

Broken bodies and broken minds: the need for a general practice approach post trauma

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For many years I worked as a PRIME doctor responding to major trauma. The highway that wound its way down from the steep bush covered hills to the open coastal plain near where I lived and worked seemed to take offence to the drivers that traversed its asphalt. Shattered steel and twisted car bodies were frequent sights as the highway convulsed and shunted vehicles into each other. My duties as a PRIME doctor required me to deal with the broken bones and bodies, that I not infrequently saw, with alacrity (and to be honest some emotional distance). However, as GPs it is the broken minds of our patients who have been in major trauma, that require us to work with slowness, compassion and empathy.

In this issue Spijker *et al.*¹ highlight the burden of mental distress in survivors of major trauma. Post traumatic stress disorder, chronic pain, depression, anxiety and alcohol abuse are common in the first year following trauma. The authors identified several risk factors, such as young age, length of ICU admission, length of hospitalisation and pre-existing psychiatric illness and substance abuse, and proposed that a brief screening tool be used in primary care.

While I can't help but agree with the sentiment that we should screen for mental distress post trauma I do wonder whether there is a more empathetic approach that we could take as GPs that utilises the art of general practice more than the science. There are some things in general practice that don't fit into tick boxes or algorithms. Recently I saw a patient whose femur had been shattered and she had gone through a long rehabilitative process. Unable to freely walk she now required the permanent use of crutches and had come to see me for the first time since her surgery to request a mobility parking certificate. I asked

her about her wairua and she responded with a quavering voice and tear filled eyes to tell me that it wasn't just her femur that had been shattered but also her sense of identity.

In my patients it is often this change of identity and the grappling with how they fit their damaged self into the world that has the most profound impact on a person's mental wellbeing. John, whose ankle had been badly broken in a motor vehicle accident and subsequently fused, told me how the Fluoxetine that he took helped him deal with the loss of his occupation and function as provider for his whānau. One explanation for the role of identity in both of my patients is the centrality of events theory. This theory proposes that our identity is formed from vivid life events that give structure to our life narrative.² If these events are traumatic then the subsequent reconstruction of a person's identity may have harmful effects on their mental wellbeing and can lead to post traumatic stress disorder or depression.³

Regardless of the underlying theoretical causes Spijker *et al.*¹ provide clear evidence of a significant burden of mental distress following major trauma in New Zealand. While we don't know how many of the patients in this study had received appropriate psychological intervention my deep suspicion is that many had not. The challenge facing us as GPs is how best to deal with this burden and how to provide support for our patients in a mental health system that is currently under substantial stress.

References

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