THE SOCIAL EFFECTS OF COMPENSABILITY FOR HEART DISEASE

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It has been said, "Change is not without inconvenience, even from the worse to the better". Thus, you might receive this paper with some misgivings because it recommends change. The conclusions reached have been reached by others who have viewed similar problems in their own different fields. The extension of Workers' Compensation benefits to cover heart disease shows the need for a change in the social security system of this country. Tonight, I propose to put this case, as others have done in the past, but illustrating it with examples from my own subject. Before doing so, I quote Leo Tolstoy—"I sit on a man's back, choking him and making him carry me and yet assure myself and others that I am very sorry for him and wish to ease his lot by all possible means—except by getting off his back".

In considering the social effects of compensability for heart disease, I shall first comment upon the activities of expert medical witnesses and the Courts in which they appear; then consider the reasons for the existence of each. One may then sympathize with the patient, or the client, or the victim, the one who is supposed to be helped. This leads, naturally, to a survey of the accidental damage induced by legislation meant to be socially progressive. Finally, one may rake in the sand to uncover the buried heads.

Recently, a medical society contemplated undertaking the study of transcripts of evidence. It wished to investigate the veracity or venality of expert medical witnesses. This was because some medical witnesses were venturing opinions in Court which they could not assert before medical societies. This desperate act was not pursued, thereby depriving our journals of reports of some fascinating damages actions. This, naturally, was in the United States of America.[1]

Anybody is entitled to an opinion, irrespective of his qual-

[1] Sprague, H. B., "Legal Aspects of Coronary Disease." *Circulation*, 22, 627, 1960.

ifications. Objection, however, can be raised to the apparent misuse or misquotation of scientific literature in substantiation of one's views. However innocent it may be, such misinterpretation of scientific literature can lead to a complete reversal of the author's meanings, while adding weight to the expert medical opinion expressed to the Court. I offer as an example the case of the Yemenite Jews, and this will be a lengthy example. In June, 1957, Toor and others published a paper on "Serum Lipids and Atherosclerosis among Yemenite Immigrants in Israel".[2] Reading the paper, it is clear that, to the authors, there were two groups of Yemenites, separate and distinct. There were the early Yemenites who had been there 20 years or more; these Yemenites were characterized by high serum lipids and by a high incidence of coronary disease. The second group of Yemenites, the recent Yemenites, there for five years or less, was totally different. In contrast to the "early" Yemenites, the "recent" Yemenites had serum lipids which were, to say the least, low, and whose coronary disease, if they had any, passed notice. Despite these differences, the early Yemenites and the recent Yemenites shared one common and unfortunate characteristic—they occupied the lowest strata of the society in which they found themselves.

Eighteen months after the publication, by then December 1958, the subject, which had been discussed by Toor as a scientific question, was found to be a material consideration in assisting the Victorian County Court to reach a conclusion regarding the rights of an employee of the Commonwealth who was afflicted by the effects of coronary disease during a period which corresponded roughly with his employment by the Commonwealth. Expert witnesses were called on both sides, each confessing modestly to the highest qualifications. One expert witness bethought him of Toor's paper. Having been duly sworn, he thus summarized to the Court the views of Toor on the Yemenites.

> "A very similar study is being carried out in Israel on a group of Jews, who, for 900 years, were separated from the main body of Jewry. They took up their residence in the region known as the Yemen, in the southern part of the Arabian Peninsula in the year 1000. They have been subjected to a great deal of privation from the point of view of a rather

[2] Toor, M., Katchalsky, A., Agmon, J. and Allaloof, D., "Serum-Lipids and Atherosclerosis Among Yemenite Immigrants in Israel." *Lancet*, i, 1270, 1957.

difficult country to cultivate and no great contact with the outside world. But they were noted for their longevity, and in particular for their freedom from arterial disease. With the uprising of Arab nationalism, they have been removed from the Yemen and have been re-installed in Israel, and after the lapse of only one decade, there is now a very marked increase in the incidence of occlusive arterial disease in this group of people. Attempts have been made to correlate this with any one factor quite unsuccessfully; they have had to point to several factors and no particular one has been emphasized. I think if we look at it objectively we must say that investigators have been perhaps trying to prove theories of their own when looking at it, but nothing has been borne out by statistical analysis. The evidence discloses that these people have a more adequate diet in terms of both calorie and fat than ever before in their history, and, secondly, they have been subjected to a great deal of psychological damage through having been resettled in refugee camps, pushed from pillar to post with uncertainty about earning a living, and yet they have been provided for on a hand-out basis through international organizations, so they have been subjected to a lot more stress than ever before".

In the face of this evidence, consider the position of the Judge. He is presented with a conclusion based upon people described as Yemenite Jews. It is not pointed out to him that there are, *ex hypothesi,* two groups of Yemenite Jews. It is regrettable that this fact is not presented by the witness himself; it is even more regrettable that this piece of information is not extracted by Counsel in cross-examination. Perhaps, from the point of view of the medical profession, the most lamentable feature is the day by day routine of the Courts which allows such evidence to be given by a medical witness in the absence of other medical witnesses, their being otherwise engaged, as always, in urgent business.

It is more important to note that in the evidence given, stress has become a damaging factor in the imagined single group of Yemenites. This is what the authors say: "Both groups obeyed religious laws and conformed to social customs to the same extent. Their ways of life were practically unchanged and no mental stress could be incriminated in the early Yemenites"—and later—"The differences in the incidence of atherosclerosis amongst early and recent Yemenite Jewish immigrants can best

be explained by the differences in total food intake determined by differences in income. Furthermore, the recent Yemenite immigrants work harder and remain in a state of caloric imbalance at the age when atherosclerosis is commonest". The Court was not to know that the paper concerned two groups of people, the first of which had a high incidence of arterial disease attributed to an increase in diet and a reduction in physical activity. Between these two groups there was no recognized difference in stress. Presented to the Court is one group of people who, largely because of stress, developed coronary artery disease. The Court can receive this with equanimity and, indeed, accepted as the doctor's view, supported by this sort of evidence, that stress of occupation contributed to the appellant's heart condition and death. Cardiologists hear this in frustrated frenzy.

When evidence is in conflict, one may elevate one's view by referring to it as representative of "a school of thought". This is suitable to the Bench; a County Court Judge recently enquired, "half of Collins Street says one thing, and the other half the other. Which school of thought do you belong to?". What is "half of Collins Street"? In New York State, the Workmen's Compensation Board surveyed opinions by questionnaire to qualified cardiologists and physicians. One question was, "In your opinion, can work to which a man is normally accustomed over a period of years, involving no unusual exertion, produce heart disease in the workman?". The answers are set out in Table 1.

TABLE 1

Answers to Questionnaire (398 internists)
"Can normal work cause heart disease?"

No	89·7%
No, with some exceptions	4·2%
Possibly	0·5%
Yes	1·5%
No answer	4·1%

This table indicated the size of the relative schools of thought. However, it leads the Board to the extraordinary statement that "there is no basis to the fiction that work can lead to any kind of heart disease"[3].

In Melbourne there is a "school of thought" which states

[3] Sigler, L. H. "Results of a Questionnaire on Relation of Exertion to Myocardial Infarction." *Amer. J. Cardiology*, 2, 78. 1958.

that with each and every attack of anginal pain there occurs microscopic death of heart muscle. Take the evidence—

Q. "Are you quite certain that that process takes place during attacks of angina?"

A. "Yes, I am quite certain."

The basic reason is revealed in further answers. "There is dispute as to the exact amount of time that it will survive. Everybody is agreed that three minutes is all it will stand"—and later—"Three minutes of complete deprivation of oxygen causes death of heart muscle. If some people claim it is a shorter time, I would not argue".

This opinion was given upon oath in a Court of Law. It is necessary shortly to speculate upon the social and economic pressures which cause such opinions to be given on oath in a Court of Law. The figure quoted does not relate to the heart at all; it relates to the most sensitive cells of the brain. The figures for heart muscle in man and animals with healthy or unhealthy hearts are between 20 and 30 minutes. With angina there is not even complete deprivation of oxygen. In the report of the committee on the Effect of Strain and Trauma of the Heart and Great Vessels (of the American Heart Association) it is stated: "For the muscle to undergo infarction, there must be a critical degree of ischaemia from coronary stenosis or occlusion for a considerable time, even hours".[4]

American authors consider that too often, evidence presented in Court is influenced by sentiment, or by being a "nice guy". They consider that too often social conscience is placed in conflict with scientific opinion. The problem in America is even greater than here. I will point out why later. In many States, Workers' Compensation legislation surpasses ours. In others, it is very similar. The State of Mississippi, in 1948, was the last to introduce Workmen's Compensation legislation. By 1952, it was clear that the pattern of interpretation of the Act was the same as that prevailing here. For the lawyers, an example was the recovery of financial recompense by the heirs of a laundry man who was shot and killed by a stranger. This injury by accident in the course of employment arose, not because the stranger objected to the laundry man's regular collection of the stranger's laundry, but to the concurrent collection of his wife's

[4] Report of the Committee on the Effect of Strain and Trauma on the Heart and Great Vessels. *Modern Concepts of Cardiovascular Disease.* 32, 793, 1963.

amorous favours.[5] We can see from this that they are as advanced as we are!

When medical evidence is too contradictory or inadequate, Courts may fall back on what is called "the commonsense viewpoint of the average man". Of course, the average man is one inferior to oneself, but who somehow manages to possess the same prejudices. A Court may go further, as in Tennessee, where the Court ruled—"The Court takes judicial notice that climbing of stairs is condemned by the medical profession as among the activities most harmful and dangerous to persons afflicted with heart trouble and arteriosclerosis".[1]

While some doctors may support the Court, and deny their patients the right to ascend 30 steps at work, they do not yet deny them the right to the pursuit of Venus, which is very interesting, because the work of the heart during this chase has been measured as the equivalent of running up five to ten flights of stairs.[6] One dare not produce this information before the Workers' Compensation Board lest Counsel may seize upon it as the explanation of why so many men die in bed. So much for the doctors and Courts.

I must concede that I have referred to extreme examples of medical witnesses and Courts straining to aid the applicant worker. The Courts administer justice according to the law as they find it. In America and here there is continual pressure at a social and political level to expand the availability of Workers' Compensation Benefits. As one physician said to me after leaving Court—"Well, we all want them to win, anyway". Now, really we do, and this is for a very good reason. This country runs second to the U.S.A. for the possession of the weakest social security system of any comparable industrial society.

Table 2 sets out the levels of sickness benefits available through Compulsory National Insurance Schemes in Western Europe,[7] together with the fixed rate Sickness Benefits available in New Zealand, Britain and Australia.[8] For the European countries, Sickness Benefits are available as a percentage of wages; premiums are from the weekly wage, as a percentage, deducted at source. The scheme may be national or through nominated Insurance Agencies. We fall behind all. In Britain,

5 "National Association of Compensation Claimants." *Attorneys Law Journal.* 9, 47, May, 1952 (Supreme Court of Mississippi).

6 Dock, W. "The Relative Etiological Importance of Various Stresses in Cardiac Disorders" in *Work and the Heart* ed. Rosenbaum, F. F. and Belknap, E. L. Pub. Paul B. Hoeber, Inc., New York, 1959.

TABLE 2

Sickness Benefits (National Insurance Schemes)
(% of wages, 1961)

Country	%
Sweden	70-90
Norway	70-90
West Germany	90 then 50
Netherlands	70-80
Denmark	60-80
Austria	50-75
France	50-67
Belgium	60
Italy	50
(% of minimum wage, 1963 for man and dependent wife)	
New Zealand	85
United Kingdom	68
Australia	48

the Welfare State also supplies free medical and hospital treatment during disability. However, in Australia, we have a non-insurance scheme of benefits, which may make us look at Eastern Europe and the Peoples Republic of China for comparative benefits.[7]

TABLE 3

Sickness Benefits (Social Welfare Systems)
(% of wages, 1961)

Country	%
P. R. of China[1]	60-100
U.S.S.R.[2]	50-90
Czechoslovakia	60-90
Yugoslavia	50-90
Rumania	50-90
Hungary	75
Poland	70
(% of basic wage, 1963)	
Australia	48

Again, expressed as a percentage of wages, one sees that sickness benefits are higher than here. Our standard of living may be higher, but this is related to our rate of fixed expenditure and does not affect the significance of these figures. One still has to pay the rent, the hire purchase instalments and buy the food.

7 *Social Security Programs Throughout the World, 1961.* (U.S. Department of Health, Education and Welfare, Social Security Administration Division of Program Research). Pub. U.S. Government Printing Office, Washington, D.C. 1961.

8 Summary of Social Security Benefits in the United Kingdom, New Zealand and Australia. April, 1964. Department of Social Services, Research Section. Melbourne, 1964.

I have not included dependent children in the calculation. It costs £150 to £200 per annum to keep a child at what we regard as a normal living standard. On sickness benefits he brings in 15 shillings a week.

The (1) over the Peoples Republic of China indicates a weakness in an otherwise excellent system because there are exclusions. One of these is for persons deprived of civil rights. Thus a sizeable section of the community must work or die or both, or escape to Hong Kong. The (2) over U.S.S.R. indicates something which would gladden the hearts of some. There are reductions; 10 per cent for rural workers (a cost of living adjustment) and 50 per cent reduction for non-unionists. Of course, the benefits are administered through the unions. The Eastern European countries have a cleaner social conscience and they do not have these restrictions or exclusions.

Having looked at the basic problem, it is perhaps advisable now to look at the patients. Workers' Compensation benefits, at a higher rate than Sickness Benefits and entitling a patient to free medical and hospital treatment, are meant to assure him of a reasonable chance of weathering his illness without economic distress and anxiety. This is usually effective where there is no question of liability. However, in the cloud cuckoo land of coronary occlusion, liability is likely to be contested. It is, for this reason, through heart cases, that the extension of Workers' Compensation into the field of social security has produced a tragically farcical situation.

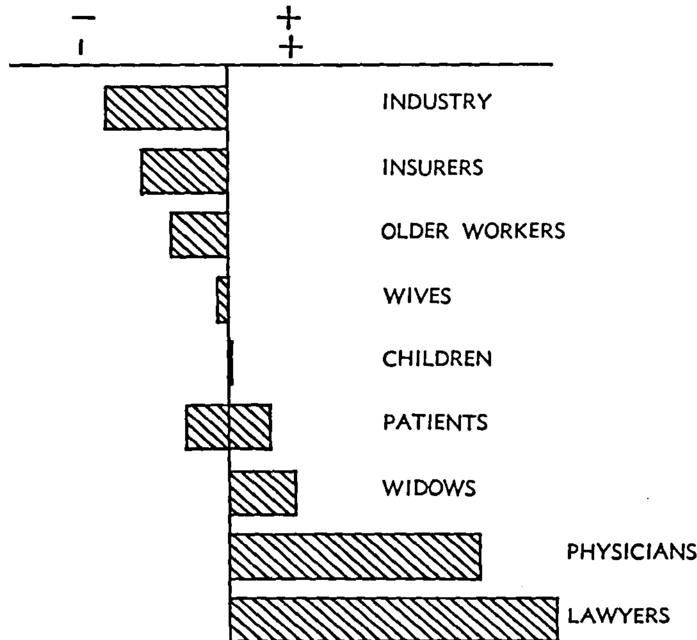
Let us view the gains and losses in this situation.

Table 4 shows a scientific way of presenting unscientific information. I ask you to look at it carefully as the implications of it pervade the remainder of this discourse. To understand it you need to know that a dependent wife brings the compensated worker twelve shillings less per week than would Sickness Benefits, dependent child a shilling more. The patient is £4/13/6 better off theoretically, but he receives his money after the time of need is past. His widow does well, in due course.

The man who suffers a coronary occlusion is likely to become anxious for several reasons; through fear of death, disability and through fear of financial insecurity. He is likely to become saddened or depressed through grief for his lost health, or his anticipated dramatic separation from his loved ones. He may become sick with worry and unfit for work. Financial insecurity may force him into pinning his hopes upon a successful Compen-

TABLE 4

Compensatibility for Cardiacs—Gains and Losses



sation claim. To Dr. Miller and to others this may be regarded as desire for gain;[9] to me, and also again to others, it represents a desire for survival.

If the patient had obtained Sickness Benefits he may have had a "bird in the hand" at least. Commonly he has not. He did not seek them. After all, he was going to receive Workers' Compensation benefits to which he was informed he was entitled. His union representative or his doctor, and others, may become angry when the money does not come, but they overlook telling him he can obtain alternative temporary benefits. Of the last ten men I have seen for Insurance Companies, who have had coronary occlusions, six had had no income from any source during the first three months, two had obtained Sickness benefits very late, and two received wages. Naturally, none was receiving Workers' Compensation.

[9] Miller, H. *Proceedings of the Medico-Legal Society of Victoria.* (this volume).

At the Work Assessment Centre of the National Heart Foundation in 1962, 45 per cent of the patients seen were unfit for work.[10] The reasons are set out in Table 5.

TABLE 5

Reasons for Unemployability of Cardiacs
(Work Assessment Centre, 1962)

Physical Handicap	76%
Psychological Handicap	69%
Age	31%
Workers' Compensation	24%
Language	10%
Poor motivation—financial	10%
Unsuitable	8%
Absconded	5%
Refused work	4%

More than one disability was present in most cases. Physical handicaps can be overcome by choosing suitable work. Age and language barriers can also be overcome if there are either special skills or little or no physical disability. The problems lower on the table cannot be overcome. Psychological handicaps could be reduced by the handling of each of the patient's problems as they were defined for him in a detailed rehabilitation programme. For these men, financial problems loomed large.

Workers' Compensation claims or actual awards were a barrier to employment for two reasons. In some of these men, fear and frustration, concerning the possible outcome of claims, outstanding for many months, produced sickness in the man which could not be overcome until the case was decided. In others, the patient who was receiving weekly payments would not attempt work because, should he do so, payments would cease, and if he were unable to continue work, he feared they may not be resumed. This is a rather important Victorian problem. A method was devised of testing whether these men would work, if their fears about risking their tenuous security could be overcome. The method was to approach the Insurer, that is the previous Insurer, with a view to guaranteeing (by gentleman's agreement) a resumption of payments should the worker be unable to continue. Should a new episode occur, this would be the responsibility of the new employer. We could tell them which it appeared to be. The undertaking was limited to three

[10] Goble, A. J., Adey, G. M. and Bullen, J. F. "Rehabilitation of the Cardiac Patient", *Med. J. Australia* 2, 975, 1963.

months. This may seem a dangerous and meddlesome little experiment.

TABLE 6

(Work Assessment Centre—from March, 1962)

Average time off work	13 months
Maximum Time off work	3 years
Assurances obtained	21
Resumed work	18
Broke down temporarily	3
Working now	17
Alive now	21

There were 21 cases. All are still alive. 17 are still working. They had all been off work a long time and would not have otherwise resumed work.

This approach proved profitable to all concerned. Here is an example. A 57-year-old man, unskilled, was seen in March, 1962, having been off work for 9 months on weekly payments. After an assurance was obtained from the Insurance Company, and after considerable difficulty in view of his age and lack of skill, suitable work was found for him. This took six months' search and psychological preparation. One year later, after some confusing and conflicting medical advice, he started to worry about his heart condition once more, feeling tired and depressed. He was unable to work. Despite his having worked for one year, the Insurance Company, only committed for the first three months, resumed "ex gratia" payments to cover him while he received treatment, for a period, for depression and anxiety. He is now confidently working once more. This excursion into social welfare, which was voluntarily undertaken by a claims manager, saved this man from psychological disintegration.

Malingering with heart disease is, I think, outstandingly rare. There are external precipitating factors of neurotic, hysterical or depressive behaviour in practically all cases. Workers' Compensation practices have been amongst the most important. These include things probably recognized by us all: delays, repeated demands for certificates, taciturn medical examinations, conflicting medical advice, failures to respect human dignity at some quite surprising levels, unreasonable termination certificates, and hearing one's case in Court, including statements about prognosis. It is as well that most people are resilient and fairly tough.

In an attempt to overcome these problems, the Queensland Government set up a Cardiac Board in 1960.[11] This was composed of three cardiologists. A similar practice had been established in Utah ten years before. The State Government Insurance Office, the sole Workers' Compensation Insurer in the State, has the responsibility for collecting the medical records. The Board sits twice weekly and handles four cases at each half day sitting, having done some homework the night before.

In Queensland, it is necessary to connect work with the cardiac condition, through causation, acceleration or aggravation.[12] The Board found favourably for 42 per cent of 542 applicants during its first two years. This was apparently liberal, being a higher percentage than was the case before the Courts. The hearing is usually three to four months after a coronary occlusion rather than nearer the two years of before. The hearing is informal. The applicant may be represented, but no other persons may; he rarely is represented. Medical examination and electrocardiagram are included. There are no privileged medical records; all are available to the Board. There are no settlements. There is no appeal. There is little place for counsel. There are now no complaints: it works.

However, there are some weaknesses. Again the money comes after the illness is past. Some people believe that every man is entitled to his day in Court, no matter how it may affect him. The decision of the Board is absolute. Brisbane Sunday "Truth" attacked the Board in 1962, as an instrument of the State Government Insurance Office and for "Star Chamber" tactics, supported by human interest stories[13]. It is now accepted and has not been attacked during the past year.

In all States, many claims are survivor's or widow's claims. The delay involved in a death case may be up to two years. The successful applicant widow has her fixed award of, say, £2,240 handled by the Workers' Compensation Board. This is usually disbursed in weekly instalments to supplement her widow's pension, at a rate of, say, £3/10/- per week. This is necessary for reasons I shall not discuss. However, this process endorses the fact that widows' pensions in Australia are as inadequate, propor-

[11] The *Workers' Compensation Acts* 1916 to 1960. See 14C (i) Queensland. Government Printer, Brisbane, 1961.

[12] *Ibid.* Sec. 14C (ii).

[13] *Brisbane Sunday Truth,* 21 October, 1962 and 2 December, 1962.

tionally, as sickness benefits. The same applies to invalid pensions and unemployment benefits. This inadequacy is recognised by some—one teaches medical students that, here, the adults with vitamin deficiencies are the pensioners and the chronic alcoholics.

Now, I think, one should look at the effect of all this on employment, industry and insurance. Employers are loth to engage men with heart disease irrespective of their apparent physical fitness. The results of surveys conducted in Melbourne and America are shown in Table 7.

TABLE 7

Reasons for Rejection of Cardiacs as Employees

Melbourne { 120 firms, 50% rejection	Minnesota, Illinois { 450 firms, 38% rejection
1. Physically limited	1. Workers' Compensation Liability
2. Safety risk	2. Other Insurance risks
3. Workers' Compensation Liability	3. Physically limited
4. Absenteeism	4. Absenteeism
	5. Safety risk

It is notable that, in America, the chief reason for rejection is financial.[14] In Melbourne, financial considerations were third. There are good reasons for this. The American Heart Association and other bodies for years have been campaigning and demonstrating that men with heart disease make good employees; that disability is often imagined by the employer, not real; that absenteeism is, in fact, less with cardiacs; that, possibly because they

TABLE 8

Changes in the Proportions of Compensation Cases and Awards for Heart Disease in New York State

	1947		1956	
	Heart Cases	% of all Cases	Heart Cases	% of all Cases
Total number of cases	167	0·14	619	0·71
Fatal cases	65	—	224	27·4
Permanent Total disability cases	10	—	16	7·3
Total compensation awarded	1·02 million dollars	1·8	5·92 million dollars	17·6
Average cost per case	6,100 dollars	—	9,632 dollars	—

[14] Warshaw, L. J. Cardiovascular Disease in Industry in *The Heart in industry*. ed. Warshaw, L. J. Pub. Paul B. Hoeber. Inc., New York, 1960.

are more careful, industrial accidents are less common for them. In Australia, this has only just begun. Also, in America, there is increasing awareness of Workers' Compensation claims experience from heart disease.

In table 8 you will note that in New York the overall cost of heart cases rose from 1·8 per cent of the successful claims in 1947, to 17·6 per cent in 1956.[14] The same pattern is apparently occurring here, but the figures are not known.

Although one may believe that the cost of the claim is borne by the Insurance Company this, in fact, is not so, certainly not entirely so, nor is the cost truly spread over an industry; in fact, it is largely borne by the employer. The book rate for insurance rises from a minimum of 6/6d. per £100 of wages for clerks (so much for heart disease), to £20/4/6 per £100 of wages for non-coal miners underground (which indicates that some industries could do with some investigation of their safety measures). Low claims bonuses, or Claims Experienced Discounts, were initially introduced to aid industrial safety programmes through financial incentive. The State Government, in 1951, amended the Workers' Compensation Regulations, permitting up to 25 per cent reduction of premiums, dependent upon the insured's claims experienced during the previous policy period.[15] One heart case can wreck an employer's claims experience, thereby costing him money.

In 1958, the State Government received the Report of a Board of Enquiry into the Accident Rate in Industry.[16] This Board recognized and predicted that claims experience discounts, though valuable in one respect, could militate against employment of older workers. The Board was correct.

This letter, quoted by Warshaw,[14] was addressed to an American State Court which had found for a Worker in a claim for compensation for heart disease: ". . . this particular award is no more vicious or false in its premise than . . . others. . . Mr. . . . suffered a heart attack which is not unexpected in a man of his age.

"I have made a firm and fast rule in all our operations in this State, wherein we employ better than 600 men, that under

[15] Amendment to the Workers' Compensation Regulations 1942. *Victoria Gazette* No. 1028, October 31, 1951, p. 7137.

[16] Report of the Board of Enquiry appointed to enquire into and Report upon the Most Practicable Manner and Means in or by which the State of Victoria might Assist in Reducing the Accident Rate in Industry in Victoria. Pub. Government Printer. Melbourne, 1958.

no circumstances will men past the age of 55 be hired, irrespective of their qualifications. If industry must pay a price for every sickness and ailment that occurs while an employee is working on the job, then, of course, we must limit our employment to the ages when diseases and infirmities, that come with later years, will not result in claims being granted by your department. This is a pity, for there are many people in the older age group, who can perform adequately in many of our job classifications.

"My next step will be to discharge employees in certain age classifications, because of the exposure involved by reason of your rulings. I am also recommending similar action to all employer groups to which I belong . . ."

You may think, gentlemen, that this would not happen here. It does. Some employers will not engage men over 50 or 55 years, and will admit verbally that they are influenced by the reason given in the letter. As yet, however, I know of nobody putting this reason in writing. There is a trend with some to discharge from employment men with known heart disease. This is done in different ways.

A 38-year-old man, working with a large firm for the past 15 years, developed a coronary occlusion. It was decided that light work was required in the future. Different reasons for rejection were given on each occasion, when an approach to the company was made regarding re-employment. The man was not re-engaged. The Insurance Company happened to be a subsidiary of the Employer Company. Alternate work was found for the man with a new employer. His employer told him, after one month, that he was to be dismissed because the Insurance Company would not cover him. This of course could not happen. What probably happens is this. The employer, or his Personnel Manager, seeks advice regarding whether his discount may be affected by employing a man with heart disease. The Claims Manager informs him that, if a further attack occurs, and the employer is liable, his discount is adversely affected. With a large firm, one or two heart attacks could cost a few thousand pounds profit. I have been informed by an Insurance Company claims manager, that this type of query is not uncommon.

Employment rejection can also occur through the doctor who screens men prior to engagement or on return after illness.

A 53-year-old metal finisher, employed by a large manufacturing concern, had a coronary occlusion. Although certified fit to resume work by his local practitioner, he could not pass the

industrial medical officer. When the doctor concerned was questioned about this, he replied, amongst other things, punctuated with vernacular, "In my job I've got a dual responsibility, to the company and to the employees. I've got to protect the Company. I've saved them a few thousand pounds on Compo, and I reckon I do a good job." The man obtained a job elsewhere. So, eventually, did the doctor.

It is difficult to determine how widespread these practices are, but if we continue following the American pattern, they will increase. The methods used there to gain a wider cover of social security through one benefit or another, do not reduce the problem; they compound it. Group Insurance, for sickness and disability, is increasing. The premium is paid by the employer to encourage employee stability. The man with heart disease presents a threat to the premium rating. This form of insurance is held with the Workers' Compensation insurer. Sickness benefits, under these schemes, are better than Workers' Compensation benefits. This has resulted in an extraordinary event. In some areas, the greater number of Workers' Compensation claims are brought by the Insurer, attempting to prove that the worker's heart disability is compensable. This, of course, would commit him to the lower benefit. When this occurs here there will be an interesting re-alignment of expert medical witnesses. Believers in the class struggle will be embarrassed to have, as medical bedfellows, those whom they presently regard as "Insurance Company Hirelings."

Another natural extension of Workers' Compensation legislation making medical evidence unnecessary, is to legislate that coronary occlusion and hypertension are due to the stressful nature of work, and therefore automatically compensable. This would presumably be supported by unions whose spokesmen have, from time to time, stated that these diseases are especially prevalent amongst their members. This is practically all unions. The painters consider it is due to the stress of climbing around inadequate scaffolding.[17]

In Massachusetts, policemen and firemen now receive automatic compensation for coronary disease and hypertension. This legislation was thought to be preparatory to similar legislation to cover the legislators. This is not, necessarily, medically unsound: prevailing medical opinion is that the outstanding factors in the production of coronary disease are "gluttony and

17 Melbourne *Herald*, 15 August, 1962.

physical indolence".[18] Before looking askance at this type of legislation, one must remember that the Australian electorate was recently given the opportunity of assuring that cancer would become due to war service.

His Honour, Judge Stretton, has written of Workers' Compensation—"It has opened up a new field of social insurance, the benefits of a great part of which are denied to many, and are to be won by the rest, by chance, and chance alone. If that was what was intended by the Legislature, so be it. Whatever was intended, one feels that one may, without impropriety, address to those who have induced the present burgeoning of the law, the question whether the perennial Hesperidean crop, which they have brought to fruition, may not yet break down the tree which bears it".[19]

I hope, tonight, I have shown you that the award of Workers' Compensation benefits for heart disease, and for similar conditions, is achieved not only through temporal chance, but through the necessary acceptance of scientifically insecure medical evidence. Though helpful to the few, it is harmful to the many. It is a cause of unemployment, disability and waste; it acts against the employment of older men; its socially damaging effects can be only partly eased by setting up medical boards; its further extension will lead to legislation bordering on the farcical; it permits us to avoid facing an important social problem.

With an adequate Social Security System, there need be no place for Workers' Compensation Acts. European experience suggests that Sickness Benefits should be, at least, two-thirds or three-quarters of the weekly wage.

It is best that this be at the same level as for industrial accidents, thereby avoiding a cause of psychologically damaging litigation. Hungary and Poland represent one model; Sweden and Norway the other. The former is preferable, being simpler, but it matters little.

Meanwhile, at a Federal level, political parties offer small handouts to sections of the community whose votes they wish to win, while in the States, squabbles continue about Workers' Compensation. The real issue is lost from sight. What is recommended tonight has worked overseas for years. The community

[18] Arnott, M. "The Changing Aetiology of Heart Disease." *Brit. Med. J.* 2, 887, 1954.

[19] Stretton, L. E. B. in foreword to *Workers' Compensation Acts,* by Anderson, K. and Beach, B. W. Pub. Butterworth, 1958.

must bear the added cost to obtain the added benefit. Of course, nobody will suffer but the doctors and lawyers, and they only financially.

Discussion

MR. G. LUSH, Q.C.: I should make it clear that I have not seen tonight's paper and I have listened to it on the same terms as everyone else here. It is impossible, in those circumstances, to deal adequately with all its social implications.

In the comparison that was made between social benefits in this country and those available elsewhere, the figures on which the comparison applicable to Australia was made were based on a percentage of the total basic wage. One can, perhaps, ask legitimately, "What is the basic wage based upon in these various places? Is it a consistent wage or is it something higher than that, and are we so far behind that if we allow bare subsistence on compensation?" I have no idea what the answer to that is. We move, at that stage, on to the field of social economics, and here, we enter the realm entirely of personal dependence and, perhaps, social prejudice, but one feels that the idea of keeping on compensation men who have had a spectacular incidence of heart disease, must have its inherent disadvantages. It must produce the result that many employers would not be willing to take them on.

I am not experienced, I am not knowledgeable on the question how all workers' compensation premiums are established, but it is within my knowledge that some companies—those following activities which are unusual, which are such that the insurer cannot compare the particular client company with a dozen others—are assessed for premium on their own experience, and those companies at least, must accordingly be reluctant to engage men who are liable to expose them to claims.

Apart from the statistical disadvantages of this, there is a very heavy personal disadvantage about it. Dr. Goble has said that in his experience actual malingering is an insignificant factor in the appreciation of the significance of heart cases, but there must be an awful temptation. That is probably the wrong word—if one discards the idea of malingering, then temptation must be the wrong word—but it is asking a great deal of a man who is safely getting his £12 a week by way of compensation to sign off that and go back to work and risk whether he will have to re-establish his right to compensation later.

There are many men, self-employed men, and men in relatively high positions in industry, whose performances after they have had gross coronary attacks are such as to suggest that most people can be very usefully employed in the years that remain to them after the first attack, but it would be interesting to see, statistically, the difference between returns to active work among the self-employed and those employed in high positions, and those who are employed on the basic wage plus some margin.

Dr. Goble was concerned to disparage attacks made on the Brisbane Board. No lawyer would disparage those attacks at all. A Board of experts sitting upon rights, sitting to adjudicate rights of individuals who are not represented by Counsel, and sitting as a Board before which cross-examination is not the practice, would never command the respect of lawyers, who would immediately attack it with suspicion. It may be suspected that in this State the Workers' Compensation Board proceeds upon certain rules of thumb, which in its judgment, appear as findings of scientific fact. A Board such as the Brisbane Board would be open to exactly the same suspicion in the minds of different bodied persons.

MR. E. C. MCHUGH said that Dr. Goble was perfectly right, but did not go far enough. Cardiacs think most of all about their essential dignity. The Workers' Compensation Act, as it is administered, deprives cardiacs of any kind of opinion. It invites nonsensical and venal medical testimony which is given, according as the medical witnesses are called, by the company applicant, or the respondent; and moreover, it puts a premium on convincing a tribunal that a man is useless; and once you have convinced a man he is useless, he is indeed useless, so he goes on £12 a week, into the scrap heap. Of course, there have been Presidents of the United States who have had the odd heart attack, but they do not count. All you have to get is a man who has had a heart attack, and he is thereupon written off, and it is worth £12 a week for him to be written off, and that is the vice of the Workers' Compensation legislation. A man with a heart attack is told that he is finished.

DR. A. WYNN said that the nature of the pathology of coronary disease is such, that one cannot speak in terms of really an actual cause even if there, at times, appears to have been a cause, in the legal sense. It is a disease which starts very often early in life, in the twenties, and progresses at a variable rate, and the actual cause is no more relevant to the attack, than the proverbial straw

that breaks the camel's back is relevant to the breaking of the camel's back. It is only a legal situation, whether the application of the straw happens at work or in bed. He said that Dr. Goble quoted extensively from the survey of the Yemenite Jews and must be very familiar with the brilliant study of the workers in the communal settlements of Israel which showed that the incidence of heart disease—of myocardial infarction particularly—is four times as high in the sedentary workers as it was in those engaged in strenuous pursuits. By that proposition, one is prepared to say it is not work that causes heart disease, but non-work. With this sort of proposition it was surprising to hear Dr. Goble advocating something resembling the Queensland Medical Heart Boards. These Boards are concerned with the proposition of whether a heart attack was due to work. I think this is intrinsically a false proposition. I do not think doctors should ever be asked this, and I do not think it will solve the social problem of workers' compensation if the present situation changed so that doctors were made to decide an issue of this sort, in those terms. One of the redeeming features of our Workers' Compensation Act is that it is not really, in any true sense, a liable compensation. There is no real implication of the employer being liable for a heart attack. It is enough for the attack to have occurred during work, or on the way to and from work. This remedies the concept of fault, and it is important that in any future discussion of social legislation for this disease, that the question of who was at fault should be removed, because this is intrinsically a question which it is not, as a rule, possible to determine.

JUDGE HARRIS said that at the moment, as Dr. Wynn has said, you do not have to show that the work caused anything at all, heart or anything else, to get compensation. It is sufficient that it happened at work, and all the expert evidence we hear, with the "expert" in inverted commas, and "evidence" in even bigger inverted commas, deals with whether that event did or did not occur.

On the other hand, if you had a system of liability which gave him compensation only if the work causes his trouble, he is going to be a scared man when he goes back to work again, if you get him back again, because he has heard all the evidence and the opinions expressed of the work that caused it last time and he will not go to work again.

Dr. Goble has got past, apparently, being concerned with that aspect of legislation because he has moved on to the logical

conclusion to this situation, that we should have some scheme of all-pervading national insurance to cope with all the ills of mankind. I have been surprised he has left out the English situation, in this regard. There, starting at the beginning of the century, compensation legislation came in, protecting a class which removed from judicial interpretation injury by accidents to the various extremes which we touched on tonight, until the mid-forties. They finally abolished that scheme for the National Insurance scheme. The rates of pay under the National Insurance scheme are, I would have thought, about the equivalent of our Social Service payments here.

This brings me to a final question, and that is: are we going to be any better off so far as the social implications are concerned, if we introduce a National Insurance scheme which requires a man to show he is totally incapacitated, as Mr. McHugh has been hinting at here is essential at the moment for payments under compensation law? If he has to show the same thing for national insurance, are we going to have any better psychological reaction on the part of the individual? Does he not have to face some barrier before he gets his benefits that way, anyway? And is the result that way any gain, or the community any better off?

DR. M. DAVIS said that one of man's important assets is his desire to continue to live, and when he gets his heart attack he fears the possibility that life may be taken away from him. I think that legislation cannot easily overcome this, and any legislation which gives him an easy way out is potentially dangerous. I see no gain—in fact, I see great danger in the Queensland system as against our present one here, in many respects, because of this very point and because of the comments already made by Judge Harris. I think it could well mean that we are substituting one form of weakening a person's morale with another and I do not think enough emphasis has been given to this aspect of the problem.

But let us get right away from this permanency of invalidity. It may surprise people here, perhaps, but I would say truthfully—I am speaking for myself alone—that it is a relative rarity for the coronary case not to go back to work. I stand up here and now and make that statement and will make the challenge—a relative rarity. Then what group, may we ask, is Dr. Goble dealing with? Might I add that I speak with experience from a public hospital and I suspect that the economic aspects of this problem, social indeed as they are, are of a nature that makes the case vastly

different from the case which, in fact, can be controlled if one can instil enough courage or desire to go back to work into the patient. Economic factors do come into it, it is true, but the most important aspect, I would repeat, is somehow or another to get the patient confident that he can work and will be able to work. Point one—give him adaquate economic control for the first few months of his attack. Point two—then make it, in fact, necessary for him, and I have had cause in certain opinions I have given to state this, that he will be better off if he returns to work.

This is the great tragedy of the present jurisdiction, and the legal profession has not caught up with the law of natural hazard. We go across a road and may slip and so on. We look immediately, from the legal point of view, for a cause—"Who placed the banana skin on the ground?" We will follow this matter up until we get someone to blame, and we will look for some culprit. All the Yemenite work of Toor shows that one aspect that comes into the problem is frustration and fear, quite apart from other factors, and I think the frustration of work is the far more important factor, so here we are arguing the toss about work, "Did he get this before running up ten flights of steps?" and so on, and what we forget is that in doing that, he was running to get there on time lest a major issue were decided without him or something of that order.

I personally consider that the worry that he could have been absent when the major issue was decided was more important than him running up the steps. Physical activity has nothing, often, to do with the case, and I think Dr. Goble will be the first to agree with this one, so let us accept the position of natural hazards and get down to reality and give the patient a little more hope, and be careful not to legislate that he will be given another way out.

MR. J. B. CURTIS: At issue is the clash between two proverbs, on the one hand, "A bird in the hand is worth two in the bush," and on the other, "It is better not to take the risk." The person who, to himself, appears to be disabled by an event in his life such as a coronary occlusion, has the bird in the hand, that is, the ability to receive compensation, and the bird in the bush is the possibility of employment. That is hypothetical. On the other hand, from an employer's point of view, or from an insurance point of view, perhaps it might be cheaper not to take the risk of re-employing such a person, but the problems that

Dr. Goble has posed tonight cannot really be solved in the interests of the community at large.

From a medical point of view, the difficulty in solving this subject or problem arises from our inability to be precise about the causation of disease, and I think this problem, particularly in regard to the law, applies not only to coronary heart disease, but to the whole gamut of diseases. Except in cases of trauma, it is seldom that one can be both positive not only to one's own satisfaction, but to others' as well, regarding the primary cause of disease and, therefore, within the terms of compensation, with such a condition as coronary heart disease, it frequently appears that the argument is concerned with legal words and phrases. A medical witness who is subject to the same psychological and other pressures as other people tends, within the terms of his oath and his medical knowledge and his social and psychological sympathies, to give evidence which must be biased in one way or the other. I would suggest, therefore, that really the solution of this problem is probably along the lines which I think Dr. Goble suggested. That is to say, the elaboration of some system which both encourages active and productive work, helps the community and the security of the patient himself, and also the psychological aid to a person who feels that he can be of some aid to society, as well as to himself, and an aid to his family as well. I would think that the solution to this lies neither in the profession of the law, nor in the profession of medicine, but really at a social level, in legislation.

MR. X. CONNOR, Q.C., said that one can understand how a person, who through absence of exercise during the last 40 years, has got himself into a condition whereby exercise, at the end, is just too much, and is a precipitating cause for the final event. It may well be if, 40 years before, he had started on his P.T., the last 40 stairs would not have mattered very much, and it also occurs to me if, for instance, the dietary explanation is ultimately accepted, one might very well get oneself into the position where, by not having adopted the correct diet for the last 40 years, the last 40 steps are pretty important. So far as the Victorian Act is concerned, it does seem that it is at least a step towards what Dr. Goble is contemplating because, it more than any of the other Acts in Australia, does seem to give benefits to workers because of purely temporal occurrence of certain events. It has

got closer to the social service idea, although it may not have got to the ultimate that Dr. Goble is speaking about.

MR. P. D. PHILLIPS, Q.C.: Listening to this discussion tonight makes me feel a very old man. I do not know whether I am the only lawyer present who made substantial money out of the word "and" instead of the word "or", but I would like to suggest that we are in danger of confusing two separate problems. First, is there some value in distinguishing between industrial or employment damage and other damage, and secondly, is there some danger or difficulty about the method of assessing compensation for that particular kind of damage? The Beveridge Report faced this problem. It contemplated an overall claim for social security or compensation for illness and sickness and accidents, and then the Commission asked itself, "Should you distinguish between accidents arising out of and in the course of the employment, and other accidents?" They considered this at great length and very carefully, and they came to a conclusion that there was a number of reasons for separating those injuries and accidents and illnesses from other influences, accidents and illnesses.

I was rather surprised that Dr. Goble said so little about the English scheme, because the whole Beveridge plan was designed to meet the evils to which he has been drawing attention, and I think, on the whole, has been substantially successful in doing so. It lifted the compensation for industrial accidents outside the sphere of litigation altogether. It made it into an administrative process, and two advantages were to try to get away from the problem of keeping a man on compensation by keeping him ill or sick or injured, and it tried to link together a plan of compensation with a whole socially-organized system of rehabilitation.

The administration gains by rehabilitating a man and getting him back to work just as much as the man gains. Here are two separate problems going side by side. One is the method for ascertaining compensation and treatment and rehabilitation on the one hand, and the second is, is there some good administrative reason for separating industrial accidents from the other accidents, though all should be compensated?

Now, I thought there was a little tendency, from Dr. Goble's remarks, because he felt they all ought to be compensated, to assume they should be treated in the same way and classified together. There are good reasons for separating them. On the

other hand, I thought he was entirely right in saying that the processes of litigation had not been appropriately carried over into this sphere of determining the amount of compensation. Beveridge saw that and rejected what had been built up in the Workers' Compensation Act in England up to that time, and substituted a new, relatively non-litigious process, of keeping accidents separate.

The hesitations of taking a man back to work are true over a great area of industrial injuries. I venture the suggestion that there is nothing peculiar about heart diseases in this respect.

I can remember in this Society years ago, hearing this kind of discussion about the coal miner who has a lump of coal fall on his spine and suffers a spinal injury. We used to be cynical and sceptical about the doctors saying, "The moment his compensation is cured, his spine will recover all its elasticity and flexibility and he will be well, and until his compensation is spent his spine is useless to him", but I suppose we have all learned wisdom by now and know that is true. The broad relations of psychological consequence of injury and sickness and compensation have now been well established. I would not have thought there was a case for lifting the cardiac problem out of other problems of industrial injury. They may be an acute example of it, but the problem extends over the whole sphere, so that I am only suggesting that this ought to be looked at in a rather wider and more general way and it should be classified into its two forms.

The great point about the Workers' Compensation Act, 1897, when it was first enacted, was that it prescribed compensation without fault. It is a different thing, of course, to say it was a liability for industrially-caused injury and accident, and that was true. I suppose it is still true that there is a liability for industrially-caused accidents, but it is less important now, because so many of the accidents arise in the course of the employment that one does not have to bother so much about the accidents that arise out of employment, but it still must be proved, even in regard to heart cases, though the problem of causation may arise when the cardiac event occurs not in the course of employment.

The great difficulty about Workers' Compensation—the difficulty between doctors and lawyers—is the misunderstanding of the nature of the causation which was required. It confuses the matter very much if one introduces the idea of fault or respon-

sibility. The whole point of the law was it was based on rejecting any such required fault. Well, the circle has now become complete. Time was when the doctors in this Society complained that this law seemed to impose a wide liability on employers. They gave evidence for the employers, and they felt that the employers were being fixed with a liability which had no moral basis. Some lawyers saying in those days, "Well, it has really got nothing to do with liability, with fault. Forget it. This is a curious and inadequate form of social security." Now the circle is complete. The medical experience is enough to have, shall we say, the more progressive doctors saying, "It is time this was treated frankly and logically as a system of social security". I think that is right.

THE CHAIRMAN (PROF. D. DERHAM): Gentlemen, before calling on Dr. Goble to reply to questions and remarks that have been made, I would like to ask two questions. In the table referred to as the Gains and Losses table, on the right hand side, there were two extraordinary tall columns, labelled "Physicians" and "Lawyers," as yet unexplained. I think I ought to ask Dr. Goble to explain them. The second question is that it occurred to me tonight that, although it may be true of the old charwoman who was dying, who said, "Don't cry for me now, don't cry for me ever. I'm not going to do anything for ever and ever," it may not be applicable to cases of heart disease. I would like to ask Dr. Goble how many compensable cases are receiving compensation like the one that I know of, who made this the occasion for exploitation, not as an employee, but as his own master, of a skill that he had, in this case, as a cabinet maker and, as the spirit moved him, to make much more money than he had ever made as an employee. Does the condition that you are concerned with prevent, in any way, in a large number of cases, the ordinary human desire, after being rested for a sufficient time to do something, and under the condition of nearly full employment, is there not perhaps a great deal of work being done illegally by some of the patients under compensation?

DR. A. GOBLE: Perhaps I could answer your questions first. I did not really wish to give offence to anyone, but I felt there was a number of members present tonight who actually made their living out of compensability of patients, whether for heart disease or any other conditions, and this includes physicians and lawyers. This was the sort of thing that I had in the mind

when quoting Tolstoy. To answer your question, considering how many patients on workers' compensation now make more money: I think probably very few. There are some who are receiving superannuation and workers' compensation benefits, or some other sort of benefits, and the compensation runs out after a time. I have seen quite a number of these people who, after four and a half years or, if they are lucky, nine years, having had an extension, the money runs out, the income drops, and then they begin to feel they have wasted the last four and a half or nine years and want to go back to work.

Most people in this situation, I think, are not very productive. They are probably wasting their lives and wasting, in a sense, the community's money, so I think we need not be influenced by the occasional one who is working in an unusual manner whilst on compensation.

I think, now, most doctors who have anything to do with workers' compensation realize that fault liability is not involved, and realize that very clearly. That has been forced on some through having, occasionally, to talk in the corridors with lawyers, and also others occasionally read. I have read, attributed to Lloyd George, the statement that "the cost of the product includes the blood of the working man." Such statements have gradually sunk into the medical conscience and we know about these things, so I think we do recognize that fault is not required in Victoria.

I feel a number of people tonight have concluded that I expressed the view that fault should be re-introduced, by my statement that the Queensland Board works. The Queensland Board of experts is, I think, immeasurably better than the Queensland Magistrates' Court in deciding workers' compensation cases for heart disease, because it decides it much more quickly—three or four months instead of two years.

I do not believe that in this State we should introduce Boards of experts to resolve our workers' compensation problems, with a pneumoconiosis panel, a heart panel, an ulcer panel and so on. I do not think this is a forward step. All it does is stop the chaos, and the chaos in Queensland had got so bad that something had to be done.

In Victoria, the chaos, I think, will get so bad that something will have to be done, and I hope it will be something sensible —an overall comprehensive national insurance scheme, whether following the British system, incorporating the recommendations

of the Beveridge Report as pointed out by Mr. Phillips, or as in Hungary or Sweden. The point I have been trying to make is that what we have now is socially inadequate and what we need is something that has been introduced in most overseas countries, but not in the U.S.A. If we do not introduce a national insurance scheme or something comparable in Australia fairly soon, what will happen is there will be increasing ramifications of the group and other forms of insurance; so we will have a large number of money-making businesses introducing themselves still further into the realm of social security. In other words, we will follow the U.S.A. and compound our present problems.

To Mr. Lush, I wish to indicate that the figures that I have set out were not a percentage of the basic wage but of the actual wage of the worker, who would be classified as a wage earner. In Australia, the figures were as a percentage of the basic wage. For New Zealand and the United Kingdom, they were a percentage of the minimum wage—a fixed rate of benefits—whereas in the others, they are percentages of actual weekly wages.

I think, on the whole, that the self-employed man is more likely to get back to work than the man who is not self-employed, and this probably for reasons obvious to all of us—that he can, to a large extent, adjust his own rehabilitation.

The Queensland Board works on a formula. I feel, with Workers' Compensation, because of the confusion regarding heart disease and so forth, that for heart disease it almost must be a formula, no matter where. I agree it is reasonable that the Brisbane Board could and should be suspected by lawyers, but as Mr. Phillips pointed out, this is not really the case in Britain.

I agree with Dr. Wynn that the question asked and the answer given to the query in New York were nonsensical because no one, in fact, does know.

Judge Harris was also worried that I thought it might be necessary to go back to involving causation. I did not for a moment. I feel the sensible thing is to dispose of workers' compensation altogether, allowing for the provisos raised by Mr. Phillips.

Mr. Curtis, I think, made the most important point from my point of view, that this is not really a medical problem or a legal problem—it is a legislative problem; and that one has to develop some concept acceptable to the community and also to the individual, as a service, embracing within it the aspects of

more security and the possibility of rehabilitation and future work.

Dr. Davis is worried about how many patients do not go back to work. Practically every doctor who has looked into this and has written a paper about it, says that the figure is something in the order of thirty to forty per cent. These are always someone else's patients, never his own!

The Victorian Act has within it a much greater social service content than other Acts. Because of other aspects of the Victorian legislation, including claims experience, it is now damaging to the worker.