

Funds asked for head-injury therapy

Shock-trauma advocates tell needs to legislators

By Tom Linticum 9/7/83
Annapolis Bureau of The Sun

Annapolis — Maryland's shock-trauma system is saving more and more head-injury victims, but the state lacks rehabilitation services to help these people rebuild their lives, a legislative committee was told yesterday.

"When you legislators approved money for the shock-trauma system, did it ever cross your mind to ask what happens to these people after they are saved?" Jane Cook, mother of a head-injury victim, asked the House Environmental Matters Committee.

Mavis Male, mother of another accident victim, said she had tried to secure medical and rehabilitative services for her son, only to have physicians question whether it was worth the time and expense to treat the severely injured young man.

"I asked then and I am asking now, was it a waste of money to save his life, and is it a waste of money to improve the quality

of that life?" she asked.

With her son Colin watching silently from a corner of the hearing room, Mrs. Male said, "In 1976, my 20-year-old son was scraped off the road. The seven years since then have been one continuous nightmare."

"These people here today are right," said Dr. R Adams Cowley, head of the Maryland Institute for Emergency Medical Services Systems, better known as the shock-trauma center.

Dr. Cowley said he and his staff have discussed the problems with the legislature for years, but there has been little or no response.

Richard Friswell, executive director of the National Head Injury Foundation, testified that at the shock trauma center, about one-third of the head-injury victims die, while 5 percent to 8 percent are left in comas and the rest require some degree of rehabilitation.

Initial hospitalization is usually for five to 25 days, Mr. Friswell said, but follow-up therapy often lasts for at least a year,

dealing with a variety of problems ranging from loss of hearing, vision and physical dexterity to personality changes. Nationally, the average age of head-injury victims is 19, which means that follow-up therapy can be long and costly if these people achieve normal life spans.

The shock-trauma center now operates a 50-bed rehabilitation unit at the Montebello Center in Baltimore, and there are plans to expand the unit to 100 beds. John Ashworth, shock-trauma's executive director, said there is already demand for far more than 50 beds, and Maryland residents are having to go to facilities in Pennsylvania, New Jersey, Virginia and Colorado.

Mr. Ashworth proposed a task force, including representatives of accident victims, the shock-trauma center and the state departments of health and education, to recommend improvements in Maryland's rehabilitation programs.

Delegate Lawrence A. LaMotte (D, Baltimore county), chairman of an Environ-
See VICTIMS, F2, Col. 6



The Sun/Paul Hutchins

Dr. R Adams Cowley, head of shock-trauma center, testifies before committee, saying that the legislature has given little if any response to head-injury victims' need for rehabilitation.



The Sun/Paul Hutchins

Mavis Male, whose son's life was saved after an accident, poses a question

Funds sought for therapy in head injuries

VICTIMS, from F1

mental Matters Committee work group that will study the topic, said his panel will examine a number of issues before it reports its findings next month.

"We will be working with other committees, looking at things like insurance, the status of the state's operating and capital budgets and our overall health policy," Mr. LaMotte said.

"I know I will be introducing legislation next session to require better insurance coverage for rehabilitation," he added. "A lot of policies cover only certain costs and or have totally inadequate limits. A policy may only cover the first \$20,000 for example, but in cases like these it's not unusual to have costs of

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\$500,000."

Although head injury is 10 times more frequent than spinal injuries, there is much less chance that the victim of head injury will be fortunate enough to find a coherent and expertly conceived rehabilitation program. The problems of paraplegia are fairly stereotyped and well understood, with solutions available for most of them. By comparison, the disabilities after head injury are complex and varied and are seldom fully recognized; even when they are, their management is often difficult. The main reason for this is that mental deficits dominate--and these interfere both with the patients's ability to cope and with the capacity for cooperation with those trying to help the patient. No wonder that therapists not sensitive to the subtleties of brain damage often tend to reject head-injured patients; even families and friends find them a trial. The aggressive muscular approach that so often pays off with paraplegic patients is doomed to failure with most head injuries. Yet many patients make a good recovery, whereas others can be taught to cope with their altered selves and to make a new life by capitalizing on their remaining assets. In this regard, head-injured patients present a challenge, responding to which can prove most rewarding for those therapists who are prepared to make the effort.

--Jennett

Like all trauma, head injury occurs suddenly and without warning. No matter how good the victim's prehospital, hospital, or post-hospital management is, the fear of brain damage is

eminent. Thus, saving the victim's life and protecting his brain is the primary goal and priority in all medical therapies. Many innovative techniques have been developed to accomplish this goal.

Most times, we win -- we save the victim and prevent the damage of brain injury. However, sometimes we fail -- and the victim dies. Even when we win, it is sometimes only a partial victory -- we save the victim's life but his brain does not recover its function as we had hoped. The family is left not

only with their disappointment but with the burden of caring for a family member who is physically well but who, because of residual brain damage, cannot function normally at home, in the community, or in school. The family is often unable to cope with the problem. Even at the state level, there is no help for these families, for we have not provided the resources to better manage the problems of head-injured patients.

Families are left with the questions: Will he ever be the same? Will this last a lifetime: What else can be done? Why did you let him live? What can we do now? What can anyone do? Today, many of those questions still cannot be answered, for many reasons. Some of these reasons, I shall list now.

1. Research - There has been little research applied to head injury. One of the major reasons is that most head-injured victims died.
2. Money - Most head-injured patients who survived had long-term problems, requiring considerable money and care--most coming from the family. Since there were no proven concepts about the kind of treatment needed, these people were cared for as if they were the victims of strokes, birth defects, or other disease entities for which there was generally no hope of the victims showing vast improvement or progress.

We need to look at the problem of head injury and where we can begin. Can we sort out concepts and ideas regarding head injury and simply attack this problem as another disease entity that needs to be studied? Can we look at it, not as an unsolved problem but as a problem for which there is a cure or at least hope of improvement. Don't forget

that these are young people, and, once recovered from their injury, they have many years to live!

Even if the brain damage is insurmountable and the victim will never be completely normal and will always have some problems, shouldn't he be taught other ways of survival and be allowed to become a useful citizen? Maybe the head-injured victim cannot articulate or move as before, but we are in an age of electronics, computers, medical engineering and chemistry. Surely the solution is not to throw ^{up} one's ^{hands} ~~hands~~ in defeat and say, "Why didn't you let him die?"

Look at what has happened to the spinal cord-injured patient— even the quadriplegic, who cannot move any of his limbs. Through therapy, muscles can be re-trained to do functions other than those that God intended them to do. And the quadriplegic often achieves goals that previously were not possible. The surgical replan^ting of muscle groups, the use of engineering devices to help and support muscle and limb groups - all have given an otherwise helpless victim a modicum of freedom so that he can use his brain to think and even earn a living. Groups of interested and concerned people have tackled the problems of spinal cord injured patients and have accomplished more this past 10 years than we would have thought possible a few years back - in fact, we probably would have termed that progress a miracle 10 years ago.

The same can be done with head injury. We need ways to measure the extent of existing brain damage and ways to predict the degree of recovery.

But the head-injury problem still exists and is destroying normal family and community life. Special equipment, laboratories, and people are needed to attack this problem.

We need a systems approach in a head injury center environment. Applying old rehabilitation processes in the traditional way will not solve the problem of head injury, for most rehabilitation techniques have not advanced beyond the 50's and 60's. We need a new approach in all aspects of rehabilitation but especially regarding head-injured victims.

We at MIEMSS are ready to make the ^{forward}~~formal~~ jump. It will not be easy, but we have made great strides in the treatment of trauma victims over the past ten years, and could do even more for head-injured patients if we had the authority and the means.

Since the Second World War, shock and trauma were considered insolvable problems. Then and until recently we heard the same reasons why they could not be managed. A similar negative feeling is hampering our progress toward solving the problems of the head-injured patient. But I believe that the negative thinking is fallacious thinking.

We have built a system of EMS excellence for our state that is unduplicated elsewhere. The same can be done for rehabilitation. The spinal cord victim is now beginning to receive his just benefit through the efforts of many devoted people. Don't you think that it is time that we do the same for the head-injured victim? We need support in helping us solve the problem -- and we need it now.

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Although head injury is 10 times more frequent than spinal injuries, there is much less chance that the victim of head injury will be fortunate enough to find a coherent and expertly conceived rehabilitation program. The problems of paraplegia are fairly stereotyped and well understood, with solutions available for most of them. By comparison, the disabilities after head injury are complex and varied and are seldom fully recognized; even when they are, their management is often difficult. The main reason for this is that mental deficits dominate—and these interfere both with the patient's ability to cope and with the capacity for cooperation with those trying to help the patient. No wonder that therapists not sensitive to the subtleties of brain damage often tend to reject head-injured patients; even families and friends find them a trial. The aggressive muscular approach that so often pays off with paraplegic patients is doomed to failure with most head injuries. Yet many patients make a good recovery, whereas others can be taught to cope with their altered selves and to make a new life by capitalizing on their remaining assets. In this regard, head-injured patients present a challenge, responding to which can prove most rewarding for those therapists who are prepared to make the effort.

Like all trauma, the event occurs suddenly without warning and regardless of the management pre-hospital, hospital and post-hospital, the fear of brain damage is most eminent and thus all therapies are directed at saving the life first with protecting^{g>} the brain ~~as~~ the prime priority. Many innovative techniques have been developed to accomplish this mission. Most times, we win. Sometimes we fail.

In those that we win, there are times when the brain did not recover as we would have liked and, as a result, families concerned with the problem - will~~XX~~ he ever be the same; will this last/a lifetime; what else can be done; why did you let him live!; what can we do now; what can anybody do?

Today so many of these questions cannot be answered now for many reasons. Some I shall list now:

1. Research - There has been little research over the years applied to head injury. One of the major reasons being that most head injury victims died.
2. Money - Most head injury patients who survived, were long-term problems, requiring considerable money and care - most coming from the family. Since previous concepts were invalid as to the kind of treatment needed, these people were treated like strokes, birth defects, or other disease entities with little or no improvement or progress.

The concept of what is the problem, where ~~XWAX~~ can we begin, can we sort out concepts and ideas and simply attack this problem as another disease entity that needs study with the goal of improvement or a cure rather than the negative attitude that its an ^{unsolvable} ~~insoluble~~ problem. Don't forget - these are ~~x~~ young people, and once recovered from their injury, have many years to live!

Perhaps the damage is insurmountable for normality, ^{but} shouldn't these people be allowed to be taught other ways of survival and be allowed to become useful citizens? Maybe the victim cannot articulate or move as before, but we are in an age of electronics, computers, medical ~~XXXXXXXX~~ engineering and chemistry. Surely the solution is not to throw up one's hands in defeat and say, "Why didn't you let him die?"

Look at what has happened to the spinal cord injury patient, even the quadriplegic, who cannot move any of his limbs. The re-training that has taken place in muscle sets to do different functions than that which God intended in order to achieve the goal.

Replanting muscle groups by surgery, the use of engineering devices to help and support muscle and limb groups, all have given an otherwise helpless victim a modicum of freedom so that he can use his brain to think and even earn a living. Tackling the problem by groups of interested and concerned people has accomplished more this past 10 years than we all would have thought ^{as} a miracle a few years back.

The same can be done with head injury. There are needed ways to measure the existing damage, its extent, and to predict as to recovery.

There is needed specially trained personnel to work with and teach these victims. Training

91 grants in head injury are essential to acquire ^{with} ~~personnel~~ ^{personnel} and research ideas. *for head injury management*

personnel There is needed the ~~applications~~ ^{of} many ~~professional~~ ^{personnel} in the basic sciences who understand nerve conduction, ^{anatomy & physiology} nerve tracks, nerve chemistry, psychology, psychiatry and engineers, ^{who can apply their expertise in} the same way we attacked the shock ^{over the years.} problem. It is not simply

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applying old

rehabilitation process, seen in the traditional way, but by a systems approach in a head injury center environment.

Most rehabilitation techniques

have not advanced beyond the 30's and 40's. There is needed a new approach in all aspects of rehabilitation.

especially now the brain injury victims.

We at MIEMSS are ready to make the forward jump. It will not be easy, but in a few short months, we ~~XXXXXXXXXXXX~~ *already* have accomplished more *for trauma victims* than *provided for in the last 5-10 years* and could do even more if we had the authority *we* and means.

Since the Second World War, ~~EMS~~ *Shock* and trauma were the unsolvable problems. We then heard the same reasons why it could not be *done as presented here* ~~done as presented here~~ today. *the above entities managed. The same negative feeling* ~~done as presented here~~ *this is fallacious thinking!* *is apparent* *Finally, What is needed today are people who*

see the problem and who care. *and are anxious to support us in solving the problem* We have built a system of EMS excellence for

our state which is unduplicated elsewhere. The same can be done for rehabilitation. The spinal cord victim is now beginning to receive his just benefit *through the efforts* created by many devoted people. Don't you think it *is that* time *we* *head-injured* *we* ~~did~~ the same thing for the brain-damage victim?