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>> Impairment and disability – a medical perspective <<

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In "The Great Debate: Impairment v Disability", *Plaintiff*, October 1999, Darren Moore demonstrated that there are lawyers and doctors who do not understand the difference in the medical meaning of "impairment" and "disability" and are not familiar with The Guides to the Evaluation of Permanent Impairment of the American Medical Association (The AMA Guides).

The *Motor Accidents Compensation Act* (NSW) 1999, provides that from the 4th October 1999, the victims of motor vehicle accidents will be compensated on the basis of Permanent Impairment as defined and applied in the AMA Guides, except where MAA Guidelines overrule them. Doctors who are unaware of, or not competent in the use of the AMA Guides, (and it is not an easy matter) will not be able to provide accurate Assessments of Permanent Impairment.

The Guides to the Evaluation of Permanent Impairment of the American Medical Association

The AMA Guides were developed to improve estimates of the severity of human impairments, defined as a deviation from normal in a body part or organ system, and to differentiate as precisely as possible the meaning of medical and non-medical statements that are made by doctors about individuals whose health is impaired. Non-medical statements include opinion on disability, and percentage loss of efficient use, compared to a most extreme case.

Part of the *raison d'etre* for the AMA Guides was to improve the quality and equity of court decisions based on the assessment of disability.[1]

The AMA Guides stress the importance of confirmation that an injury actually took place and the extent and severity of it. This information is contained in hospital, medical and paramedical records made at the time of accident or onset of symptoms. One must bear in mind that both "diseases" and "injuries" can cause "permanent impairment".

Medical impairment

The AMA Guides define "impairment" and "disability" in much the same way as the World Health Organization (WHO). "Impairment" is defined as an alteration of a person's health status. Accordingly, impairment is a medical issue and can only be assessed by medical means. An impairment is a deviation from normal in a body part or organ system and its functioning. "Impairment" is the expression of pathology, which is permanent when recovery/improvement has peaked and unlikely to change in the future. The assessment of permanent impairment is based solely on objective medical findings. Because it is based solely on ▶

objective findings, different doctors' assessments must be the same and cannot differ. Patients' symptoms and difficulties are not part of the assessment process.

Disability

"Disability" is defined in the AMA Guides as, "An alteration to a person's capacity to meet personal, social, or occupational demands, or statutory or regulatory requirements". It may be thought of as the gap between what a person needs or wants to do and what he or she can do.

The distinction between impairment & disability

An individual who is able to meet life's demands is not disabled, even if a medical examination discloses an impairment. It is also true that a small impairment can lead to serious disability. The loss of a part of a finger may cause little disability for a labourer, but total loss of livelihood for a concert pianist. Under the new system of compensation in NSW, it would appear that both the labourer and the pianist will receive the same compensation. A back injury, as well as some other injuries, which may be assessed at 5-7% permanent impairment of the whole person, may cause one person none or very little disability, yet result in serious incapacity for another.

To compensate each one equally for their impairment does not seem quite fair, does it! The one may return to work, the other may not work again, and be restricted in the performance of the activities of daily living (see below) for the remainder of his or her life.

The assessment of permanent impairment

The various organs and limbs are assigned values relative to the whole person. Assessment is based on abnormal clinical findings and measurements, both clinical and laboratory, and in the case of the spine, either on diagnostic-related estimates (DRE) or reproducible loss of motion of the back.

In assessments of the thoraco-lumbar spine, voluntary movements are measured three times, using inclinometers, and if there is >5 percent variation in the range of the three readings, three more readings are taken. If the variation is again >5 percent, the assessment is considered to be invalid.

Pain, loss of sensation and dysesthesia, resulting from peripheral nerve injuries, and sciatica, are assessable and the resulting percentage impairment figure is combined with those for other impairments. A final whole person impairment may be rounded to the nearer of the two nearest values ending in 0 or 5. Thus, in appropriate circumstances, impairments of 8 or 9% may be rounded up to 10%.

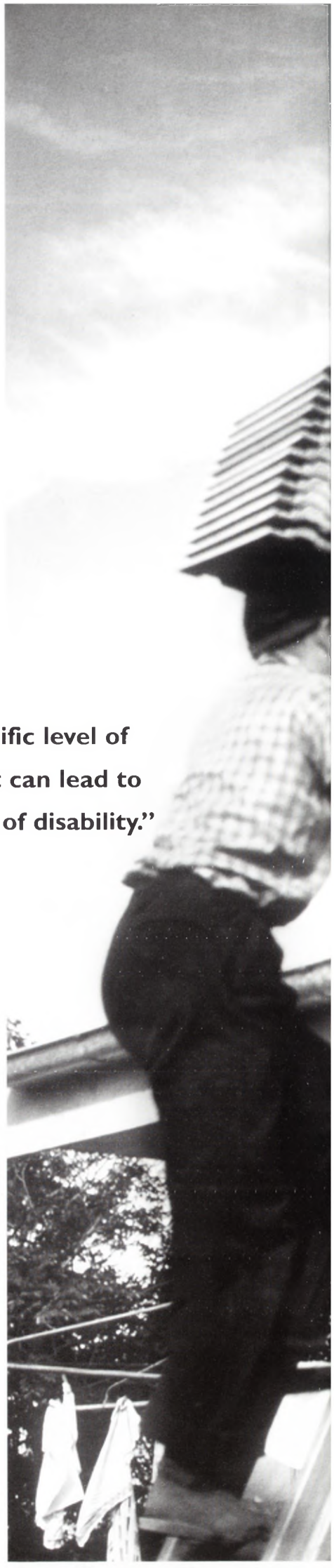
Pain and suffering, loss of enjoyment of life, disruption of normal lifestyle etc, are assessable if they are permanent. Chronic Pain Syndrome and other disorders which limit daily activities may cause an impairment in their own right. However, impairments related to chronic pain and psychological disorders cannot be added to percentage impairments resulting from physical injury.

During 1999, the Victorian WorkCover Authority accredited a number of doctors, including myself, to assess impairment according to The Guides to the Evaluation of Permanent Impairment of the American Medical Association (4th. ed.) after 'training' provided by the Monash and Melbourne Universities.

The introduction of the fourth edition of the AMA Guides was not without controversy because it required the assessing doctor to decide whether diagnostic criteria, ("Diagnostic Related Estimate (DRE) Model") or examination criteria, ("Range of Motion, or Functional Model") best described the impairment of the spine of a specific patient.

Slater and Gordon, wrote to doctors in Victoria suggesting that the doctor should use whichever method gave the worker the larger impairment figure, rather than choosing the method which the doctor felt was appropriate. The WorkCover Authority disagreed.

"...any specific level of impairment can lead to a spectrum of disability."



The assessment of disability

The assessment of disability depends on reliable information about what a person must or wants to do and what he or she can do. The assessment of disability is not based on medical examination (a method for making diagnosis) but on practical issues. If a person cannot work, or carry out with ease all the activities of daily living he or she has a whole person disability, regardless of the cause. In my opinion, "disability" is a narrative assessment, not a numerical one, taking into account such questions as:

- Is a person capable of returning to his or her former occupation?
- Is a person capable of returning to any gainful occupation? If so, what?
- Has the claimant's ability to perform any of his or her activities of daily living been affected? If so, what activities and to what extent?

The activities of daily living include all of those functions and activities which are essential and normal, but do not include gainful employment.

The activities of daily living

- Self care: personal hygiene, the preparation of food, caring for the home and personal finances.
- Communication: hearing, speaking, reading, writing, using a keyboard
- Physical activity
- Sensory function: hearing, seeing, feeling, tasting, smelling
- Hand functions: grasping, holding, pinching, sensory discrimination
- Travel: by aeroplane, train, bus, car, motor-cycle or push bike
- Sexual function
- Sleep
- Social & recreational activities: group activities, sports, and hobbies.

Medical opinion, supported by the evidence on which it is based, may be helpful where there is restriction of the activities of daily living. Where this is the case, abnormal clinical findings are usually present and there should be consistency between the original injury, the claimed disabilities and the findings on clinical examination. For example, displaying a full range of movement of the arms is not consistent with inability to comb one's hair. Restriction of elevation of the arm to 45 degrees, however, is.

Criteria for the assessment of disability as a percentage have not been established.

The AMA Guides state: "The critical problem is that no formula is known by which knowledge about a medical condition (impairment) can be combined with knowledge about other factors to calculate the percentage by which an employee's use of the body is impaired for industrial purposes".[2]

Assessment of percentage loss of efficient use, compared to a most extreme case.

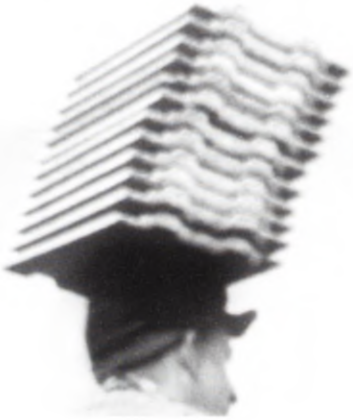
Criteria for the assessment of the "percentage loss of efficient use of a body part, compared to a most extreme case" have likewise not been established. There are no principles which doctors might use to arrive at a result on which a Court could rely. While one doctor might assess a plaintiff to have 20% loss, another might assess the same patient to have only 10% loss. The numbers are arbitrary, based on the doctor's personal opinions or prejudices.

The idea of percentage loss of efficient use of a body part, compared to "a most extreme case", sounds reasonable until one considers how one would go about making such an assessment. For example, consider the back - quadriplegia might be the example of "a most extreme case". All movement, all sensation, control of the bladder and bowels, sexual function, the ability to sit, stand, walk and run, to perform the activities of daily living is lost. Then compared to a quadriplegic, a person who has a painful back and cannot work, would appear to have only a very small loss compared to the most extreme case.

The concept is based on a false premise that comparison to "a most extreme case" is a medical reference point for the gravity of an illness. The idea of a most extreme case is hypothetical. In real life, doctors relate the effects of illness or injury to the patient's normal state.

If "a most extreme case" was interpreted not in quasi medical terms, but in the context of Worker's ▶

"Compensation based on assessments other than disability cannot be fair."



Compensation, then "a most extreme case" could be one that has permanently lost the ability to work. In the event that a worker cannot return to his or her previous occupation, but is capable of lesser paid work, then his or her situation might be assessed as a percentage of "a most extreme case".

In The AMA Guides, "The Activities of Daily Living" are regarded as intrinsic, and necessary for ordinary life as a human being. Employment is not one of the activities of daily living. It is extrinsic, pertaining to human material needs. Loss of any of the activities of daily living might be regarded as "non-economic loss", and of higher priority than pain and suffering, psychological reactions etc.

Permanent impairment and compensation

The AMA Guides have never intended that "impairment" should be the basis of compensation:

"It must be emphasised and clearly understood that impairment percentages derived according to The AMA Guides criteria should not be used to make direct financial rewards or direct estimates of disabilities." (4th ed. chap.1, p.5)

The AMA Guides urge that each legal or administrative system that uses "permanent impairment" as a basis for disability ratings should define its own means for translating knowledge about an impairment into an estimate of the degree to which the impairment limits the individual's capacity to meet personal, social, occupational, and other demands or to meet statutory requirements. Whether the NSW Government has addressed this issue is not known. How it could possibly do so, is also not known, as any specific level of impairment can lead to a spectrum of disability, ranging from none to severe, depending on the individual.

"Impairment" as the determinant of compensation must produce inequitable results, as have previous systems. But whereas previously, excessive payments may on occasion have been made, and unjustified claims accepted, it is now likely that some might receive much less than is needed to maintain their former standard of living.

There are potential beneficiaries under the new system. For example, those who simply claim continuing lower back pain after an MVA and on X-ray have features of degenerative disease may be assessed to have 5-7% permanent impairment.

The MAA guidelines for the assessment of permanent impairment of a person injured as a result of an MVA.

The difficulties for doctors assessing permanent impairment in NSW have been compounded by the development of "MAA Guidelines for the Assessment of Permanent Impairment of a person injured as a result of a motor car accident".

These Guidelines which are available on the web site: www.maa.nsw.gov.au, provide directives and modifications to the use of The AMA Guides and restrict the use of The AMA Guides in some areas.

In the Introduction to the MAA Guidelines it is stated, "The MAA Guidelines make significant changes to The AMA Guides to align them with Australian Clinical Practice and to better suit them to the Act".

There is nothing specifically Australian about assessing the end result of injury. Impairment and disability assessments relate to human beings, not the place where an examination is performed. Aligning The AMA Guides to the political will however, may be the important issue. For example, the MAA Guidelines direct that "recurrent dislocation of the shoulder" is a condition that can be repaired through surgery and so is considered to have an impairment rating of 0%. Can it always be successfully repaired? Always and without complications? This directive conflicts with the views of the contributors to the AMA Guides (and with my own) that if a patient declines treatment, that decision should not increase or decrease the estimated permanent impairment.

Compensation based on assessments other than disability cannot be fair. The fairness of compensation based on disability depends on the attention paid to "medically documented injury" and its severity, the presence of "permanent impairment", "disability", "employability", restriction of the "activities of daily living" and the overall consistency of the medical history and findings. In cases where symptoms and disabilities may be false or exaggerated Key Functional Assessments and reliable information about the day to day activities of the plaintiff assume greater significance. These provide confidence in the validity of the plaintiff's presentation.

It seems that new laws are urgently needed, not new interpretations or amendments of tired old and outdated legislation. Modern laws should embrace Evidence Based Medicine and current medical research. Where legal precedent is at variance with current Evidence Based Medicine, it is the legal precedent which should change, not the medicine.

Compensation on the basis of impairment is simply not fair. PL

Footnotes:

1. Darren Moore, "The great debate: Impairment v Disability", Plaintiff, 35, October 1999, pp.39-40
2. The Guides to the Evaluation of Permanent Impairment of the American Medical Association, 4th Ed., 1993, Ch 1.5.
3. MAA Guidelines for the Assessment of Permanent Impairment of a person injured as a result of a motor car accident. www.maa.nsw.gov.au (16.02.2000)