay (USA).

Freeman summarised his impressions of this meeting:

It was a bit daunting to have the responsibility of presenting a medical paper to such an international and distinguished group of people in the august precincts of the Royal College of Physicians. When the time came to give my paper, I walked to the front of the lecture theatre and stood while Lord Walton introduced me.

My paper was concerned with the care of so-called vegetative patients in their own homes. This was a very difficult subject because most of the patients whom I had been asked to assess over the years had been diagnosed as vegetative but were in fact locked in. Therefore I modified my paper in order to provide the hierarchical basis for the regaining of awareness and function, stressing the importance of the family in both diagnosis and treatment.

The introduction to the conference manual contained brief summaries of the background of each participant, written by Keith Andrews. In summarising Ted Freeman's achievements, he wrote:

Dr Freeman has an international reputation for his practical approach to the rehabilitation and long term management of patients in Persistent Vegetative State which is explained in his book, *The Catastrophe of Coma*. He has a particular interest in managing patients in the community and using family and non professional carers to encourage optimal levels of care.

Correcting the parliamentary record

Freeman made a number of attempts during the 1990s to have Collins' attack on him formally refuted in the NSW Legislative Assembly. In the course of

attempting to rehabilitate his reputation, a number of letters from overseas specialists attesting to Freeman's professional standing were collected, and extracts from some of these were included in the parliamentary statement below. One not included, but very informative, was provided in a 2002 letter to Freeman from Ross Harris, formerly Professor of Pain Rehabilitation in the Flinders University Faculty of Medicine. Its concluding paragraph merits unabridged quotation:

In 1999 I visited the University of Glasgow at the invitation of Sir Michael Bond, to meet with members of his brain injury research group—arguably the most impressive body of brain injury researchers in the world. My purpose was to establish collaborative links to support and strengthen our Australian longitudinal research study. At my first meeting with two professors of the University's medical faculty the discussion was all but taken over and dominated by questions from them of me about Dr Ted Freeman and his work in Sydney and Canberra. The statement was made directly to me that Dr Freeman's writings have become much valued in UK brain injury rehabilitation. Furthermore, I was informed that the senior researchers present regard you [Freeman] as one of the most interesting and important contributors to the world medical literature in brain injury rehabilitation.¹²

In accomplishing redress for disparaging statements made under privilege, a possible alternative to the unavailable Citizen's Right of Reply was to request a member of the NSW Parliament to make a statement, and Freeman succeeded in doing this. The *Hansard* records of the NSW Legislative Council, dated 2 December 2002, state that the Hon. Tony Kelly, the Deputy President of the Council, said:

On 1 March 1989 the then Health Minister, the Hon. Peter Collins stated in another place that:

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

The Hon. Peter Collins was understandably reliant upon advice from his advisers, who in turn relied upon a report prepared by management—not medical—consultants. That report is known as the Cuff Report.

I am now pleased to be able to correct the views expressed by the Hon. Peter Collins in 1989 with respect to Dr. Ted Freeman. Some years ago Dr

¹² Ross Harris, Letter to Freeman, 16 April 2002.

Freeman's son, Matthew, died as a result of a brain injury sustained in a motor accident. Shortly before this Dr Freeman had become interested in the longer term rehabilitation of people with brain injuries, and it became his mission in life until his retirement some years ago.

By walking the same path as the families of people with acquired brain injury, Dr Freeman gained insights which few of his professional colleagues shared and which, sadly, some of them dismissed as irrelevant.

Dr Freeman's internationally recognised approach to assisting patients with brain injuries and their families became known as community-based rehabilitation. It entailed learning from his patients in the very best tradition of 'pre-technological medicine' and distilling from his learning a compassionate wisdom which was to offer hope to many amid a barren mindset of therapeutic nihilism. Dr Freeman achieved a rare combination of humanitarian and cost-effective outcomes with his patients.

The reality and extent of Dr Freeman's achievement in pioneering a new response to brain injury can be best appreciated by noting assessments from two disparate sources: patients' families and international authorities on rehabilitation after brain injury. A request made in the mid-1990s by the then MHR for Gilmore, who had taken a strong interest in the subject of brain injury, was answered with scores of letters from the families of people whom Ted had helped. Any medical practitioner would have been honoured to receive testimonials such as these.

This pioneering work on brain injury therapy and intense rehabilitation was recognised recently by Justice Barry O'Keefe in a case in the Supreme Court of NSW—*Northbridge v Central Sydney Area Health Service*—in which Dr Freeman was called as an expert witness.

Justice O'Keefe acknowledged the value of seeking the views and opinions of the family of a person suffering brain injury. In closing I will cite a few recent assessments of Freeman's calibre and of his contributions.

I am writing to express my deepest appreciation to you for your outstanding work in the field of Brain Injury Recovery and Rehabilitation. You have contributed much to families of persons with brain injury (George A Zitnay, Chairman of the World Health Organization, President Emeritus of the International Brain Injury Foundation and formerly President of the Head Injury Association of America).

Dr Freeman has an international status for his work with patients and families who have been affected by the trauma of such profound brain damage (Keith Andrews, Director of Medical and Research Services, Royal Hospital for Neuro-disability, London).

Dr Freeman is recognised internationally for his expertise ... His work has generated further research and is undoubtedly of benefit to patients with severe brain injury (Sarah Wilson, Senior Lecturer in Psychological Medicine, the University of Glasgow).

Dr Freeman's concept of working with brain injury victims and their families early as well as later, when others have given up, is something we all need to follow (Henry Stonington [sic], Founding Editor of the journal *Brain Injury* and retired Professor and Chair, Departments of Physical Medicine and Rehabilitation, Virginia Commonwealth University).

Ted Freeman had at last been able to clear his name.

Conclusion

In summing up this chapter, its striking feature is undoubtedly the contrast it presents if compared with the preceding one. Three differences in content stand out. The first of these concerns the attitudes expressed towards Freeman and his work. The differences could hardly be sharper: in one case, unremittingly denigrating, in the other, universally laudatory. The second difference is in the source of the expressed attitudes. Denigration originated exclusively within Australia; acclamation for his work came predominantly from overseas practitioners. The third salient difference relates to the professional standing of the practitioners assessing Freeman. Those providing strongly positive assessments were invariably pre-eminent, as judged by the positions they held in first-class institutions and also by their publication records. Those responsible for negative assessments could not be classed as pre-eminent on either count. A useful indication of the esteem in which Freeman was held by overseas practitioners is provided by reading the list of invited participants at the PVS 95 meeting described above.

Two reasons were given for attacking Freeman and disparaging his work. The theoretical basis he presented for his clinical approach was not underpinned by laboratory findings. There was consistent reluctance to accept his reports of favourable clinical outcomes attributable to his therapeutic initiatives, a reluctance that was preserved by a resistance to dialogue with the man in any scientific forum. Two responses to these two reasons should have been

evident immediately they were advanced. Laboratory findings supporting the prevailing, very conservative approach to management of comatose patients were non-existent. Favourable outcomes of that conservative approach were attributed to 'natural healing', rather than to any therapy per se, hence the attitude prevailing among most Australian rehabilitation specialists embodied in the belief that 'we are all spectators' (in the recovery process). When the predicted outcomes were not favourable, they could be catastrophic for young people who were committed to four or five decades of life confined to aged-care institutions.

The consequences for Freeman's life of the concerted attacks he experienced—most commonly taking the form of professional ostracism and physical exclusion from some hospitals—were often severe. Freeman, however, is adamant that the consequences for patients and their families—for example, those directly affected by the closure of the Brain Injury Therapy Centre—were much more so.

The relevance of Freeman's efforts on behalf of people living with severe brain injury can be evaluated much more clearly after an interval of 25 years, in terms of both scientific basis and clinical outcomes. The manner in which recent investigation of brain function following injury has supported his theories about recovery is summarised above together with endorsements, by well-qualified professionals, of the value of clinical outcomes possible with his approach. Recognition of that value has been reflected by the incorporation of many of Freeman's proposals into what is now mainstream practice.

A phenomenon attributable to advances in brain-scanning technology and the consequent recognition that patients who are clinically regarded as unconscious may not necessarily be so has been increasing advocacy for the replacement of the term 'vegetative' with descriptions that are biologically more accurate and less crass. It may be recalled from earlier chapters that many of the patients whom Freeman was asked to examine had been diagnosed as vegetative, which exacerbated family distress.