THE ASSESSMENT OF POST-TRAUMATIC DISABILITY

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"*De minimis non curat lex*" This respectable and ancient tag should surely be kept before us in discussing the subject of the assessment of post-traumatic disability.

Recently, I was giving evidence with regard to the degree of disability from an ankle injury and there was some slight difference of opinion on the medical side about the range of movement which the plaintiff could produce in this joint.

My estimate of the disability was some five degrees greater than that of the medical expert for the defendant, which was the Commonwealth Government. When I was cross-examined on this difference, the judge said, "Come now, you can't make a liar out of a doctor for five degrees". Later on, I asked the learned judge the source of this opinion and he told me that during the depression, when he was present in the Lower House, he heard the present Prime Minister speaking in support of a Moratorium Bill, handling an interjector in very much the same terms. The interjector had queried Mr. Menzies' accuracy on the mathematical result of the clause and his reply was, "Well, as the Honorable Member for Northcote (who was the late Jack Cain) would say, 'you can't make a liar out of a man for threepence' ". "De minimis non curat lex".

The title of this talk was to have been "The Assessment of Damages After Injury". Damage to the doctor means one thing, damages to the lawyer another: money, and this meaning is the popular one. Who has not heard the query, "What's the damage, mate?"

Most claims for damages are made for injuries received either on the roads or at work and the medical man's role in helping to assess these damages is to try to estimate disability.

The Standards of Disability

In times past an estimate of permanent disability concerned only the victim of an injury, who had to adapt his depreciated physique and function to the circumstances of his environment to the best of his ability.

At the present time, the community has accepted the responsibility of trying to express disability in terms of money, and this implies that it is possible to estimate the extent of personal incapacity with arithmetical precision. However, as Gillard, Q.C., implied in a paper before the Medico-Legal Society of Victoria in 1953, it is a difficult task indeed to measure the immeasurable.

Still, society demands to know the variation from normal after recovery has proceeded as far as it will. There are various directions in which the court can look to obtain help in carrying out this difficult task.

I suppose the most important of these is the plaintiff. Evidence may also be obtained from those engaged in the same employment as the plaintiff and from his fellow citizens, but a large proportion of the advice must come from the medical witness and it is largely his responsibilities that I wish to discuss in this paper.

There is only one common ground on which the medical analysis of a physical handicap may stand—that common ground is function. Sentiment, emotion or economics should not, ideally, come into an assessment of disability from a medical point of view; I say ideally advisedly, for it is almost beyond the bounds of human ability to exclude such factors from one's calculations.

Medical evidence, however, should be unbiased and descriptions and assessments of disability rarely vary much; when doctors differ in court it is nearly always on the matter not of disability, but of causability, to coin a word for the sake of euphonism.

Assessment of disability

The physician has an unrivalled knowledge of the human body and should therefore be able to describe deviation from normal with reasonable accuracy; but he lacks training in this skill. To translate this deviation from normal into terms of percentage or into amounts of money should be the function of the various courts of the country.

It is frequently expected of the expert witness that he does express disability in terms of percentage. If he does so, he should be prepared to indicate the method of this assessment.

There is no real uniformity amongst Medical examiners as to how disability can best be expressed and various statutory bodies lay down different standards. I submit that this lack of uniformity and these varying standards are largely the cause when opinions presented differ considerably.

There are, I believe, four separate ways in which disability—especially percentage disability—can be estimated:

1. That based purely on anatomy and physiology; in other words, an expression of the disability in terms of interference with normal function because of a change in structure.
2. That based on loss of the use of a part for the purpose of employment at the date of the injury.
3. That based on the disability of the injured man in the general labour market—the extent to which the person is restricted by his disabilities from engaging in employment in the general labour market.
4. That based on the percentage of time that it is estimated will be lost from work as a result of the disability.

I propose to deal with these in turn.

Disability in terms of function from changed anatomical structure

When used in relationship to the Workers' Compensation loss of life, or both hands or both feet or both eyes, or total loss of part of the body is concerned and a Table of Maims is provided. The question of negligence, of course, is not relevant.

The maximum amount payable is £2800 and a table lays down the figures payable varying from the maximum for the loss of life, or both hands or both feet or both eyes, or total loss of mental process (here we get away from arithmetical exactitude) to £55 for the loss of a toe joint.

The figures laid down for the physical loss of a joint or part of a limb are also accepted as covering the total loss of the use of that part. Partial loss of range of movement of a joint may not be easy to evaluate; an instrument known as a goniometer is in use in the United States but more commonly a simple protractor is used. This, of course, is not precise and variation in the amount of soft tissue near the joint may cause difficulty in the reading.

I have fixed in my mind, I hope, the various easier fractions of a right angle—20, 30, 45 and 60 degrees—and I find that this enables me to estimate loss of range of movement with reasonable accuracy.

The simplest form of medical report is probably the hand chart, used to record the level of amputation which has usually been confirmed by X-ray. There is space provided on these hand charts for description of loss of function over and above that

caused by amputation. The evaluation of disability in cases of amputation or loss of function of terminal joints should lead to little argument.

It is not easy, however, to arrive at the percentage loss of function of a limb if an intermediate joint is involved. I refer, for example, to a man with loss of function in the knee joint with hip joint, ankle joint and foot joint all normal.

It is my opinion, that the doctor, when he has fully described the loss of function has carried out his medical responsibilities —the percentage or monetary loss should be in the hands of the court to decide; however, demands are made on the expert witness to express such percentages and I have adopted the procedure of giving equal value to hip, knee and ankle, or hand, elbow and shoulder.

Disability in terms of the occupation of the injured man

In its narrowest sense, this problem arises in the Workers' Compensation sphere with regard to Commonwealth employees. There has to be a "permanent loss of effective use of a part in and for the purposes of employment at the date of the injury".

An example in my own experience concerns a linesman in the Postmaster General's Department, who fell off a ladder in the course of his employment. Because of an injury to his ankle joint, there existed a permanent disability here of some 50 per cent of loss of flexion at the joint. This was not a grave disability as generally accepted, but it effectively prevented him from climbing ladders with safety—he had, to all intents and purposes, total disability for his "employment at the date of the injury".

A wider approach to this problem concerns not the employment of a man at the date of the injury, but his occupation, for it is obvious that the loss of the left thumb to a surgeon means much more than it would to a barrister. It is in this type of assessment that the evidence of an unbiased witness employed in the same calling may be of great help.

It is of interest when considering this question of disability in a particular job to consider the hand in rather more detail. The hand has three main functions as a motor unit:

(a) grasping by the hand as a whole (a hook),
(b) grasping between thumb and fingers (a vice),
(c) grasping by combined use of palm and digits (as with a screw-driver).

Depending on which of these three functions plays the largest part in a man's occupation, then the degree of loss of function can vary greatly with the same deviation from normal.

Disability expressed in terms of employability on the general labour market

This is probably in general terms the fairest way to consider the problem but it is also the most intangible—many difficulties exist which are capable of no easy solution and a percentage figure here is nearly always a guess—the number that first comes into the head. If the head is an experienced one, it is usually a very fair figure.

The Repatriation Department Tribunals use this method largely. In that Department the role of the Medical Officer is to "assess the degree of incapacity as an appreciation of the amount of disablement suffered by the pensioner as the result of some disease or injury". The report made by the Medical Officer then becomes the expert evidence which is put before the determining authority who assesses the degree of incapacity.

The assessment is made regardless of the pensioner's economic position and consideration is given to the extent to which the person is restricted by his disabilities from engaging in employment in the general labour market and this term is intended to include all classes of employment.

The Fourth Schedule of the Act specifies percentage of the general rate of pension and these percentages vary considerably from those implied under the Workers' Compensation Act in the Table of Maims.

The assessment of incapacity is made on general functional capacity and not with reference to the pensioner's specific trade or occupation.

I failed to apply this principle when acting as Chairman of a Medical Board during my Army service and I earned a severe reprimand. The soldier under consideration was a middle-aged man who possessed a very low intelligence and a dozen children. He had a minor disability but I persuaded the Board to recommend that he be discharged from the Army and returned to the stud, where, it was obvious, he would be of much greater service to his country than as a steward in an officers' mess.

Disability related to expected lost time from work

If monetary loss is the main one to be considered, this is

probably the most reasonable approach, but the figure, of course, can be but a forecast. Such a forecast turned out most inaccurate on one occasion from my experience.

The plaintiff had suffered a permanent disability as a result of tripping over a stanchion support which should not have been present on the deck of a ship. I had estimated that this man's injured back had resulted in a 60 per cent disability based on a combination of loss of range of movement and loss of employability. The medical expert called by the defendant had quoted a figure of 30 per cent and I was cross-examined on this discrepancy. I suggested that my colleague perhaps had felt that the chronic and intermittent nature of the pain might lead to this man's absence from work for about one week in three. This man was awarded damages based on a 60 per cent disability. This award promptly produced 100 per cent disability as the money was spent on whisky which produced permanent total disability. My reward for my perhaps too generous estimate was one bottle of whisky: the special damages turned to alcohol too!

This matter of time off work is a very real one. A man with a painful back may well be able to work for two or three hours at a time and then have to cease because of pain: if he be self-employed, this may present no real problem, but if he is an employee and he must rest or be absent from work frequently, then his employment must be in jeopardy. Such a man, however, may show little disability on physical examination at a given time.

Which of these methods is best? Doctors must be prepared to use any of them or a combination, but an expert witness must, I think, be prepared to state the grounds for his opinion.

Earl McBride in his comprehensive work on Disability Evaluation, states that the factors to be considered are—vocation loss, cosmetic loss, loss of earning capacity and loss of employability in the general labour market. My presentation has, I think, covered all these points except the cosmetic loss.

Assessment of stability

I use this term to cover the problem of assessing whether the disability under review has become stabilized. Not only must the possibility of improvement or deterioration in the plaintiff's condition be considered, but the possibility evaluated of long-term after-effects. It may well be that this is the most difficult

aspect from the medical point of view in the whole problem of assessing general damages.

If the plaintiff is given too much because of an alleged probability which never eventuates, or if a plaintiff gets too little because a probability which has been rejected does eventuate, there can be no review and so many factors are intangible

Oliver Gillard quotes the question of a loss of a limb to a barrister—this may well lead to a more extensive study of his books and a considerably increased earning power.

Two common problems arise in this regard.

Counsel frequently ask the medical expert his view on post-traumatic arthritis in weight-bearing joints. No figures exist to help the surgeon. Each case must be an individual problem and yet his opinion is expected.

More difficult still is the problem of the recovery to normal after head injury (the "post-traumatic syndrome"). This problem is closely related to the question of accident neurosis which deserves rather more than a passing reference.

Accident Neurosis

When "Compensation" sets in, especially in cases of head injury, back injury and joint injury, the assessment or real disability may be nigh on impossible.

In the *British Medical Journal* in April, 1961, Henry Miller —neurologist to the Royal Victoria Infirmary, Newcastle-upon-Tyne—discusses this problem in two excellent articles. [Reprinted in the Appendix to this Volume—Ed.]

He points out that trauma is the major epidemic scourge of our civilization and that the functional nervous disorders which sometimes follow accidents may be in some way related to the machinery that society has evolved to deal with the results of these accidents: indeed, he states, accident neuroses may arise quite independently of physical injury of any kind.

It is impossible to maintain, in cases of accident neurosis, that the victim would be in his present condition if no accident had occurred; but an assessment of pre-accident personality is extremely relevant and often presents special difficulties.

The picture of the post-concussive state is familiar to all of us —headache which may be agonizing, postural dizziness, instability and failure of concentration. How much of this is organic and how much neurotic?

If there is a failure to improve, a neutotic background is very likely.

Miller stresses several important aspects:

1. There is in these cases an inverse relationship to the severity of the injury and a direct relationship to the social status.
2. 25 per cent of the sufferers are unequivocally psychoneurotic.
3. The effects of concussion from sporting injury do not last nearly as long as those from car or industrial accidents.
4. Only two out of fifty unselected patients with accident neurosis were still disabled two years after settlement.

What can be done about this problem?

Neither counsel nor their expert witnesses, nor the judge nor jury, who must assess damages can give a reliable prognosis or even a valid assessment of statistical probabilities—so much depends on one man's assessment of what is going on in another man's mind. We must decide how much of the disability is such as a normal person might suffer—and who is normal?

Related to this problem of accident neurosis, is the equally difficult one of malingering.

The legal profession often deplores the inability of the medical profession to recognize malingering—or at least admit to recognizing it in evidence, though they will in private conversation. It is indeed difficult to decide whether exaggeration of symptoms is conscious or unconscious.

I don't think real malingering is common, though it is human nature to magnify disability—we all do it at times, though the size of the magnifying lens varies. I think we must just agree that a pain in the back is a pain in the neck to the medical expert witness.

The Pre-existing Disability

The important aspect of pre-existing disability from the Medico-Legal point of view is mainly related to the question of causation which is not relevant to this paper.

However, its existence must be sought and its presence considered in the question of final disability.

The use of the terms aggravation and acceleration is fairly wide-spread—aggravation referring largely to cause, and acceleration to disability. Only a very confident clinician will, I think,

be prepared to express an opinion as to whether an injury has accelerated a disability and by what length of time.

I recall the difference between irritation and aggravation in terms of an anecdote which concerns a secretary answering the telephone. The caller asked to speak to Mr. Jones, but there was no Mr. Jones at the address and the enquirer was told so. Three times in the next hour the episode was repeated: that was irritation. Ten minutes later the telephone rang and a voice said, "Jones here—any messages?" That was aggravation.

The doctor as an expert witness

There are very few doctors who enjoy pitting the uncertainties of human nature and the intricacies of physiology against the exacting fire of a skilled barrister in court.

Exposed to this exacting fire a doctor unskilled or inexperienced in the witness box may well be persuaded to change his opinions from those expressed in his original report, but a medical officer should be so honest in his report that his findings could be substantiated by any other doctor completely disinterested in the case.

The doctor should recognize that he has certain advantages as well as certain responsibilities. He starts with a skilled knowledge of his particular subject, otherwise he should not be used as an expert witness. He has a somewhat less skilled knowledge of anatomy and physiology and an above average knowledge of human nature. He is expected to use these to assist the court in assessing disability in three main ways: describing the loss of function, advising as to the stability of the disability and attempting to give a prognosis.

If the counsel is to work well with his expert witness, I would make these points:

1. There may need to be several expert witnesses for one case, and not just to win a count of heads. To assess disability, for instance, in a case of head injury, opinions may have to be sought from neurologist and neurosurgeon, ophthalmologist and general surgeon, physician and psychiatrist.

2. The medical witness called on a question of fact—history and examination—should not be treated as an expert witness unless he is qualified to speak as such.

3. The doctor's role as an adviser should be separate from his role as an expert witness.

A doctor's report and his evidence should be completely unbiased and should bear no relationship to whether the patient is plaintiff or defendant.

The medical profession expects, and its high standing demands that the medical expert witness should be neutral. However, it becomes known amongst solicitors that certain consultants have expressed in the past views on some subject or other which would be advantageous to their client and such consultants are then naturally asked to see the patient.

The legal profession, I am sure, expects more than neutrality from the expert witness and the solution of the problem, I feel, lies in a conference between counsel and the expert witness, unhurriedly, before the case is opened. Here the doctor can act in his role as adviser. He should be ready to discuss with counsel those aspects of his report which can be most favourably developed on behalf of counsel's client, be he plaintiff or defendant.

It should be easy to suggest to counsel, from a technical point of view, questions which could be asked either in the evidence-in-chief or cross-examination, but his part as an advocate should end before he enters the box.

I may be treading on dangerous ground here, advising a neutrality benevolent to one side and perhaps I had better not develop the point. I should like to emphasize again, though, that a doctor should keep his roles as adviser and expert witness remote from one another.

If a doctor goes into the witness box with complete faith in his own report, and prepared if he is uncertain on a point to say so, then he will be giving his best service to himself, his patient and to the cause of Justice.

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