DAMAGES FOR DISFIGUREMENT

By Mr. B. K. RANK

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WHETHER as witness of fact, or expert witness, those of us intimately concerned in the medical management of injury and its aftermath are nowadays regular Court attendants. It is not in the establishment of wrong-doing, but in the difficult problem of assessment of damages that our evidence generally seems to play some important part. Before proceeding to more particular consideration of this current problem of assessment of damages, however, I wish first to make two points about medical evidence in general which seem to me very pertinent to this matter.

One feature of medical evidence, generally misunderstood by laymen and juries, and often, I am sure, misunderstood by legal men, as sometimes too by medical men themselves, relates to the simple fact that medicine is far from an exact science. Despite a current jargon of "modern scientific medicine", it contains vast tracts of speculation and many a gaping hiatus of the unknown. In diagnosis, prognosis and treatment, indeed in the simple clinical observations of morbid conditions, the borderline between statement of fact and statement of opinion, is much closer to the latter than is generally realized. Time and again, statements which are made with aplomb and dogmatic assurance, are but matters of opinion in the particular case under question.

Rightly or wrongly, in the teaching of medicine, the common and the probable are learnt rather in literal fashion as set out in our text books. It is only in this way that a student can get any baseline on which to develop his observations and understanding. Tracts from these same text books one hears quoted in litigation proceedings as a gospel of fact, even beyond the claims of the author himself. There is little place in medicine for the words "always" and "never", though we often use them in our teaching and writing, "I always do this", "We must never do that". When such statements are frequently used or quoted, unfortunate precedents are built up which can even have a prejudicial effect on medical practice itself, creating an unnecessary

attitude of scare towards particular procedures irrespective of their particular merit and application. One hears this time and again in relation to the use of unpadded plasters, or the use of tourniquets. I have never used anything but a type of tourniquet which, according to one commonly quoted authority on tourniquets, should never ever be used.

When it comes to the cause of conditions we are often asked about, generally in attempts to prove or disprove their relationship to injury, for example, after a great build-up of one's personal authority on the subject under question, there is often the cold air of anticlimax. One has many times been regarded as unco-operative, or even stupid, in answering "I do not know", or "That is unknown" (e.g. Cancer and Dupuytren's Contracture in relation to injury). There are many conditions where the cause remains unknown despite what theories the books expound, and the final settlement can only remain with the onus of proof. Repatriation entitlement, as you know, is loaded with this.

My second general point concerns the extreme difference which often exists between possibility and probability. A difference which, I believe, frequently remains unclarified in evidence.

In our practice, we can only work on probability, and yet clever Counsel can so put his questions to the witness that the unwary interprets an exposition of possibilities as the basis of assessment.

On one of those very rare occasions where one had been called to a previous conference, a very spectacular sum for that time was ultimately awarded the plaintiff. I answered truthfully every question Counsel asked as though he had just made them up seriatim going along. They were, in fact, questions I had suggested to him the day before. It concerned a young lady, severely burnt, and ultimately healed with extensive scarring on her legs and nether regions. She was actually exhibited in Court, and asked to show her scar. As she unwound bandages, long since, in fact, discarded, up the length of her legs, not downwards, as would be usual, because when we put a bandage on a leg as a rule we wind them on from below upwards so if we were taking them off we would take them off from above downwards. By some clever piece of trickery not thought of at the conference, she started to unwind the bandages up and the further it got the worse it appeared until the Judge said "Enough". The jury was left to imagine the rest, when in fact little more existed. Counsel asked, "Doctor, what is the future of these scars? What

could happen to them?"—"Breakdown with repeated or chronic ulceration". "If, by the slightest possibility, Doctor, perchance, she married and had children, would this be more likely to happen?" "Yes". And then the final question, "Could such ulcers turn to cancer, Doctor?" "Yes". "Thank you".

So a picture, horrible, but most unlikely, was cleverly drawn, and yet the defending Counsel asked no questions! The point was completely lost, that even if chronic ulceration persisted under enlightened attention, if would nowadays never be allowed to proceed to a condition of malignancy, an index of neglect in chronic ulcers which belongs to a bygone era. What might happen is a far cry from what is likely to happen, as in this case, now a happily married woman with a husky family, scars long since forgotten and most unlikely to give any future trouble whatsoever.

One can only answer a question as put to one—a system by which I find one does not always get the opportunity to tell "the whole truth". Many times, when in a position well-equipped to put perspectives and realism into a claim, I have left the Court with a feeling not only of disappointment, but of sheer waste of time. One has never ever been asked, "Have you any other appropriate information about this condition or this case?"

Now we come to this question of assessment of damages. The reasonable assesssment and translation of damages to financial compensation today poses a social problem of a very high order which must interest all medical and legal men.

Many factors contribute to the magnitude of this problem—the sheer number of potential plaintiffs from the present day accidents on the roads or in employment—the accent given to more spectacular verdicts by a press avid for large headlines—vague but prevalent ideas that only rich insurance companies have to pay up—a general recognition of the falling value of money whenever we cater for the future—recognition, too, that a plaintiff can only come once. All these things must be conducive to extravagant standards in the minds of potential plaintiffs and their relatives—as too of potential jurors.

Whether the determination of damages be the ultimate function of a Judge, as in some States—or of a jury, as in Victoria—does not affect the inherent difficulties in this problem, for which there can be no clear-cut financial yardstick. What can be easily totted up as "special damages" has no counterpart in arriving at "general damages" for every case is different and the

circumstances about it even more widely varied. In the elaboration and colouring of opinion relating to these individual problems, the medical witness must play a significant part—not only the nature of his evidence, but the way it is elicited.

Monetary compensation for "pain and suffering", for "loss of amenities and general disability", and for "loss of potential earnings", each of which result from the injury, are all apparently lumped together in this entity of "general damages", and what goes on in the minds of individuals in computing these separate factors of "general damages" remains a mystery. If it is a difficult task for a Judge, it must be far more difficult for the conglomeration of a jury and there seems good reason for the English practice, where a plaintiff has no right to a jury for personal injuries. However, I am not qualified to pursue that argument.

I would like to take two facets of general damages—the first one, "Pain and Suffering" (so-called) and the other "Disfigurement."

So far as pain and suffering is concerned, how this is assessed in terms of notional money payment is difficult, for we are dealing with an entirely subjective phenomenon. We must consider this under two headings:

1. Pain and Suffering immediately related to the trauma of Injury:

With the average hospital accident case, and with operations involved in its treatment, with ordinary care pain is not a real feature, and if it is, something can generally be done about it. The shocked and unconscious are oblivious and modern anaesthetics are not unpleasant. Nevertheless, pain and suffering in early days and weeks after injury can be a very real thing in certain cases, especially where large, raw surface areas are concerned, after burns, for example, which require frequent handling and multiple dressings. So, too, if there are exposed sensory nerve trunks in open wounds or amputations, and especially where gangrene is going on. There is no pain relating to dead tissue structures, but incipient gangrene, whatever its cause, is a notoriously painful business. This is often seen after severe electrocution injuries. It is why post-radiation necrosis is so painful.

One remembers very specifically those individual cases where pain and suffering was a real and protracted business, but they

are sufficiently few and far between that one does remember them as individuals. I can quote about six by name over twenty-five years where pain and suffering, despite every help we know, has been a nerve-wracking business for all concerned. I have often questioned these very people retrospectively, and it would seem that with the passage of time, this brute type of pain and suffering means little. It can, of course, be described in great detail to a Court by the medical witness in a relative manner, but not very well by plaintiffs themselves, for it cannot be remembered as such. It is but a transient experience, and I am not so sure that, having been put up with and long since forgotten, it really ever deserves more than some token reward. Much of the aftermath is by objective description which can easily be given a very high emotional and unreal colour.

2. *Persistent or residual symptoms of pain or tenderness long after healing is completed:*

This is a much more difficult problem. An evaluation of this calls for the highest order of vigilance and discretion on the part of medical men and its warranty for compensation or monetary reward must be full of hazard for the Courts.

In average wounds, and one can illustrate this "par excellence" in the case of injuries of the hand—a region well-endowed with sensory nerves for obvious reasons, under normal circumstances, symptoms of pain and tenderness in an area of damage generally elicited by touch or use will in time gradually disappear. Stimulation of previously sensitive areas will no longer elicit the central or subjective registration of pain. Add to this, that people learn unconsciously to adjust their efforts that they avoid touch and activities which might elicit unpleasant sensations, i.e., they develop an unconscious protective functioning screen and no chronic aftermath in terms of pain or tenderness remains. Loss of function and earning capacity, then, remain an easy assessment for the surgeon and for the Courts.

Frequently, however, subjective painful symptoms persist, as local tenderness, painful or abnormal sensation (paraesthesia). Assessment of these is a more difficult matter. We, as medical men, have to sort out from these cases with persistent painful symptoms those for which some anatomical reason is apparent, and there are many of them, and those for which there is not. Unfortunately, this is a matter which often is not regarded with the urgency due to it. With care, and perhaps after repeated

examinations, this differentiation can and should be made, so that any obvious cause can be corrected at the earliest opportunity—such things as inadequately covered bone ends, or nerve structures, or the partial damage of nerves and their involvement in scar, or the drag of scar on sensory structures during ordinary function, or hypertrophic neuroma. Careful examination, maybe with a few elements of trickery, will ascertain those who have real reason for sensory disturbance or painful paraesthesia. It is an exercise in anatomical precision and the established symptomatology of known post-traumatic entities. Why, I repeat, it is so urgent to deal with this class, is that if we do not, then subjective responses and reactions to pain become so ingrained that they can remain, despite treatment, as a "functional" overlay or habit. The longer they remain uncorrected, the stronger this functional element becomes, and the more difficult it is to distinguish these cases from the second group who do not have demonstrable anatomical reason for persistent symptoms.

In this second group of cases, persistent symptoms are entirely without known or apparent reason. It may suit them to persist. It is fundamental again that we act in these cases also with some expedition. The correct action is some appropriate explanation to the patient, and to press for earliest conclusion of compensation claims. Unfortunately, however, this does not often happen, and these cases are then complicated by two means—first, by medical mumbo jumbo, namely continued and persistent treatment, trying this, trying that, and the urge to "do something" with the vague hope or theory that it might help. "Physio" so-called—that is, physical methods of treatment, are much widely abused to this end—blue light, red light, wax baths, percussion, ultra-sonic! These methods either get the credit due to the process of time in itself, or else aggravate and underline the subjective reactions and the central registrations of symptoms which the normal individual would long since have subjugated. We can aggravate functional disabilities. No less harmful is a multiplicity of well-meaning and disconnected professional opinions, because these people go, or are sent, the rounds from one specialist to another.

The other factor which so commonly complicates these cases is the administration of the law itself, involving the protracted legal wrangling, interviewing of solicitors and multiplicity of examinations by experts and insurance doctors. Unresolved litigation time works sadly against these people, who hang on

to their symptoms and their clinical picture is complicated more and more by elements of anxiety, at loss of earning by some, or at anticipated loss of invalidity by others.

Whether due to persistent anatomical reasons or unrecognised functional symptoms, there comes a time when residual pain symptoms and reactions are so fixed in their cerebral cortex that they remain indelible. The paradox is that people of more lowly intelligence are more susceptible to these subjective or functional complications of injury which, when they do arise, call for higher court awards. It is my belief that they should be compensated if and as they exist.

I am not referring to cases of open trickery, for the real malingerer is uncommon, for most of these are people of low-grade intelligence and easy to assess. What we commonly refer to as "functional" complications of injury are facts which must be accepted and paid for. Their numbers are probably a monument to poor medicine, uninformed legal advice and the lugubrious workings of the law itself. Not only do uncorrected physical lesions develop a functional overlay, but unresolved functional disability will in time acquire physical handicaps—from disuse, postural deformity or stiffness. End results in either case are equally complicated. We could, I am sure, do much more to recognize the potential functional problem and deal with it by more definitive management where reason exists, and more definitive legal procedures where reason does not exist. Failure on either score by medical men or lawyers must add to the mass of problem cases, with more "functional" disabilities and higher payments and further cluttering-up of the legal machine.

In surgical practice, we pay much attention to the optimum time for reparative procedures. We do not just operate when it suits us, or when it can be "fitted in". Administration of the law seems to give no counterpart consideration to an optimum time for legal recompense and repair, and one sees some appalling effects of this.

Disfigurement

The second component of general damages is Loss of Amenities and General Disability. I can touch only on one aspect of this, and that is "residual disfigurement". This, too, is an increasing present-day problem, so supercharged with subjective and personality reactions that it is futile to generalize. Unfortunately, too, it is a matter which can be played up on an emotional basis

with touches of psychology and psychiatry out of all reasonable perspective.

Quite apart from the objective order of any disfigurement—usually due to face scarring—the ultimate concern to any individual is influenced by many factors. The effect of age and sex is obvious, but general intellect and social status produce the widest variation in the effect of the similar disfigurement in similar age groups. With present-day standards of social and employment values, disfigurement is certainly a handicap to young people. In this age of high pressure advertising, television and modelling, there are many young women whose livelihood and marriage potential depend on a dolled-up face and nothing more, or little else. These are the very types who are shot through the windscreen of a boy-friend's car, and for them, an order of disfigurement, considered minor by other people, may be a serious matter. The effects of acquired face scars on prospective or established marriage relations when the contract was made with an undamaged article, may be far-reaching.

I have followed with interest over the years, the careers of some of the men grossly disfigured in the last war. Some have been quite unaffected, even proud of the blemish, while others with much less to show have suffered obvious handicap and personality reaction.

Disfigured children are a special problem, especially if exposed to the unconcealed and uncontrolled concern of parents. In parental eyes, a disfigured child can never be adequately compensated, and the child is open to an atmosphere of recrimination and bitterness, perpetuated by a mother who stupidly persists in repetitive assertions in front of the child—"She was such a pretty child before all this happened." If the blame for accident can be laid at the driver of a bus or another car, no limit is set to concern and claims.

Most accidents cause multiple injuries of some degree or other, but early preoccupation of concern and treatment is naturally with life itself, or more severe injuries, such as broken bones or head injuries. It is generally about the time a patient leaves hospital that panic about scar disfigurement commences. Early thankfulness for life itself or for what might have been worse soon evaporates. Gratitude for a social system of prompt public hospital attention, eagerly sought and graciously given at the time, may be soured. Blood and bandages are no longer in evidence, and wounds declared healed are exposed for all and

sundry to scrutinize. Broken skulls or legs are soon forgotten, but residual disfigurement will be emotionalised to full capital advantage at this stage.

This is the time that lawyers are consulted, and we see large numbers of cases at this stage, on reference from doctors, solicitors or insurance companies. We are asked to report on the future—what, if anything, can be done; what costs are involved and what will be the ultimate order of residual disfigurement. At the same time, most patients seem to be told that surgeons do wonderful things these days, and so they are led to expect miracle procedures.

To restore some perspective in this atmosphere of early panic, our advice and management must be unwaveringly adjusted to two sets of cold facts. One concerns the normal behaviour of scar tissue with lapse of time, and the other concerns the practical limits and realities of surgical procedures at our disposal.

Let us consider each of these. I hope my medical colleagues will forbear while I give a simple thumb-nail sketch of the healing process and its aberrations for the benefit of our legal friends.

The healing process is a normal body function, no less normal than the function of the organism to reproduce. Like all normal functions it has abnormalities, and the failure to separate the normal from the abnormal is the cause of much confusion. When we have a breach in the surface, such is the elasticity and tension of tissues that a wound will gape to some degree, and there follows in such a wound an orderly sequence of physiological reaction. Fibrinous exudate occurs into the wound and out into the fibrinous exudate is the growth of cells and budding capillaries which make fibrous tissue together, making what we call granulation tissue or proud flesh.

At the same time the surface epithelium grows over this. At the same time in relation to the wound there may be various amounts of inflammatory reaction, swelling and oedema. If such a wound is repaired and the edges brought edge to edge by stitching, this cellular proliferation is a minimum and the growth of epithelium is a minimum. We get healing in a minimum of time with a minimum formation of new tissue. This is what we call primary healing. If we have a big wound the healing depends on the formation of a lot of new tissue and growth of epithelium over the edges, and a second mechanism comes into play and this is wound contraction. Distortion or deformity, is, there-

fore, part and parcel of the mechanism of secondary healing. The point I want to make is that the difference between primary and secondary healing is only one of degree.

There are many abnormalities of secondary intention healing. The wound may become infected and it may fail to heal altogether, especially in a region where contraction cannot take place. If it becomes infected, as any open wound tends to do, then when ultimate healing occurs, you have a hypertrophic, or a thick raised scar.

On the other hand, there is only one complication which can occur in relation to primary healing, and that is what we call keloid. Normally, when a wound is covered with skin, the proliferative process ceases and the scar tissue starts to shrink and contract. For some reason we do not know, and it is a fact that we do not know, in certain individuals under certain conditions the proliferative process does not cease. After the wound is healed it goes on proliferating and spreads out into normal tissues and makes a big lumpy keloid scar.

The normal behaviour of scar tissue is to become less vascular and fade, and it will become far less obvious than the recently healed wound. Much of what appears as lumpy and ugly is due to inflammatory reaction and will slowly resolve. Hard areas will soften, scars will contract in dimension. How many lawyers' letters has one written on this basis? For example, that time will be kindly and we must be patient if we are interested in the optimum end result.

The likely residual effects of normal resolution as a rule cannot be properly assessed until a few months hence. Only then can we give a worthwhile indication of likely residual disfigurement and whether or not we can reduce this. A waiting period also enables us to ascertain the highly individual factor of how people scar, so that we can face with confidence the paradoxical choice of more ambitious or radical procedures for a higher standard of result in those who scar well on the one hand, or on the other hand, to do a minimum, if anything, and gladly accept compromise for individuals who obviously scar badly.

There are many natural factors, some known and some of them unknown, which influence the quality of scar production. We know that age, skin texture and the direction of a scar have a profound effect on its quality, no matter how it is produced, or by whom. Scars in tension lines in no way compare with those in normal crease lines, as noted in comparing a vertical with a

horizontal scar line, on the forehead, for example, or again if we compare an oblique scar in the bulk of the cheek with a vertical scar across the line of the mandible. It is an unfortunate fact that the sex and age group in which best results are sought is often the most difficult and unpredictable. Middle-aged people with wrinkled and relaxed skin and reduced keloid tendencies make far and away the best scars. Tension plays some part in the production of keloid, but in young females especially, the erratic basis of scar hypertrophy and keloid reaction is still, in the main, an unsolved mystery.

"How long must we wait?"—"The longer the better, but about three to six months is the usual order of time". Where it is apparent that improvements can be made, it is unreasonable and rarely practicable to wait indefinitely, but if in doubt, one might well postpone decisions concerning operation for longer periods.

Such is the normal behaviour ot linear scars. All this requires lucid and confident explanation to oil the troubled waters and deflate prevalent ideas of urgency and alarm.

What can surgery achieve? Confining our attention to the common scar disfigurement resulting from road accidents, namely front seat passengers injured by impact and broken glass, among the chief principles are:

(a) Normal contours are more important than scars. Bumps and irregularities make shadows and highlights which cannot be camouflaged. The common contour defects are the stepped or serrated scars often resulting from haphazard conditions of primary repair avoidable and unavoidable, or from organized haematoma. Any linear scar will contract in its length and if it is in the segment of a small circle, it will bunch up the tissue it surrounds to make the ugly jagged little lumpy scars we commonly see from the undercut wounds of small splintered glass fragments. These are corrected by turning them into linear scars, or if larger, breaking them into angled linear segments.

(b) Wide scars can be reduced to acceptable linear scars. If in natural lines and not crossing concavities, such as the lateral nasal groove, for practical purposes they leave negligible disfigurement.

(c) Scars in unnatural lines and directions or which tend to web concavities can often be much improved by rearrangements involving flap interdigitation generally on the "Z" principle.

This gives relaxation in the scar line at the expense of tension in an opposite direction. Long scars in unnatural lines may also be improved in this way—but not the vertical scar up the forehead, many of which are best left alone if otherwise acceptable.

(d) Those obvious scars adherent to deep structures, especially the face muscles, can also be improved by flap rearrangements or a layer repair, ensuring a fatty plane beneath the skin wound.

It is a significant fact that much of what we do at an elective secondary procedure in accident cases is exactly what we would elect to do under favourable conditions at a primary repair. Most of the primary work is done in public hospitals. In view of the increasing demands for this work, the large amount of money which is spent on secondary corrective procedures, litigation costs and figures of compensation awards, teaching and hospital organizations should pay more heed to this problem than, in general, they do. Few hospitals are geared to the demands for definitive primary repair under the conditions which are indicated. I believe the biggest contribution of the Plastic Surgery Department in any hospital is the teaching and training of housemen in this direction. This is fast improving, but it is yet far from ideal.

In spite of our respect for time and natural processes, there are some indications for earlier surgery. Scar contraction, causing dysfunction, may require early correction, scar ectropion involving eye exposure being the classical example of this. Other indications are for foreign bodies, glass or ingrained dirt. Foreign bodies in general promote deep scar and reaction, and we would wait indefinitely for softening and ideal local conditions. The almost insoluble problem of a severe diffuse tar-ingraining warrants every order of precaution or trouble at its earliest recognition and management.

How is ultimate disfigurement assessed in terms of money? This I have never yet been able to fathom. One is often surprised by apparently fantastic or incongruous figures awarded in the courts on this score.

I have said the likely effects of scar must be considered in each case. Nevertheless, once we have the indication of how the individual scars by passage of some time, three to six months, the sooner litigation procedure is completed, the better. Rather than wait for the ultimate, I believe it is very much in a patient's

interest and well-being, and I believe it will little affect his financial compensation, to settle his case before any plastic repair operations are commenced. Costs can be allowed for and a fair estimate of the ultimate order of disfigurement can be made. The waiting and suspense associated with legal procedures and pending litigation again add elements of anxiety and many complicating factors, including the patient's ultimate attitude to the effects of surgery. If a patient receives a reasonable settlement, and his surgeon can exert some pressure to this end, he can elect his operation in his own time, it becomes his choice, his responsibility and his pride. He is more likely to be pleased. The operation becomes his own concern, and it is surprising how many who have earlier created much song and dance, after settlement of their cases, ultimately decide to stay as they are and not proceed with surgery. The urge to cash in is a very real thing.

In this somewhat rambling discourse, which I am the first to admit has very little to do with the title, I have tried to indicate that we are dealing with very complex issues, in which the personal elements and implications are such that generalizations and precedents can play little part.

If the medical witness is to be used to best advantage in the solution of these problems, I believe it involves far more than the formal writing of reports. There are many points that just cannot be properly set out in simple language in a report, without being open to much misinterpretation and half-truths. Some of us are a little wary of what we write. There are two directions, I think, in which we can do much in the public interest to alleviate this present-day problem of settling damages.

First and foremost is to keep as many as possible of these matters out of the courts. This can be done in various ways.

There are many trivial and stupid claims where plaintiffs are "on the make", which I am sure doctors or lawyers could prevent at first consultation. I am staggered at some of the cases I see, quite beyond the bounds of common sense, which, I am sure, could be resolved by a few minutes' straight talking. In the Welfare State, where more and more hand-outs are available, and citizens have more and more rights, they expect more. It is a vicious circle. In my short experience, there is no question that the relative numbers chasing compensation with some grievance or other are on the increase. Any social service is embarrassed by pandering to the many at the expense of the more deserving unfortunate few. By that I mean the vast multiplicity

of small pension or compensation hand-outs for trivial disabilities drain off much of available funds which would be better added to more care, and compensation settled more promptly, for the more severely disabled. Furthermore, the administrative machinery for claims and hand-outs is cluttered up by the numbers in the queue. We see this very clearly in the Repatriation Department and the National Medical Benefits Scheme. Politics and votes are doubtless the basis of this. The more severe the handicap, the less the relative compensation. It is a law of diminishing returns. In our National Health Service, there is a closed upper limit, and the percentage rebate gets less and less, the more deserving the case. When one reads the current figures of numbers awaiting litigation proceedings, nicely featured on occasions by Frith, the same process is at work. I see it in my consulting room every week. Patients referred by solicitors are embarking on what we know will be long, delayed wrangling for some trivial aftermath of injury. I think in both professions we have some obligation in this regard to keep a strong element of perspective in the advice we give and to ensure that reasonable settlement offers are gladly accepted.

Next come the large majority of patients, or plaintiffs, as the case may be, with obvious and adequate reason for compensation, most of whom, I believe, can be well advised to accept reasonable settlements. One sees many people who have been advised to proceed with Court actions who, if talked to with reason and their expenses are met, and future expenses reasonably catered for, are happy to accept settlement with thankfulness to providence in realization that the injuries could have been much worse.

The long time lag between accident treatment and ultimate legal settlement is a defect in legal administration. This may be understandable sometimes, in relation to assessment of damages, but in the establishment of a wrong-doing, is it necessary? Why can't the two be divorced?

Thirdly comes the residuum of gross or problem cases where litigation must be necessary. Legal men, like the Courts, would perhaps be able to devote far more time and thought to these if the congestion were relieved as I have been indicating.

The second means by which I believe we could contribute to better justice concerns our mutual professional relations.

If the problems I have touched on are real and as common as I suggest, it would seem reasonable to have some proper conference or briefing of a medical witness. Yet in practice I have

been struck by how rarely this is applied. It is possible to help and advise that particular points are brought out in evidence to favour either party, and it is up to the opposing party to highlight contrary facts and viewpoints. It is difficult, however, to do this in a formal written report which most barristers seem to accept and go no further. Under these circumstances, more often than not, one leaves the witness box with a feeling of incompleteness and lost opportunity which enlightened previous discussion would never have let pass.

In the medical management, both of painful symptoms and scar disfigurement after injury, I have endeavoured to indicate that there may be elements of urgency or it may be equally important to postpone action. Furthermore, when the optimum time does arise, the sooner we get on with it, the better for all concerned. Surgeons pay much attention to the time factor—that correct things are done at the correct time. I am suggesting that perhaps no less important is prompt legal attention and finality. If cases drag on interminably because the legal machine breaks down with the weight upon it, this is prejudicial to optimum rehabilitation and health of body and mind. As in all things with an expanding population, the supply of legal attention will inevitably drag years behind. There seems no end to the vicious circle of matching supply to demand. Everyone seeks and enjoys the advantages of the mechanical age, but no one accepts any of its disadvantages. If litigation is to proceed at the earliest opportunity, it is clear that the solution will not come from more law courts, but from the cultivation of more reasonable-mindedness, and a more aggressive policy by our learned profession in keeping cases out of the courts.

Discussion

MR. W. KAYE, Q.C.: It is not a matter of clever Counsel at all in litigation, yet it is most important that the medical witnesses should remember that when they give evidence that is not the end of the case. A doctor comes into Court, he is one of many witnesses, and he leaves the Court after having given his evidence. Then there are the addresses and then there is the Judge's charge, and it is wrong to assume that because the doctor was not cross-examined about something which to him might seem very, very important, and no doubt that it will be accepted by the jury in the sense that he thinks it has been brought out from him.

It is not the function of a doctor, to come into Court to

get damages for somebody or to deprive somebody of full damages, and in fact that is not what happens. What happens is that a doctor gives his evidence and subsequently there is a discussion about it. The judge will say to the jury when they have been told that this could turn to cancer, as in the case of Mr. Rank's, "That is not the test. The test is the probabilities". The good judge will advise and inform the jury not to be guided and not to award compensation for the fact that a condition of chronic ulcer could turn to cancer, and compensation is not in damages assessed in that way.

Gentlemen, I was very interested to hear the doctor's plea for this unreasonable time or unreasonable delay in bringing cases into Court. That is a problem which we, as members of both sides of the legal profession, are well aware of, and we join with the medical profession in hoping that litigation can be brought to an end promptly. We are aware that in so many of these cases the delay does not facilitate proper or reasonable resolution of claims, but unfortunately some of the blame does lie with the legal profession, and some of it lies by reason of things that we have done in recent years. We have a thing that is called a Certificate of Readiness. This has been a scheme that was introduced in the hope that it would cut down the delay by making solicitors indicate whether a case was ready to proceed. What has happened has been that whereas previously cases sometimes were delayed for, say, 18 months or two years, some of them now take a lot, lot, longer.

Gentlemen, the matters relating to disfigurement, from the purely technical side, appear to me to be very interesting. Mr. Rank referred to this matter of the delay, and he also mentioned the fact that there are increasing numbers chasing compensation. We must acknowledge that; this is a growing community, and the population is expanding. There are more people who are associated with industry and who are subject to and exposed to all sorts of physical risks, and accordingly we have to accept the fact that there will be increasing numbers of people injured and maimed, who, in turn, are claiming compensation—whether in the form of Workers' Compensation or common law damages. It is not our function to say to people, "Do not claim what the law says you are entitled to." The law says, a person who has been maimed or injured, is entitled to compensation in one out of two forms, and accordingly, it is up to us to tell them what they can have, and to get it for them. On the other hand, we cannot

say, "This is a terrible thing—there are too many people seeking compensation", because that is outside our function.

Perhaps the real answer to it is that it is a matter for increasing safety measures, better research into road accidents and things of that nature, but that is also outside the function of our two professions. Indeed, it seems whenever any one thinks of amending the Road Traffic Regulations, the last section of the community that is consulted, if even thought about at all, is the legal profession.

I think that there is not a legal member in the audience who would not agree that conferences between medical witnesses and counsel are very essential, but, there again, there are two problems associated with that. First, is to get the medical practitioner to attend a conference, and next is the question of costs.

From our point of view, it seems that there are two kinds of disfigurement that are commonly met in everyday practice, and those are the disfigurements to parts of the body which are not normally exposed to the view of others, and those that are commonly and daily seen by others. The first type of disfigurement covers what can be seen in the daily papers anyhow, as the female sheds more of her clothing, but, nonetheless, that is a form of injury that has to be considered. My experience has been in this connection that juries, in particular, do not want to see that sort of injury. I have never had the experience of seeing a lady unwind a bandage in Court to show a disfigurement on a part of her body which would otherwise be concealed. Indeed, in those cases where a woman before a jury shows a readiness to expose a scar in an area such as that, generally the damages are reflected the other way—the damages are disappointingly low. Australian juries seem to be a bit prudish about that.

On the other hand, so far as the scars which are visible are concerned, what compensation is really awarded for in these days is what subjective effect it has on the person. Physical or facial disfigurement, invariably, is much more important for a woman than it is for a man, and, once again, juries are not terribly interested in what the state of the injury was in the initial stages. The juries are concerned to know what is going to be the ultimate effect of this injury, and this seems to be where there is quite some problem, which I did not fully appreciate until tonight.

Mr. Rank says the best thing to do is for the claim to be resolved immediately, or, quickly at any rate, and that we

should not wait until surgical intervention has taken place. But, on the other hand, the jury has to be satisfied as to what the condition is ultimately going to be. Very often, we advise the client to defer making the claim until he or she has undergone a form of plastic surgery, because as a result of our experience, it seems that juries want to know what a person's face will look like when all this surgery has been done. They will often enquire of the surgeon, "Can you improve these scars?" or "How are the scars going to look in the future?"

I suggest, if we adopted Mr. Rank's suggestion to bring on the claim immediately, that is, presenting the patient to the court in the form in which he or she appears, without any surgical intervention, the damages in fact would go up considerably; litigation would become much more prolonged, because you would have two or three doctors coming into court expressing different views. One would say, "You cannot do anything with that," and another one would say, "I can remove these scars," whereas, it is probable the person concerned will not have any signs of disfigurement at all later on. On the other hand, you may have a third doctor who will say, "Oh well, there will be some improvement, but not very much." and accordingly, the jury will probably come to the conclusion, looking at the plaintiff, "My word, there is a great risk that she will not get much better", and this is the point on which I disagree with Mr. Rank, when he says we should bring on these cases.

Finally, let me say this, gentlemen: It is not right to say, "Put the blame for the delays on members of the legal profession", that is, the delay in bringing on many of these claims. The delay in resolving many of them is due to the insurance companies and, in part that is due to no small extent, to the medical profession and the legal profession who advise the insurance companies that an injury will disappear, or that there is not much substance in a claim. Naturally, the insurance companies try to wear the plaintiff down by making him or her wait for money, but you cannot lay the blame exclusively at the feet of the legal profession. There are a lot of cases which never come anywhere near courts of law.

DR. P. JONES: May I mention two cases to emphasize the importance of the time of hearing a case? The first concerns a 23-year-old girl who was injured by being run over by a motor boat and sustained severe facial lacerations which were very skilfully repaired by a member of the audience here this evening.

Her case was deferred for some years, and finally when it was heard she was not only married but it was obvious to the least sophisticated by-stander that she was pregnant, which I have little doubt severely and adversely affected her claims.

The other case is of a boy who sustained a severe destruction of part of the anatomical constituents of his phallus. This case was at a relatively early stage when it was heard before any reparative procedures had been undertaken.

The results were that in the first instance, despite considerable pain, grief and distress and some residual deformity, the damages awarded were less than £500. In the second case they were something more than £25,000. I think this does underline considerably the great importance of certificates of readiness, or the time any particular case is heard. I would like to know just what are the governing circumstances which determine the time at which the case comes to Court in which the repair has not only been completed but has been completed for some years, and so successfully that mariage and pregnancy resulted on the one hand, and the other in which no reparative procedures had as yet been undertaken whatsoever and the ultimate, therefore, could not be decided.

MR. JUSTICE SMITHERS: I think, Mr. Chairman, that practically everybody thinks he is an expert in arranging for the satisfaction of compensation claims. It is commonly thought that there is nothing to it, that you just walk up and take the money. It is not like that. If you want what you ultimately may get at the hands of skilled legal advisers a claim is usually fought and the thing to remember is that this is war. It is because it is war, I think sometimes, that claims are very much delayed. There is no golden rule as to whether it is a good thing to get your case on early or a good thing to get your case on late. I know as far as I myself was concerned in a scar case, I always wanted to get them on early because they get better. The defendants know that and so it is war. You are trying to get it on, they are trying to delay it. Some legal people are better at it than others, and the result is that those who are clever in things like that get the case delayed.

This certificate of readiness in my opinion is a disaster. It is, in my view, a repudiation of what courts are for. Courts are places to which Her Majesty says people having claims can bring them, and can bring them to her. She does not say, or did

not say until this new rule, "You may only bring them to me when your opponent is ready".

When this rule was suggested about three or four years ago it was opposed very fiercely by the wisest of the members of the Bar Council, including myself. It was opposed for this very reason that it is incompatible with the purpose of courts, which should always be there, subject to reasonable procedural provisions, to receive the complaints of any citizen who says he has a claim against another. Under this rule the plaintiff cannot get to Court until the defendant says he is ready. What is wrong with that? That is quite true. Let us get this cleaned up. You cannot set your case down until you have got your certificate of readiness, and the certificate of readiness has to be signed by both sides and the defendant does not have to sign it until he is ready. Subject, of course, to this, that when he has demonstrated that he is unreasonable in this, and not until then, the plaintiff who is being cheated may take out a summons. It will be then necessary for him to file an affidavit setting out the long course of his trial and how he has been trying to get it on and how the defendant has been blocking him at various points.

The thing that is wrong about all this is that it puts the Court too far from the plaintiff.

The most bona fide plaintiff cannot afford to get well. Every time he begins to feel better he says to himself, "Well, it is probably a flash in the pan. No doubt I am as bad as ever I was, and in case I am as bad as ever I was I cannot admit I am as well as I feel". When he has got his case over, whether his damages have been large or small, at least every time he begins to feel better it puts a song into his heart and that in its turn makes him feel better still. Every subconscious function which is going on in his mind at that stage tends to grasp on to any little sign that he is getting better, and in the end he really begins to be better. So that somehow or other it seems to me that what we ought to be doing with these cases is not keeping them out of courts by things like certificates of readiness, but by getting them in.

MR. XAVIER CONNOR, Q.C.: I think medical men, as jurors, would probably give less for a scar than non-medical people, because they are more used to dealing with this sort of thing than the average member of the community. They live with it and they become used to and perhaps somewhat immune to carnage.

DR. SPRINGTHORPE: I was just saying to Smithers, J., with whom I am in almost perfect agreement, it is incredibly difficult

to assess the subjective effects of disfigurement. It is not what happens to a person (whether it is disfigurement or a breach of their domestic life, or any other trauma) that is the matter in question—it is how they react to it. You may have three or ten girls with a similar injury to the upper thigh, and it is almost certain they would all react differently—partly due to their own intrinsic personality, and more particularly, if they were young when it happened as to how the situation was handled—or, as is found, how it is mishandled by their parents, relatives and friends. I do not think there can be uniformity, and if there is uniformity, it will be inadequate because of the differences I have mentioned.

I suppose it might be thought by some people, if you have particularly sensible parents and friends, and you have a particularly resilient personality, and you do not have your life ruined by some disfigurement, you should get less damages than a neurotic person with a neurotic family, who goes to the pack completely because of some trivial injury.

I do not think juries, judges or psychiatrists are completely adequate to solve these problems, and I wish to end on this rather mournful note.

PROFESSOR DERHAM: It might be arguable there should be no measure of damages for subjective pain and suffering when it is all over. As I say, I would vote for that, but I would not be prepared to accept the answer Mr. Rank gave, that because the patient says afterwards, "This is in the past, and I do not remember very well", that you forget all about it.

Most of what was said in tonight's paper, apart from the medical aspects of treatment, seems to assume two things, firstly, the Judge or a jury in a Court was there to establish or find out what the truth is. Secondly, they were there as a last resort to give a decision which would achieve justice, and it appears that in some way a medical practitioner who has patched up the face had a vision of justice which was greater than the Judge or jury who heard the case. The Judge is not there to find out the truth and in the particular case the Court is not there to give justice. We hope that the system in the majority of cases will produce nearer the truth than any other system will. We hope that the system will in the majority of cases produce justice. A greater majority than any other system will. The Judge is there to decide issues and questions brought to be argued between parties. The Court is there to decide those issues. We hope that in deciding

them by our methods that truth will be served more faithfully than by other methods, and that justice will be served more faithfully than by other methods.

We deceive ourselves, lawyers as well as doctors deceive themselves, if they think in a particular case the task is to discover truth or justice. It is to decide the issue in accordance with the law as it is at the time. I would invite Mr. Rank to answer this. The assumption seemed to be that as a master of his art he could judge the justice of a case.

All that the certificates of readiness have done is to say that you do not get into the list until you have gone through certain procedures. At the present time when you get into the list you will probably be heard in about three months, not earlier. What the gentlemen from Owen Dixon Chambers do not realize is the large number of cases that are happily settled without their receiving trial briefs.

I do not feel that our medical friends, Mr. Chairman, should be entirely misled by the gentlemen from Owen Dixon Chambers, who after all, are the Army who do the fighting. There is a lot of work done behind the scenes which results in happy settlements of disputes without actual open warfare occurring.

MR. RANK: Somebody got up right near the finish and suggested that a Judge is not up there to uphold the truth and achieve justice. My only answer to that is, if he is not I give up. What is he there for? He twisted it around the other way and said as an expert you must not think that you can achieve better justice as an expert on this, whatever the subject might be, than the system would achieve. That is not what I was trying to suggest. I was trying to suggest all along that in evidence as an expert, one's expertness is not used. It seems to me quite wrong that you should go into the thing and either the *cons* are taken out for you or the *pros* are taken out of you but never the *pros* and the *cons* of the case. It is not matched up. I am quite aware that a lot of things are happily settled out of Court, and I think it would be a very good thing if the lawyers who can settle the cases out of Court got something very special for it such as an out of the Court fee.