

BREATHE!

Thanks, Dan.

Look, there's no more certain death to an audience's attention than bogging them, YOU, down in MY preliminaries. But I need to, what, disburden myself of a few true confessions.

When Dan called Brain Injury Australia in search of someone who could represent the patient experience at this meeting – in what was a conversation of some length, I...think - I was so transfixed by the words "BYRON" and "BAY" that everything else about it remains a blur. And, almost as soon as my Pavlovian salivation had subsided, first thoughts were: what the hell am I going to say to these people? To keep the canine connections coming, I stick out - good Australian expression? - I stick out like dogs' balls on a program like this. On two grounds, at least. Firstly, I work where your...dust settles. I'm a DISABILITY advocate, the closest thing you'll find, perhaps, to a national level lobbyist for people with a brain injury, regardless of external cause, or age. So – thinking about THIS WEEK'S phone calls - I “do” everyone from the “shaken baby” to the “young stroke” to the chronically concussed sports person to the elderly man who falls off a ladder while clearing gutters, and all points in between.

Secondly, as you know from what you've just heard, I'm not - NOR HAVE I EVER BEEN - a clinician, an allied health practitioner, a medical researcher. Look, my only real credential for being in this job? On the 8th February, 1996 I like to say – in my partly comical, mostly MINIMISING kind of way - I like to say: armed with a bicycle, I attacked two cars. With my face.

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Comminuted fracture right zygoma. Incomplete avulsion right pinna. Four skull fractures. Fracture mid-shaft right femur. Multiple lacerations and abrasions.

Two weeks in hospital. Three weeks in rehabilitation. Back at work – full-time - by August. Which makes it all sound like a... canter. Through brain injury. (I'll come back to that in a moment.)

I'm hardly representative of recoveries from severe brain injury, though I have some glimpses of what LIVING WITH A BRAIN INJURY is like, but perhaps it's more in the nature of having a brain injury as a kind of housemate; a former housemate, one who moved out, and moved on. Or perhaps I did, I can't always tell. However it happened, in the way of housemates, my brain injury left a few things behind – half-empty cartons of milk in the fridge, odd socks, a pot plant or two. Less lost property than mementos, reminders. However it was, if it was me who moved, moved on, that's really all that...QUALIFIES me talk to you today.

Next confession. Needless to say, and in spite of multiple surgeries, in the loopy fog of those days, I can't remember a thing about the anaesthesia. In the almost ten years that I've been in this job – and I field about 300 inquiries a year – I can count on the fingers of one hand those related to anaesthesia. And most of them have come from the children of ageing parents in search of some splitting of hairs on the differential effects of neurotrauma from a fall and general anaesthesia after surgery, to explain Dad's or Mum's delirium. (FALLS are now the leading cause of TBI throughout the developed world, due to ageing populations. Advocating for neurotrauma in older Australians to be taken, well, more seriously is one of Brain Injury Australia's five multi-year public education campaigns.)

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That anaesthesia mightn't necessarily be top of mind for those who interact with Brain Injury Australia is as obvious as the circumstances that ordinarily prevail in neurotrauma. But in 2014, the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland published a large study of accidental awareness during general anaesthesia – finding it happens in around 1 in every 20,000 patients. If fears of finding yourself a surprise guest at your own surgery are any guide – and here I'm thinking of MEDIA coverage of Australian journalist Kate Cole Adams' recent book on anaesthesia – a family's interest in anaesthesia for neurotrauma is likely to begin and end with their loved one being...kept under. The results of your College's own survey work in 2013 might be relevant here as well – one in every 10 respondents thought anaesthetists weren't doctors and a further 50 per cent weren't sure.

So, in talking with my session co-presenter, John Moloney, [POINT] earlier this week, I have HIS permission, at least, to stay downstream of where YOU play. So, I want to spend some time trying to describe who it is that I THINK I...represent, with some stops at the obvious along the way. I hope that you will hear, and forgive, them/ this as old tunes beautifully played.

Soon after I started in this job, like any...politician I wanted to find out how many...constituents I had. I asked the Australian Bureau of Statistics for their best estimate based on their triennial Survey of Disability, Ageing and Carers, disaggregated for brain injury. From its most recent – 2012 - iteration, they came back with 730,000 - crucially, Australians whose brain injury MEANS daily "activity limitations" and "participation restrictions". That number often surprises people. As high. I'm not a statistician, so can't

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debate the finer points of the Bureau's multi-stage sampling technique but I reckon it's still likely an UNDER-estimate, though, when you consider the Survey doesn't – NEVER HAS – captured QUOTE “persons living in gaols or correctional institutions” - where as many as 80 per cent of adult prisoners report brain injury. Neither does the Survey reach QUOTE “persons living in very remote areas”. Only three per cent of the NATION's population live there, but nearly half of them are Aboriginal and Torres Strait Islander - whose rates of brain injury (and it's a very rough rule of thumb) are 3 times that of the rest of the population. AND when you think about the circumstances under which such surveys are conducted - where the respondent has to KNOW they've got a brain injury, IDENTIFY as a person with a disability, as well as one they're willing to share with a complete stranger.

Australia is...blessed with the some of the best, and longest, longitudinal surveys of the outcomes from severe TBI. Their findings, BROADLY, include the following. As many as 9 in 10 people return to the care of their family; their costs of care are over \$100,000 per year; half report losing friends, becoming socially isolated since their injury; only 40 per cent of people are employed 5 years post-injury; they run a 60 per cent likelihood of a major mental illness during the course of their lifetime; half of all marriages involving a partner with a severe TBI dissolve within 6 years of injury; and 1 in 5 attempt suicide.

Take anything from that grim catalogue and I reckon it'll make for a safe marker of unmet need. Yet, at the time I made my request to the Australian Bureau of Statistics, only? 16,000 people with a brain injury (out of a total of 310,000) were using a National Disability Agreement-funded service. Only 21,000 (out of 820,000) were receiving the Disability Support

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Pension. Only 2,200 people with a brain injury (out of 160,000) were using Disability Employment Services (and, while the TOTAL number of participants in Disability Employment Services has INCREASED 7 per cent since 2011, those with a brain injury have FALLEN by 10 per cent).

I may be hanging way too much on just one estimate, but the way I see my core representational-political challenge remains unchanged since the ABS sent me the results of their survey - to somehow solve the puzzle of high prevalence (relative to other disabilities) matched by apparent high unmet need, confounded by low service and income and other support uptake. At the risk of gross stereotyping, a potentially very large number of Brain Injury Australia's "known unknown" constituents comprise men AND women, sometimes in their 40s or 50s, living in their pyjamas being cared for, more often than not, by...mum.

Among the range of answers to that puzzle is seizing every opportunity to hammer the differences between the lived experience of ACQUIRED versus DEVELOPMENTAL disability. For many of the 2,000 or so people who sustain a severe TBI each year, it is also a PRIME OF LIFE disability, occurring right at that point of entry into adult life, and everything that promises: the maximal expression of independence from the constraints of a too-long childhood - leaving home, adventuring in the world of gap years or work, of embarking on further study and so on. For many people living with a severe TBI, they describe it as THE watershed event of their life. (GEOGRAPHICALLY speaking, a watershed's a line, a strip of land that separates two bodies of water – two lakes, two rivers.) What many? most? people profoundly disabled by their brain injury feel most keenly is having been cut adrift of BOTH their past, and ITS imagined future, marooning them on an alienating, and seemingly fixed, present - in

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concrete terms; that they cannot do, or think, or feel as they once did. And it seems clear to me that one of THE FIRST RESPONSES to a person radically challenged by the adaptation to such a disability should be to help them reach for any and all continuities with their...PAST. To try and tap any wellsprings of pre-injury work, diversions, interests, to harness and steer pastimes and passions – AS A MEANS OF...BREACHING THAT WATERSHED. I'm still surprised by how uninterested many professionals who work with people with a brain injury, how uninterested they seem to be in...excavating what person the person in front of them was...BEFORE. A corollary of which - and believe me, there's nothing more RE-disabling - a corollary of which is being thought nothing BEFORE, thus nothing ELSE than the sum total of your...impairments.

I'm not sure how many of you have had dealings – professional or personal – with the National Disability Insurance Scheme, but one of Brain Injury Australia's areas of acute disappointment with the headlong rush to jam 460,000 participants into the Scheme by 2019-20 is the abandonment of the blue-sky-blank-sheet-of-paper planning promise of "trial site" days. Perhaps to ensure that Scheme fits within the funding envelope at full implementation, what WAS going to be a systematic mapping of the QUOTE “reasonable and necessary supports” UNQUOTE to reach long-term goals has given way to a more a narrow, canalised, and curtailed conversation about a participant's future, restricted to immediate needs, and held – more often than not – over the phone. One thing that I suspect has happened once medium-to-long-term goal setting has been cut adrift from planning, and SHORT-TERM planning at that, is that participants and their families accentuate the NEGATIVE, stress what they or their loved one CAN'T DO – on the reasonable presumption that the bleaker the picture painted of disability, the greater the supports they'll receive.

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Because they're not sure what supports might be funded around the corner, let alone over the horizon of their current plan.

Talking about what MOTIVATES social insurance schemes like the NDIS, what motivates INDIVIDUALS - in what's often a life-long struggle to adapt, to come to terms with, their brain injury – allows me to venture UPSTREAM to some of the earliest communications between clinicians and patients, their families and to prosecute the case for how indispensable the use of the imagination is in ACQUIRED disability, as is the dispensation of hope. By imagination I mean not the staring-out-the-window, daydreaming of a desert island kind but something much more instrumental that, I believe, can give physicians more...play with their patients.

Because if I've become convinced of ANYTHING, it's that ANYONE involved in the "human services" business has to not only at least try and transplant themselves in imagination into SOMETHING of the life circumstances of their patient and his or her family – as both a first principle and a starting point, as the foundation for (quickly) building rapport, but also evoke something of the world from whence they came.

Recently, I had someone contact me who'd had a horse...fall on her head. Certainly, a severe brain injury. And a non-compensable one. But she'd been able to afford her own rehabilitation specialist, someone senior, very experienced, experienced in brain injury, someone you'd imagine would be up on the latest evidence from research, someone well-acquainted with brain injury as a disability that often occurs in the prime of life, precisely at that point of entry into 'adult' life – as was the case with this young

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woman – and everything that promises, someone REFLEXLY able, you'd imagine, to transplant himself, in imagination, into the life circumstances of a person trying to imagine what it would be like to come to terms with their recovery coming to an end, let alone the injury itself and, thus, someone to whom such experience had taught the light touch, the human, the humane touch with such a "patient".

When asked what kind of recovery she could expect, how long it would last – common enough questions, you'd imagine – he told her that she could QUOTE "bake a cake" for the second anniversary of her injury and the way she was that day would be the way she'd remain for the rest of her life.

I should stop there to state the bleeding obvious. I didn't witness the exchange. Perhaps no group of people understands better than you the vagaries of memory: that it ordinarily plays tricks; that posttraumatic memory positively bedevils; and to never underestimate the memory-distorting potential of early-stage grief. But I've heard often enough about patients and family members being prescribed the myth of the "two years" that the truth of such experiences takes on a, what, iterative quality. And look, chances are the cake-making advice came with, what, a bit more HAIR on it than she remembered. Somewhere, someone has done the definitive research into how much – the 1, the 2 per cent of (just) the "bad news", perhaps – consumers and family members take away from the countless hours of conversations and consultations with health professionals, what they take away from that deep and long crucible of such life-transforming events as these. And, given the context, can anyone really make misinterpretation-proof, as it were, what for the clinician counts as no more than an opinion informed by experience, by

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what she or he read somewhere, sometime. Well, no. But it's been my repeat experience that statements – such as the cake-baking one – are hastily stored away by patients, their families, taken out regularly, a...MILLSTONE dusted off, re-examined, held up to the light of recovery and recovery measured against it – in the hope they're proven wrong, or in dread, right.

However the cake was prescribed, whatever was said, I have so many problems with “it”, it's hard to know where to start. That, first, it's wrong. As I understand it, recovery from brain injury – in some shape or form – can continue beyond 2 years post-injury; for 5 years, for 10 years or more. Second, you want to learn the first rule you'd know if you'd ever spent a day in your life in the company of people recovering from brain injury? Prepare to be surprised: that the very nature of bell curves is they comprise both normal distributions and outliers. Third, I would have thought that the only mental set professionals could bring to dealings with patients and their families – one that would truly reflect the state of the neurosciences – is one of a general uncertainty that, to paraphrase a former United States' Secretary of Defence, what's known about the brain, brain injury and the brain's ability for repair and recovery are easily outstripped by both or either of the “known unknowns” and the “unknown unknowns”.

Fourth, and this comes at how crucial hope is in the recovery from, and adaptation to, brain injury, why would anyone – their imagination bypassed, or otherwise – consider saying such a thing at all, even out of the most pressing need to inject realism into a patient's prospects for recovery, or even – and I'm bending over backwards here, I know – as some perverse reverse psychology, that the patient will somehow, with a

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drop-dead date threatening, work even harder with the recovery time they have to spend.

Though it mightn't sound like it, I've given some thought – hopefully as DEEP as LONG - to the place of hope in recovery from injury. I'm intrigued – as someone working in disability advocacy from a background in journalism (where “bad news” is nothing less than stock in trade) – by the public's, our preferences (insofar as the media mostly serves them) for narratives about individuals “overcoming” disability (a bit like “beating” cancer) and by the relentless parade of what I've seen referred to as “super-crips” (“super-cripples”). What ‘we’ seem to most crave are those odds-beating, expectations-defying, outlying (back to bell curves) recoveries. And what fuels them all, perhaps, is the hope that triumphs over experience. Trumps...experience.

Hope is commonly defined as the desire for something combined with the expectation of obtaining it. But that doesn't quite capture what, for instance, differentiates it from just plain wishful thinking. One can want to win the lottery and even, in delusion, expect to win. It doesn't seem to me that you can hope – hope (just) for the best - always from the position of one's...couch. Hope, instead, is...active. Hope implies that obtaining what's desired involves – it is the return on, even if the FORTUITOUS return on - effort.

(I take you back to my opening disclaimer – that I've never worked where you do.) Even so, it is hard for me to imagine – as it must have been for this young woman after her 2 years' worth of recovery – a literally hopeless physiotherapy...speech therapy and other therapies delivered in... DESPAIR. Surely, one aim of, perhaps the core aim of, any therapy – indeed, any INTERACTION with ANY professionals engaged with

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patients and their families in maximising the recovery from injury - is to enable the client, and his or her family, to live in hope – REALISTIC hope – for as long as possible?

I hope this comes across as, well, a little more nuanced than my wagging a METAPHORICAL finger at you, with; “watch what you say”. And while I am not sure that the nation’s hospitals or rehabilitation units should necessarily be in the business of dispensing hope – let alone forlorn hope, false hope, hope against hope – neither do I think they should resemble the hell of the 14th-century Italian poet Dante’s Inferno, with “Abandon all hope, you who enter here” inscribed over their front doors. But Brain Injury Australia hears regularly from patients or their families that health professionals – within hours, days, weeks of injury, too early, too soon - gave up hope, told a family member that their injured love one will be unlikely to, will never be able to do x or y, walk or talk – curtailing, dashing, hopes, cutting people off from both their past and future; and, taking my lead from Dante, damning them to an alienating present.

I don’t mean to piss in your pockets either, but I can only...imagine what it would be like - in an age of the quick fix, the miracle cure – how DIFFICULT IT MUST BE to prescribe uncertainty, to counsel patience – that’s P-A-T-I-E-N-C-E; for instance, that (as I’m wont to say) recovery from brain injury’s a marathon, not a sprint. Perhaps it’s no surprise but the research suggests that, while physicians who share their uncertainties reduce the power differential with their patients, it’s at the COST of patient satisfaction. Uncertainty is negatively associated with perceptions of self-confidence, competence and likeability. And those associations were stronger when the physician was...a woman.

I ask you to change places with the mother, the father, the wife, the husband – the bad news broken, the bad news coming to grips with – making that lonely, sometimes daily, trek, in trepidation, through the front doors of a hospital, or a rehabilitation unit. These places must seem like black boxes, with all the mysteriousness and hierarchy of a Catholic mass. And if your only point of reference is the hospitals of Hollywood – clinicians their high priests, god-like in wisdom. Little wonder, then, that patients and families hang on their every word. I don't think this can be overstated once, in imagination, you're able to...trade places.

In further adventures of the bleeding obvious, the last Roy Morgan Research "Image of Professions Survey" – conducted in 2014 – scored "car salesMEN[sic]" lowest for ethics and honesty, who were just below advertisers, who were just below real estate agents, who were just below politicians. But at the other end of the scale, 91 per cent of respondents rated...nurses as the most ethical and honest profession, followed by...DOCTORS, pharmacists then High Court judges.

I've just finished reading an anthology of research into placebo (from the Latin "I shall please")...inert pills, sham surgery, dummy acupuncture and the like. What struck me, among all the theorising about best practice randomised controlled trials, was how little credit was given to key contextual factors: for instance, the physician's role play as heroic healer; that what the physician prescribes, what he or she says about a patient, a patient's prognosis, produces a different, MORE, response expectancy – to use the jargon of psychology (that a patient's, a patient's family's, experience of healthcare depends partly on what they EXPECT to experience) – that what a physician says produces, what, "more"

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response expectancy than what might be said by, say, a hospital orderly, or its CEO.

With all that in mind, I want you to transplant yourselves, in imagination, into as much as you can conjure of MY life circumstances post-injury. Aged 32. GETTING the results of my second neuropsychological assessment. I was 3 months into a 'graded' return to work at the ABC – you might know the kind of thing; 1 day a week, then 2, then 3 etc. I can, I THINK I can remember – my memory wasn't crash hot – individual days, incandescent instants when I thought I was stepping up in recovery, that damaged synapses were somehow re-firing, or new ones swung into operation. And this accelerated recovery hadn't hit that slow, abject taper that – at the time – I thought began SIX months post-injury.

A second neuropsychological assessment was my recovery's dead reckoning. The standardised tests found that my Performance IQ had QUOTE 'declined significantly', that my 'attention, concentration and memory' were QUOTE 'significantly impaired', and that my 'academic potential' would be QUOTE 'significantly compromised'. This for someone – working full-time as a journalist, in postgraduate study part-time and coming from a family of intellectual over-achievers – this for someone rendered, I thought, still sometimes think, dumber. Permanently. So, whenever I choose to remember the neuropsychologist (one of the many luxuries of occupying the high ground of an exceptional recovery is that I get to choose what I remember, and forget) I've always reconstructed him in memory as wearing a labcoat, perhaps with a stethoscope slung around his neck. However he was – and his report was professional and detailed – I think he walked me through the report. I can't remember whether he

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offered me any counselling to go with it. I can't remember him offering me any...hope.

But I certainly remember the sunset.

I took the report and headed home on the train. Walking westward down the street near where I lived in Sydney's Inner West, I was asking then, as I'd been asking with every step down from the neuropsychologist's office, what would being 'significantly compromised', intellectually, turn me into? I looked up into the sunset, one of those sunsets where the colour was so brilliant, so bright, as to be gaudy – hot pink clouds, with fluorescent orange linings. The colours were so UNNECESSARILY bright, they made me smile. Though, at some other time, they might have made me laugh. I thought then, as now, MOSTLY: if this is what being "significantly compromised" feels like, amounts to, I can probably live with it. And I turned the corner to home. Though it's a delicate distinction, I know that this was an expression of resilience, not resignation, not a hope fail, a failure of hope.

Let me explain. Colleagues will regularly say that 'brain injury doesn't discriminate'. And if you're working in injury PREVENTION, for example, I imagine that you'd want to try and capture as many pairs of ears and eyes to your message as possible, to include as many PEOPLE as possible within the ambit of risk of the injury that you are trying to prevent. But brain injury – like other disabilities – tracks social-locational disadvantage: those people at the greatest risk of a brain injury are drawn from exactly the same populations as those at risk of ANY injury – from backgrounds of low income, low levels of education, high levels of unemployment, poor housing and so on. To bring it...home (or to New South Wales, at least) – HALF of the greater Sydney metropolitan area's

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young, risk-taking, severe traumatic brain injuries occur between the longitudes of...Parramatta and Penrith.

That's not the..."world" I came from. And I'd hazard a guess – and whether it's transplanted to Melbourne, to Adelaide, to Perth or elsewhere – that MOST of Australia's 5,000 or so anaesthetists don't come from that world either. I'm no bleeding heart (10 years, 10 months, 10 weeks in journalism will drain that out of you) but many, perhaps the majority, of Brain Injury Australia's constituents were already born behind society's eight ball. Their brain injury also, mostly, serves to add, and add significantly, to their disadvantage. Less than 1 in every 5 of the 450 clients of New South Wales' no-fault Lifetime Care and Support Scheme – who've sustained a TBI from a motor vehicle accident - comes from postcodes with a mean taxable income of \$55,000 and above.

Call me quaint, but in a broader culture of creeping – some would say, galloping – competitive individualism (of sink or swim, with some safety nets) – I just don't reckon that society's capacity for overcoming, its quantum of resilience (of rebounding from adverse events, from trauma), gets shared around equally; between individuals, between communities. And I do wonder, should worry, about the increasing disconnect between the lives of Brain Injury Australia's constituents and those who TEND them: the clinicians, the allied health professionals, the service providers. It's perhaps nothing more or less than a perfectly natural expression of where income inequality meets real estate purchasing power, but Sydney's - and my sense is a similar residential apartheid applies to other Australian metropolises - Sydney's northerners and easterners get a nosebleed adventuring south of Parramatta Road or west of the Harbour Bridge (unless it's for the purposes of 'ethnic' food tourism). Sydney's

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southerners and westerners dare not stray north or east, unless it's to the beach. And you know what happens then – the 2005 riots at Cronulla, for example.

I used to think of myself as...lucky. My thinking's...matured since then. One of the many graces of journalism, IF you can get out and about – and I timed my run PERFECTLY – is you get to see how the equality of opportunity dice get rolled. I've never believed in fate. Nowadays, I don't much believe in LUCK either - let alone, as I can remember a famous rugby league coach once saying; that HIS team, HIS players "made their own luck". I've come to believe, instead, in systems, in structures - whether they're governments, their publicly-funded services, the economies, the businesses that those services depend on for money. And I believe in communities, in families. Don't mistake me, I'm sure an individual's - whatever you choose to call it - their drive, their determination are still crucial, perhaps indispensable, to recovery from any injury, any adversity.

But because I was on my way to work – in New South Wales – I was covered by worker's compensation.

But I got hit...in the right place - when I think about the parts of the United States, Ireland, the parts of Australia that I've ridden my bicycle – I was minutes by ambulance to a major metropolitan hospital.

But I had private health insurance. I wasn't really in any position to exercise my rights to, what, a private room, my choice of doctor.

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But my family were. You see, my mother's a doctor. My sister's a doctor. My father's a...neurosurgeon. Not only did they hand-pick my care, but – unlike the, what, 99 per cent of the individuals and families I...represent, where very often the first time they hear the words “brain injury” is upon entering hospital to visit their injured loved one – my family knew brain injury backwards, frontwards, sideways and, crucially, were directly involved in my care ALMOST at equality with the staff of the hospital. For instance, I was the off-the-rack head case – agitated, aggressive, clearly a... flight risk - in need of both physical and pharmacological restraint. My family was able to engage in the highest level discussion - and debate - with the hospital's psychiatrist about the kind and amount of anti-psychotics and sedation I was being administered - so as not to impede my recovery from brain injury.

It's one of those screamingly obvious life lessons you can only TRULY learn going through something like rehabilitation and recovery from brain injury is; THAT ALL OF US LIVE AND OPERATE IN THE WORLD ARMED WITH, AND PROTECTED BY, THE STORIES WE CAN TELL ABOUT OURSELVES. In my case, an innocent bicyclist hit by not one, but two, cars. (Remember me saying that I could count the inquiries I receive about anaesthesia on the fingers of one hand? The SAME applies to my constituents for whom their brain injury was fully, or partly, THEIR FAULT.) In MY case, double victimhood. And double heroism. The heroism of the physical. I was barely post-prime of life/ the browning ends of my salad days, in the peak of fitness. And...I was on my way to work, to a job. And protected by our LIFE stories – all those accidents of birth, birthplace, of family, and of a person not just born but created. Look, my purchase on the memory of that time in my life ain't crash hot - and I don't deny that thinking from this distance in time can distort things - but I still

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reckon the greatest part of the reason for my recovery IS my life story - the kind of formed, created and supported person - supported by family, by communities of friends and work colleagues - the person I was BEFORE I hit the cars. And all the relative advantages they bestowed - they BESTOW - that I took with me into - and through - my brain injury.

So, when I, again, CHOOSE to remember my neuropsychologist, I realise I've never really forgiven him for letting, NOT ME, but the next someone UNLIKE ME, or the next, or the next – someone with perhaps fewer resources – to simply take that kind of report and walk off into THEIR sunset. It is, I believe, no exaggeration to liken it to saying: HERE'S A HAND GRENADE. I WANT YOU TO HOLD IT FOR ME WHILE I TAKE OUT THE PIN. Now goodbye and good luck. And when I choose to, I can remind myself that no one escapes a brain injury of that QUALITY completely unscathed. Some people have glass jaws. I've now got a glass IQ. And I'll long wonder whether this speech tried a little too hard to be too smart by half.

Thank you.