THE MEDICAL ASPECTS OF PERSONAL INJURY ASSESSMENT

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Paper addressed to an audience of judges, lawyers, insurance practitioners and doctors.

The role of the Medical Specialist in the assessment of personal injuries consists in his establishing a mass of medical facts, necessarily coupled with a certain amount of medical options, on which will be based the considerations of his legal colleagues, in their various advisory or judicial functions, and often of the insurance practitioners who will have to cover such compensation as may be payable.

The medical assessor is therefore required to determine as clearly and as completely as he can:

- *the precise nature of the injuries, their extent and degree, and any supervening or complicating factors*
- *the effects of these injuries with the resulting sequelae and residua, especially of a "permanent" character*
- *a disability rating, usually expressed as a percentage, to express the degree or structural or functional impairment resulting from the injury, especially where such disability can be regarded as "permanent".*

"Permanence" of disability requires special consideration in Maltese law which does not seem to allow for consideration of such very real though imponderable matters as any pain or suffering or other "moral damages" the injured person may have undergone, but seems to focus on practical "measurable" considerations of reduction of working capacity or earning capacity. Even in this limited field, the doctor's task is by no means an easy one, and he cannot go further than expressing a personal opinion. He can, and should be, scientifically precise and unassailable on such matters of fact as the loss or permanent damage of a bodily part or function, but he can never give more than an **opinion** as to how much permanent adverse effect this will have on that particular sufferer. Although the doctor is pressed to assess the "permanence" of disability, he cannot really do more than give this as it appears at the time of examination. If he can foresee further complications and deterioration, he should try to indicate this. Likewise, if there is a prospect of improvement with time, by further operations or other treatment, by provision of prostheses and artificial aids, this should be mentioned.

Although it is obviously important to the doctor to know what the law is and what the law says or requires, I believe that the safest path for him to follow is to confine himself to **medical** facts and **medical** opinions, and to leave to the lawyers the judgement of what use they make of the reports that he can supply. For instance, there are many aspects of human life which go far beyond working or earning capacity. The duration of expectation of life itself can obviously be shortened by injuries though the computation may be impossible or very difficult indeed, and yet in certain circumstances the doctor may need to give an estimate, although I shudder at the thought of bringing this to the knowledge of the patient! Then, the **quality** of life is always a prime consideration, though how does one go about assessing it in percentages? The normal daily activities of the average human being, even though unemployed or unemployable, can be seriously and permanently affected by injury; but to what "percentage" extent? The **enjoyment** of life, in the sense of "joie de vivre", is a very real thing, and the patient may lose some or all of it; but which doctor can say how much? Leisure pursuits are an essential part of life to most humans and a very personal matter; these too

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can be lost or impaired, and certainly deserve compensation in the light of common sense, if not in the light of the law. When the physical loss or impairment is of an "all or none" character, assessment is relatively easy; it is the infinite degrees in-between that create difficulty and may call for rough approximations, if not guess work. What most doctors abhor is being asked questions they cannot answer from their medical knowledge. They may have to fall back on saying: "I am sorry, but I do not know and cannot tell you: all I can say is that this injured person can no longer walk, or he cannot run to catch a bus,or he cannot wash himself, or she cannot make her own bed, or she cannot teach a large class, or he cannot swim ... Please do not ask me what that is in percentages!"

On the question of reduction of working capacity, the reporting doctor's considerations must include the distictions between "sedentary" work and heavy strenuous "manual" labour, between skilled and unskilled occupations etc. In certain cases, restriction to "light duties" (for a period) may be envisaged; in other cases, return to the previous occupation may be dangerous or outright impossible. Sometimes the doctor may be able to suggest possible alternative employment compatible with the patient's altered abilities. The patient's physique, even his social standing, and particularly any special skills he may have possessed, will determine his future prospects of employability and thus his "disability rating". A stiff finger will affect a professional violinist more than a stevedore.

Ideally, the doctor who writes a report on injury cases should be a **specialist** in this very specific field of medico-legal science, with considerable experience. Naturally, the doctor who has treated the injured person will usually provide his own report, often with assessment of disability; such reports will usually be regarded as being "ex parte". The specialist in injury compensation assessment will be required as a "second opinion" or as a court appointed expert. As guide lines and criteria he will rely on his experience and on "case law" of previous similar cases, and on certain agreed schedules; there are also compendious text-books on this very subject to consult.

It is essential that the reporting doctor be supplied with the fullest possible information about the injured person right from the time of the accident, including all hospital reports with full details of operations, X-ray findings, pathology reports, etc. Obviously, technical details cannot be extracted by the examining doctor's interrogation of the patient, and many such details cannot be discovered even by the most complete physical examination. The examiner will often require to see for himself fresh X-ray films, etc., particularly if some time has elapsed since the accident. It is notorious that some of the original "certificates" and reports submitted to the Medical Assessor are excellent, complete, clear and comprehensive and thoroughly reliable, while others are grossly deficient and totally useless.

There is hardly need to stress that the Assessor's own examination of the injured person must be thorough and accurate, as the nature of the case demands, and that the ensuing report must embody the same qualities. Facts must be made clear and opinions honestly affirmed without equivocation.

In modern insurance compensation practice, road accidents probably contribute the majority of cases through the agency of that notorious destroying angel known as the motor vehicle in its various forms. Drivers and passengers may or may not outnumber the hapless pedestrians.

Occupational and industrial accidents constitute a very important sector of insurance practice, while ordinary or household accidents, although probably the commonest of all, seldom figure in insurance litigation in Malta.

Fractures and dislocations, particularly of the lower limbs, represent some of the commonest injuries, and even when they heal soundly, they often leave sequelae that may entail some disability. It must be borne in mind that at least in theory, the patient is entitled to expect **restitutio ad integrum** and a practically full rehabilitation. The sequelae may be no more than subjective complaints of persisting pains and discomforts, difficult to prove or disprove, but claimed to limit the sufferer's activities; sometimes, they may be attributable to muscle adhesions. Open or compound fractures where there are also external wounds in the vicinity certainly are more serious, and may often be reasonably expected to have worse sequelae. Involvement of a joint surface by the fracture invariably has deleterious effects, while joint stiffness is probably the commonest important end-result of most fractures. Progressive and potentially crippling degenerative processes in joints, termed osteoarthosis or osteoarthritis, may occur years after such injuries; they have to be identified and distinguished or sometimes just

predicted years ahead, since some joints are notoriously thus liable in a spontaneous form simply as part of the ageing process, the normal wear and tear of every human; it is the **premature** onset of such degeneration after injury in relatively young subjects that poses little difficulty in diagnosis, though the ultimate degree of degeneration and interference with joint function may be difficult to predict. Nowadays, many fractures are treated by operative insertion of various metallic devices; some of these may safely be left in situ indefinitely, but others demand late removal after healing of the fracture; in either case, i.e. their persistence or the necessity of their removal, may modify the disability rating.

Cases of amputation or other mutilation are among the easier to assess since they are all covered in full detail and distinction in various agreed schedules of compensation or in the textbooks. Loss of substance and limitation of function are here fairly obvious and indisputably assessable. Thus, in the hand loss of the all-important thumb is rated at 30%, whereas the index finger rates 14% and other fingers appreciably less than this. On a personal note, except where the schedules lay down other figures, I prefer to use an arbitrary scale of multiples of five.

Injuries to nerves, whether motor or sensory or mixed, seldom heal with a perfect end-result, even where operative treatment is possible. The consequent disability ratings are also well covered in the schedules and texts.

Internal injuries, as those of the abdominal and thoracic cavities and contents, are less common. They obviously can leave serious and disabling sequelae, though equally even disastrous injuries sometimes heal without trace. The law specifically labels all penetrating injuries as grievous, though it is debatable how to assess this feature as a separate percentage. Any intra-abdominal wound can cause peritoneal adhesions, and these may also occur or even multiply each time the abdomen is opened; adhesions in themselves can seldom be held to cause symptoms or disabilities, and they may very well be innocuous for a lifetime, but in some unfortunate individuals they are the cause of recurrent or life threatening intestinal obstructions. Percentage assessment of these liabilities and disabilities is obviously difficult and uncertain; all too often the outcome is just a matter of luck.

Special difficulty in assessing disability attaches to the common problem of disfigurement, scarring and other "cosmetic" impairment. Where this has also a functional impact, as in scarring on the fingers of skilled workers, percentage rating is possible; but in other instances it can be extremely difficult even though regard is had to the site of scars, their extent, the sex and occupation of the victim, and the remediability by plastic surgery; here let it be pointed out that the lay person's hopes from plastic surgery do not always correspond with reality. Of supreme importance is the psychological impact of the disfigurement on the sufferer, and on her or him **alone**, in this totally personal matter. Be it noted that "very severe facial disfigurement" with its social and economic implications is scheduled as **100%** disablement, like total loss of sight or hearing, since it can drive some persons into reclusion, or worse! Fortunately for the doctor, he may be absolved from pronouncing a percentage or a monetary figure for compensation, a task perhaps better left to the common sense of a jury of laymen and women.

Head injuries are exceedingly common especially in traffic accidents. They range from the most transient and brief states of cerebral concussion to the most disastrous degrees of structural and functional brain damage. Here my lay audience may be interested to learn of an axiom attributed to Hippocrates, and therefore most venerable: "No head injury is so slight as to warrant being disregarded, nor so serious as to be despaired of"! This is quite true in clinical practice, and perhaps also in compensation assessment.

With any head injury, the apparent sequelae may be none or slight or serious. They are often loosely grouped under the term "post concussion syndrome", a term which may impress the layman and especially the injured person with its pseudo-scientific ring, but which I disapprove of as lacking scientific clarity. The elements of such post-head injury complaints are often almost wholly subjective, "functional" or "non-organic", and present as symptoms rather than physical signs: they often appear as headaches, vertigo, lassitude, fatiguability, lack of concentration, impairment of memory, loss of interest, loss of libido, drowsiness, intolerance of noise, change of personality, etc. They may be real enough to the patient, and may sometimes find corroboration from impartial outsiders, but no amount of testing by the doctor may serve to establish or disprove their genuineness. Their severity may be related to the duration of the

original unconscious state, but by no means necessarily so. They may constitute a true neurosis or psychological disturbance, or they may lead on to such. I repeat that when the assessing doctor encounters such complaints, he should specify and describe them and not dismiss them under the meaningless rag-bag term of "post-concussion syndrome". He will try to assess their reality and their impact on the patient from repeated observation, knowledge of previous history in relation to personality traits and psychological disturbances, work and sickness records, etc. Pre-injury sufferers from true neuroses like anxiety states, "hysteria", "inadequate personality", etc. are particularly prone to develop similar complaints after head injury. Also, in the recovery period, some patients are particularly liable to pick up "suggestion" from anxious relatives or even from unguarded remarks of their medical attendants. Above all, as my audience must have for some time been expecting me to say, these subjective symptoms are at the command of any malingerer and especially the more intelligent ones; these may defeat any doctor's attempts to pin them down by detecting inconsistencies in their presentation and so on. Here it must be stated that in certain true and serious organic lesions like subdural haematomas there may be for months and years only vague subjective complaints very similar to those suffered by the "neurotic" patient or simulated by the malingerer, and let us not forget that many an unfortunate thus unjustly labelled, has ended up dying from his "complaints"! Brain scans and surgical exploration solve some of our problems in this field.

Apart from obvious organic damage as with cranial nerve lesions or other neuronal defect, it may be quite impossible to expect a percentage disability rating. Even the most experienced assessor will often need to refer such questions to the judgement of a psychiatric colleague.

Injuries to the back and especially to the spinal column are exceedingly common both in traffic accidents and at work in certain occupations. The position in regard to compensation assessment is very similar to that in head injuries. Spinal injuries of any sort are notoriously liable to initiate neurotic complaints, and they are also simulated or abused of by the malingerer. But they can obviously be quite true and real as in actual rupture or displacement of intervertebral disks. Disk lesions can usually be scientifically identified and effectively treated; the same cannot be stated for the far more numerous and heterogenous cases that go under the vague terms of backache, low back pain, strains and lumbago. X-ray examination are not as revealing or reliable as the layman thinks; any person around 50 or over may have spontaneous "degenerative" changes loosely labelled "osteoarthritic" quite unrelated to any injury. On the other hand, it is surprising how occasional cases of fracture with evidence on X-rays go undetected for months or years. Returning to the problem of post-injury neurosis, back injuries have a special psychological impact on certain persons and it is quite common for consciousness of a "weak back" to disable some workers in a very real sense. On the other hand, the malingerer can sometimes be identified by certain "trick tests", absence of muscle spasm and other features. Of course, injuries to the nervous structures of the spinal cord with their serious consequences of paralyses, loss of sensation, bladder and bowel dysfunction, nerve root compression, etc. showing little or no recovery are readily identified as giving rise to serious permanent disabilities.

I must finally attempt to give some views on so-called "compensation neurosis syndromes". These have been defined as "a group of allied conditions which (a) follow injury or disease when the patient believes that there is a reasonable hope of financial compensation; and (b) show a mixture of organic and psychiatric complaints and disability which lack obvious connection with the pathology or are out of proportion to it". As such, compensation neurosis overlaps with malingering (which does not need further definition than wilful deception), and both conditions are embraced within the wider circle of **exaggeration** to which practically every human being, except the stoical and taciturn, is all too prone!

There are many valuable studies of these important psychosomatic states by neurologists, psychiatrists, surgeons and lawyers. Perhaps one of the best is by the late Professor Henry Miller of Newcastle, who held that these neuroses have a relatively good prognosis in that in most cases the patient's complaints will abate or disappear when he has received adequate financial compensation. Not all authorities are agreed on this point. On the related subject of malingering, one of the best writers is Dr. Richard Asher, who described the notorious "Munchausen syndrome" which takes some persons from hospital to hospital simulating illnesses and seeking repeated unnecessary operations, a very peculiar form of self-inflicted injury! To the doctor, even these

persons are patients, sick people who merit kindness and sympathy and care even when they most try his patience!

It is on this note that I will end. As an assessor in compensation cases, the doctor must assume a judicial role of impartiality, and as the care of the patient does not devolve upon him he can do this with complete honesty and equanimity. He may reflect, as everyone is bound to do, on the inherent unfairness of the inequalities of Nature, or Luck or Chance, which decree that one person may receive terrible injuries which recover splendidly and of which he may hardly complain, while another person sustains lesser injuries which through no one's fault, cause lasting real disability. He will try to avoid being forced into consideration of what is beyond his competence. Although he may be temporarily cast in the role of a judge, he will not think himself to be a god. He will always be ready to acknowledge his falibility in matters of fact and even more of mere opinion. His one aid will be to act to the best of his ability in equal fairness towards all concerned.

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