



Physician Heal Thyself

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Received date: 16 Sep 2014; Accepted date: 19 Nov 2014; Published date: 24 Nov 2014

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Introduction

Hippocrates reported that 'No head Injury was so severe that it must be despaired of!' over two thousand years ago [1]. We now divide Traumatic Brain Injury into open and closed varieties, with open brain injury having a communication between the brain and the external world. Closed brain injury can still be a very severe injury, with contusion and oedema. As well as the initial injury there are complicating factors which make rehabilitation difficult. It was previously recognised that a long period of Post Traumatic amnesia meant patients did not benefit from rehabilitation for some time [2]. Similarly associated psychiatric illness [3] and age [4] can limit rehabilitation. Dramatic interventions, such as Hypothermia have been used to preserve Brain Function, but the effectiveness is not generally accepted [5]. Rehabilitation with a trained team is currently the best practice.

The quotation 'Physician Heal Thyself' comes from the Luke Gospel, Chapter 4 verse 23, and is part of a proverb spoken by Jesus on his return to Nazareth. It is thought to mean, "Look at you own faults before criticising others". I feel the literal meaning of this is still very relevant for those who practice medicine. The patient is part of the healthcare team and often learns how to be their own physician. I wish to highlight how this role evolved for me by illustrating it with my case history.

In May 2008, I was involved in a car accident resulting in severe brain injury, while driving an open top sports car in Epping Forest, UK. I have no memory of the accident but have studied my hospital notes, and have recounted what family members, hospital staff and colleagues relayed to me.

A Stag Deer leapt into my car, during the Rutting season, and caused me to lose control of the car and hit a tree. Paramedics and the Fire Rescue Service took 90 minutes to release me unconscious (Glasgow Coma Scale 9) from the car, which was vertically lodged against the tree. My obvious injuries included much superficial bruising, and fractures of my right clavicle, maxilla, and mandible. A Brain Magnetic Resonance Scan showed bilateral Frontal and Temporal Lobe contusion. After a Grand Mal fit I was transferred to intensive care at a neurosurgical unit.

My family were told that I might die that night, and if I recovered I would never be self-caring. I required no neuro-surgery and after a few weeks were transferred to the rehabilitation ward in the hospital where I had worked.

My physical state improved rapidly, but my cognitive ability remained very poor. I was unaware of the ward I was on and the staff working to help me. I was aware of a sombre fabricated world, populated by my dead father and grandfather, and a very fair young girl named Crossie. I gradually gained some insight into my situation and the real world returned, with the fabricated world ending.

My rehabilitation went well with the therapists taking a close interest in my progress. I now realised how badly I had been affected and that I might be able to make some recovery. I felt it important that I took an active role in my recovery and saw myself as a child who had much to learn. I felt comfortable with a strategy which I called "being back at school", as this meant I could progress, if I worked hard.

The therapy team remained pessimistic about my recovery implying I would never regain my memory and that my age (60 years) was a major factor in limiting further progress. I felt very frustrated, realising that if this prognosis was correct my quality of life would always be very poor. This state continued until I walked past an old family home. Although it was 30 years since I had stayed in the house, I found I could remember much of the time I had spent there. This exposure to Experiential Memory had a profound effect on my confidence. I realised that my memories were still stored and patience would allow me to find how to locate them again.

The first stage in my recovery was gaining insight into my brain injury. I found that joint sessions with other patients who had not gained insight into their condition was very frustrating as they made no progress, and their poor cooperation required much input from the therapy staff. This stopped the progress that others would have made.

Special Therapy Approach

My therapy team consisted of two doctors, a speech therapist, a physiotherapist, an occupational therapist and nursing staff. They worked in group sessions with all patients, as group sessions are better for patients when they are done in a specialist centre [6].

As I progressed I was allowed to formulate my own rehabilitation program, and stimulated by contact with a clinical psychologist. His psychometric assessments stimulated me to do Sudoku and IQ tests. I designed a daily timetable for learning, and planned an Independent daily living program with the help of my wife. We both felt it was important to get out of the rehabilitation unit as much as possible. At first it was short walks, but I became disorientated very easily and lost my sense of direction. I found going by myself on the Subway very daunting because I could not initially read the maps. Once I gained confidence it all became easier. At this time I was also having Aromatherapy which seemed to help [7]. I also feel the Psychological support I had helped my anxiety [8]. Once discharge I went to London Zoo, saw films in the cinema, and went to the theatre.

Gradually I re-discovered my previous successes, interests and disappointments. It was like being re-introduced to a younger me. Realising my general ignorance, and seeing what I had been, gave me a great drive to improve myself. I spent time reading up on all topics. I also spent a lot of time trying to remember all family members and important family events. As an inpatient I had been allowed to use the internet, where search engines helped me enormously. This allowed

me to take a different role in my therapy sessions. I changed from being an unfortunate patient who was supervised didactically, to one who participated and questioned what was being done in a more Socratic way. I questioned, not for a single answer, but to gain a fundamental insight and understanding. The starting point to gain insight would be different for others. A musician would start with their instrument, and a sportsman, or sportswomen with their particular sport. This would hopefully start a journey back to where they were before their injury. As I learnt, the most important aspect to convey to a patient is positivity. "Can't do" attitudes may be well intentioned, but will limit patient progress! Advancing age might be seen as senility, and the in-ability to learn, but there are talented, and industrious older people. What is more important than age is appropriate patient application and perseverance.

Conclusion

I have spoken about developing my own recovery pathway, but this would not have been possible without the support of the rehabilitation team. Recovery from Traumatic Brain Injury is a long journey which may take years and requires great perseverance. Progress is made harder by Post Traumatic Amnesia and Psychological issues such as anxiety. It is important to receive Alternative Therapy, such as Acupuncture, Aromatherapy, Massage and other options which are very supportive. I feel that age is overstated as a limiting factor, the pre-morbid personality and the application of the patient is more important.

It maybe that being a doctor helped me, the title derives from the Latin Infinitive Docere meaning to teach. If you are to be a good teacher then you must be a good learner.

Acknowledgement

I would to thank the staff of the Alderbourne Rehabilitation Ward for their help in treating me. Work was unfunded. There is no conflict of interest

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