1. INTRODUCTION AND PURPOSE

1.1. Recognising flaws in the existing RAF legislation, and bigger flaws in the proposed RABS Bill, APRAV has established a medical committee to investigate and develop proposals for an improved system of medical assessment and reporting for persons injured in road accidents.

1.2. The primary purpose of such injury assessment and reporting system is to determine appropriate awards of compensation for general (non-pecuniary) damages. If successful, the system should additionally provide a sound medical basis for the subsequent calculation of pecuniary damages.

1.3. Ideally such improved methods should reduce effort and time for medical practitioners, representatives, administrators and courts, and should result in substantial cost-savings.

2. THE MEDICAL COMMITTEE AND MEETINGS TO DATE

2.1. The APRAV medical committee was established on 5 September 2015. The members of the committee are : -

2.1.1. Dr HJ Edeling – Neurosurgeon (Chairperson of Medical Committee - Deputy Chairperson of SAMLA*).

2.1.2. Dr P Engelbrecht – Orthopaedic Surgeon (SAOA* Representative).

2.1.3. Dr H Enslin – Orthopaedic Surgeon (APRAV* Founding Member – STT* Member – SAMLA Board Member).

2.1.4. Ms E Jacobs – Occupational Therapist (APRAV Founding Member - STT Member).

2.1.5. Mr T Reynolds – Clinical Psychologist (STT Member – SACNA* Representative - SAMLA Board Member).

2.1.6. Prof H Klopper – Professor of Law UNISA (Chairperson of APRAV Solutions Task Team).

2.1.7. (* SAMLA - South African Medico-Legal Association; APRAV - Association for the Protection of Road Accident Victims; STT - APRAV Solutions Task Team; SACNA - South African Clinical Neuropsychological Association; SAOA - South African Orthopaedic Association.)

2.2. These senior practitioners have volunteered their expertise and time on a pro-deo basis as a service to the community. Since September 2015 regular meetings have been held, and members have communicated with one another on a more regular basis by telephone and email.

2.3. By March 2016 the principles and proposals set out herein have been formulated.

3. PROPOSED PRINCIPLES

3.1. The system should generate offers of compensation for general damages that : -

3.1.1. are fair and in line with principles of common law and constitutional values;

3.1.2. will substantially reduce the need for legal representation;

3.1.3. will substantially reduce the need for medico-legal expert reports; and

3.1.4. will be accepted by the majority of injured persons, thereby avoiding disputes and the need for litigation or mediation.

3.2. The system should be sufficiently simple to be amenable to accurate and meaningful reporting by existing healthcare practitioners without the need for special training.

3.3. The rather arbitrary concept that injuries are to be qualified as serious, or relegated as non-serious, is abandoned. This is replaced with the more natural concepts that injuries occur across a wide spectrum of seriousness, and that awards for general damages should be provided according to a sliding scale, greater for more serious injuries and lesser for less serious injuries.

3.4. Awards for general damages should be based principally on the permanent consequences of injuries after MMI (maximal medical improvement).

3.4.1. This necessitates the adoption of a meaningful and workable classification system for "outcome diagnosis", i.e. the diagnosis of permanent impairment after MMI (maximal medical improvement).

3.4.2. The outcome diagnosis, considered in the light of the circumstances of the injured person, should automatically generate an appropriate offer of compensation for general damages.

3.5. In order to establish the nexus of an outcome diagnosis to the accident in question, it is necessary to adopt a separate meaningful and workable classification system for "injury diagnosis", i.e. the diagnosis of injuries at the time of the accident.

3.6. Because general damage awards are intended to compensate for non-pecuniary pain, suffering and losses, the system should include reasonable methods of considering not only physical pathology and impairment, but also psychological impairment and the individual's subjective experience of pain and suffering.

3.7. Whereas the system will probably be paper-based initially, it should be amenable to reporting and storage in a digital cloud-based database.

4. COMMENT ON CLINICAL MEDICAL REPORTS AND MEDICO-LEGAL REPORTS

4.1. It is necessary to distinguish between clinical medical reports and medico-legal reports prepared by medical practitioners, and to comment briefly on the required qualifications and training to complete these reports.

4.2. Clinical medical reports relate to the standard clinical consultations that are conducted by all medical practitioners for the primary purposes of diagnosis, cause and treatment. Clinical medical reports are generally brief.

4.3. Medico-legal reports include the components of a clinical medical report, often in more detail than in a standard clinical medical report, as well as facts and opinions related to medico-legal issues such as disability, prognosis, long term treatment requirements and costs, complex issues of nexus (cause), apportionment in cases of co-morbidity, retirement age, life expectancy and/or general damages.

4.4. All registered medical practitioners should be competent to provide adequate clinical medical reports.

4.5. Medico-legal reports, which require expertise over and above that required for clinical medical reports, are normally produced by senior specialists, ideally those with post-graduate medico-legal training and experience.

4.6. In terms of current legislation, RAF 4 serious injury reports, which represent a limited form of medico-legal report, require calculation of the percentage of permanent WPI (whole person impairment) after MMI (maximal medical improvement), as well as the application of the so-called "narrative test".

4.7. The only formal post-graduate medico-legal training that is currently available in South Africa is the short course provided periodically by ABIME, under the auspices of the RAF. As much as this training is excellent, it is confined to a very narrow medico-legal aspect, namely that of calculating the WPI after MMI.

4.8. There is no formal training in the application of the narrative test, and there is no formal training in the broader requirements of medico-legal reports.

4.9. SAMLA is in the process of developing a multi-disciplinary post-graduate medico-legal training course.

5. BRIEF OVERVIEW OF PROPOSALS

5.1. At or about the time of the initial clinical consultation of the injured individual, the (any) attending medical practitioner will complete a simple "First Injury Report", as part and parcel of the clinical consultation.

5.2. At regular intervals after the accident, probably one month, six months and thereafter every six months until MMI, any available medical practitioner will complete a simple "Progress Injury Report", as part and parcel of routine clinical follow-up consultations.

5.3. The most vital purpose of the progress injury reports will be the early referral of injured persons to necessary further treatment and/or rehabilitation.

5.4. The medical practitioners who complete first- and progress injury reports will need to read and understand the directions included with the report forms, but will not require any special training over and above their standard clinical competence.

5.5. Once MMI has been reached, which in many cases may be as soon as six months after the accident, a suitably trained and experienced medical practitioner will complete an "MMI Outcome Injury Report", which represents a limited form of medico-legal report. This outcome injury report will be similar to the existing RAF4 serious injury report in certain respects, but will be far superior in terms of providing useful information to the compensation system.

5.6. The medical practitioners who complete outcome injury reports will need a suitable level of clinical qualification and experience, and will need to attend a short training program, probably no longer than 2 days.

5.7. On the basis of the envisaged outcome report, the administrative system of the RAF will (automatically) generate an appropriate offer for non-pecuniary damages.

5.8. Medical practitioners should have the option of providing reports either on paper or in digital form from a computer, tablet or smartphone.

6. PROPOSED IMPLEMENTATION WITH RESPECT TO MEDICAL ASSESSMENT FOR GENERAL DAMAGES

6.1. Step 1 – First Injury Report

6.1.1. The committee has already developed a simple yet effective "APRAV RAF Injury Diagnosis System of Classification" for South African purposes, to be used in the first injury report, and has also designed a workable "First Injury Report Form".

6.1.1.1. The "APRAV RAF Injury Diagnosis System of Classification", as well as the proposed "First Injury Report Form", are described and demonstrated in the attached annexures "APRAV-FirstInjuryReportContent-Draft" and "APRAV-FirstInjuryReportForm-Draft".

6.1.1.2. From these it is evident that the report can be completed quickly and easily by a medical practitioner without any special training.

6.1.1.3. It is also evident that although simple, and therefore relatively immune to error, the proposed "APRAV RAF Injury Diagnosis System of Classification" will provide useful and meaningful information for the subsequent purpose of determination of the nexus between the accident and the outcome diagnosis after MMI.

6.1.2. As soon as practical after an accident, a First Medical Report will be provided by an attending medical practitioner.

6.1.3. An initial injury notification report, to be completed by persons other than medical practitioners in circumstances that a medical practitioner is not available, is under consideration.

6.2. Step 2 – Progress Injury Reports (Multiple)

6.2.1. Injured persons will be required to attend a follow-up assessment at regular intervals after the accident, probably at one month, six months and thereafter every six months until the injuries have stabilised, i.e. MMI has been reached.

6.2.2. At each follow-up assessment a progress injury report will be provided by the attending medical practitioner.

6.2.2.1. The required content for each progress report is set out in the attached annexure "APRAV-ProgressInjuryReportContent-Draft". Once the required content is finalised it will be formatted into a form for ease of use.

6.2.2.2. Each progress report will be supplemented by a pain/disability self-report questionnaire, to be completed by the injured person. Proposals in this regard have been formulated by Ms Jacobs. Please refer to the attached document "APRAV-PainDisabilitySelfReport-Jacobs-Draft" for a brief description of the reasons and methodology, together with the proposed questionnaires relating to pain and disability.

6.2.2.3. Particular advantages of the pain/disability self-report questionnaire include : -

6.2.2.3.1. affording the injured individual the satisfaction of speaking out and "being heard" in relation to the subjective experiences that are important to him or her;

6.2.2.3.2. early and repeated reference to the circumstances of the injured individual and the influence thereon of the injuries;

6.2.2.3.3. reducing the clouding influence of subjective expressions of pain and suffering on the objective medical assessment of diagnosis, nexus, impairment, treatment etc.

6.2.2.4. It is evident that that the envisaged progress report can be completed quickly and easily by any competent medical practitioner who reads and understands the instructions, but without the need for any special training. This practitioner will preferably practice in the proximity of the place of residence of the injured person.

6.2.2.5. It is also evident that although simple, the series of progress reports prior to MMI will provide valuable information to be taken into account at the time of the outcome assessment after MMI.

6.2.3. Major features of the proposed progress report are : -

6.2.3.1. Review, confirmation and/or updating of the injury diagnosis, according to the same injury diagnosis system of classification used in the first report.

6.2.3.2. Description of treatment since the accident or previous report.

6.2.3.3. Determination whether the injuries are responding to treatment and healing according to medical expectation or not.

6.2.3.4. Determination of any evidence of complications.

6.2.3.5. Review of a self-report pain/disability questionnaire completed by the injured person, and the examiner's opinion as to whether such subjective reports are medically credible or inappropriate.

6.2.3.6. Determination of whether MMI has been reached.

6.2.3.7. Recommendations for further treatment if required.

6.2.3.8. Recommendations for rehabilitation if required.

6.2.3.9. Recommendations for personal care and/or supervision if required.

6.2.4. A vital component of this system is the early referral for necessary treatment, rehabilitation etc.

6.2.4.1. The recommendations recorded on the report should be communicated (automatically) to the RAF so that injured persons can be referred timeously for necessary treatment, rehabilitation etc.

6.2.4.2. At the time of subsequent assessment, injured persons should be asked to comment on the adequacy of the assistance provided by the RAF in facilitating access to treatment and rehabilitation?

6.2.4.3. The relevant non-medical committees (i.e. legal / finance / intergovernmental) should consider practical implementation of such treatment/rehabilitation recommendations.

6.2.4.4. On medical grounds it is anticipated that appropriate early treatment and rehabilitation will reduce the extent and costs of permanent disability, and will return greater numbers of injured individuals to the productive workforce.

6.3. Step 3 – Outcome Report After MMI and Offer of Compensation

6.3.1. Once MMI has been reached, injured persons will be required to attend an assessment for the purpose of obtaining a defining "MMI Outcome Injury Report", which represents a limited form of medico-legal report. In most cases this should be the final medical assessment leading to compensation for general damages.

6.3.1.1. The initial draft of required content for each outcome report is set out in the attached annexure "MMI-OutcomeInjuryReport-Draft". The committee needs to do further work on this report. Once the required content is finalised it will be formatted into a form for ease of use.

6.3.1.2. This defining report will need to be completed by suitably qualified and experienced medical practitioners, who have successfully completed a short training program specific to the outcome injury report.

6.3.1.2.1. Suitably qualified and experienced medical practitioners would include general medical practitioners and medical specialists who have at least 5 years' experience in clinical practice.

6.3.1.2.2. The training should ideally be provided by a committee appointed jointly by the RAF, APRAV and SAMLA.

6.3.1.2.3. It should be possible to provide adequate training over a period of 1 to 2 days.

6.3.2. For the required "outcome diagnosis" classification system, the system published in the "British Guidelines for the Assessment of General Damages in Personal Injury Cases" has been selected as most directly applicable and useful. Permission to use this publication as a basis, which will need to be slightly modified in accordance with South African law and realities, will need to be obtained from the publishers.

6.3.2.1. For each diagnosis in these guidelines, the British authors have allocated a monetary range in pounds sterling, within which the presiding judge exercises his or her discretion to arrive at an award.

6.3.2.2. In South Africa, where the need is to avoid litigation and unnecessary burden on the courts, the system should generate a fair offer without the necessity of recourse to the court.

6.3.2.3. Therefore, for each diagnosis according to these guidelines, 3 ZAR values will be proposed by Prof Klopper, in conjunction with the relevant non-medical committees (i.e. legal / finance / intergovernmental), in order to offer fair compensation for each of 3 levels of severity, namely upper or more severe level / average level / lower or less severe level.

6.3.2.4. At the time of assessment after MMI in South Africa, and having diagnosed an injured person's outcome in terms of this classification system, the reporting medical practitioner should allocate the injured person's outcome to one of the 3 levels of severity, i.e. upper or more severe level / average level / lower or less severe level. The medical report will contain no reference to any monetary value.

6.3.2.5. In considering this allocation, the circumstances of the injured person should be taken into account.

6.3.2.6. In suitable cases, most commonly physical impairment resulting from orthopaedic injuries, the reporting medical practitioner may additionally refer to the WPI calculation according to the Sixth Edition of the AMA Guides to the Evaluation of Permanent Impairment.

6.3.3. On the basis of the medical outcome report after MMI, in particular the outcome diagnosis and the medical practitioner's allocation to a level of severity, the administrative system of the RAF will (automatically) generate an appropriate offer for non-pecuniary damages.

6.3.3.1. This offer will (automatically) be communicated to the injured person, who will be free to accept or reject the offer.

6.3.3.2. In designing the system, and particularly in allocating ZAR values to each diagnostic level, the aim should be for offers to be reasonable, so that they should be accepted by the majority of injured persons.

6.3.3.3. The overall vision is for 80% or more of claims to be accepted by claimants according to this simple and cost-effective path. It is anticipated that these will largely represent claims for relatively less serious injuries, as well as claims for more serious injuries that are relatively simple to define according to objective criteria.

6.3.4. Whereas the intention of this system is that literate claimants of sound mind, with access to electronic communication, will not require administrative assistance or legal representation in order to obtain fair and reasonable compensation for general damages, it is anticipated that, because of conditions in South Africa, many claimants will require such assistance and/or representation.

6.3.4.1. The relevant non-medical committees (i.e. legal / finance / intergovernmental) should consider access to appropriate assistance and/or representation.

7. PROPOSED IMPLEMENTATION OF A PARALLEL PSYCHOLOGICAL ASSESSMENT PATH FOR GENERAL DAMAGES

7.1. The need has been identified to develop a parallel stand-alone psychological assessment path for persons who suffer psychological trauma rather than physical injury.

7.2. Proposals in this regard have been formulated by Mr Reynolds. Please refer to the attached document "APRAV-PsychologyPath-Reynolds-Draft" for a brief description of the problems, together with proposals for a system of reporting with respect to first-, progress- and outcome psychology reports.

7.3. In cases with significant psychological sequelae of physical injuries, and in those with psychosomatic symptoms that complicate the assessment of the physical injuries and their sequelae, the progress- and outcome psychology reports should be used to supplement the progress- and outcome medical reports.

7.4. Further development is in progress in relation to the methods by which the outcome psychology report will enable the administrative system of the RAF to (automatically) generate an appropriate offer for non-pecuniary damages related to psychological impairment.

7.5. The intentions of the psychological assessment path are that it : -

7.5.1. should lead to fair compensation for psychological sequelae of motor accidents; and

7.5.2. should reduce the burden of psychosomatic complaints that often complicate and cloud the medical assessment of physical injuries and their sequelae.

8. PROPOSED PROCEDURE FOR CLAIMANTS WHO REJECT THE GENERAL DAMAGES OFFER

8.1. Any claimant who does not accept the offer of compensation for general damages flowing from the outcome medical report and/or outcome psychology report, hopefully less than 20% of claims, will have the right to lodge a dispute.

8.2. Disputing claimants should have access to any legitimate avenue of dispute resolution, principally mediation and/or litigation.

8.3. It is anticipated that disputed claims, whether they are dealt with by way of mediation or litigation, will require legal representation as well as medico-legal expert reports in most cases.

8.4. In order to avoid duplication of factual evidence, legal representation and medico-legal expert reports should deal simultaneously with general damages and pecuniary damages (see below).

9. PROPOSED PROCEDURE WITH RESPECT TO MEDICAL ASSESSMENT FOR PECUNIARY (PATRIMONIAL) DAMAGES

9.1. The series of medical reports described above in relation to general damages will form the foundation of the medical assessment for determination of pecuniary damages. The outcome injury report may be regarded as a "first-line medico-legal report".

9.2. In appropriate cases, relevant medical specialists will be required to provide "second-line medico-legal reports", to address any unresolved medico-legal aspects such as disability, prognosis, long term treatment requirements and costs, complex issues of nexus (cause), apportionment in cases of co-morbidity, retirement age, life expectancy and/or general damages.

9.3. These will need to be supplemented by the reports of necessary quantifying exerts, such as clinical/neuro psychologists, speech therapists, educational psychologists, physiotherapists, occupational therapists and/or industrial psychologists.

9.4. Multidisciplinary summary reports, in the form of joint minutes between the medical specialist/s and quantifying exerts, would facilitate the administrative and legal determination of pecuniary damages.

9.5. Methods must be employed to limit the costs of legal representation and medico-legal reports to those that are necessary and reasonable, without infringing on the rights of individuals to representation and assistance. Recommendations in this regard include : -

9.5.1. Mediation in preference to litigation, with retention of the right of access to litigation if mediation fails.

9.5.2. No duplication of medico-legal reports for general damages on the one hand and pecuniary damages on the other.

9.5.3. Joint appointment of single experts in fields that are necessary for fair calculation of damages.

9.5.4. If the legal representatives of both parties perform their duties honestly and properly, and if the medico-legal experts report honestly, logically and objectively, there should be no case that requires adjudication in Court.

9.5.5. Frivolous use of litigation should be discouraged by adverse risk/benefit ratios of potential gains and cost implications.

9.5.6. Potential gains and cost implications should be predictable, within a reasonable degree of accuracy and reliability, on the basis of factual evidence and the law.

9.5.7. If a jointly appointed expert appears to any party to be incapable or biased, the offended party will retain the right to a second opinion, i.e. the appointment of an additional expert in the same field.

9.5.8. Sanctions should be applied to legal representatives and medico-legal experts who are guilty of ethical misconduct.

10. FINAL COMMENT

10.1. I wish to express my sincere appreciation and gratitude to each member of the committee for their constructive and creative work, given in a spirit of friendly and selfless service to the community.

10.2. The work of the medical committee continues. No doubt the existing proposals will be improved and fine-tuned. The principal outstanding issues that require further action and/or development are : -

10.2.1. obtaining permission from the publishers to use the British Guidelines for the Assessment of General Damages in Personal Injury Cases;

10.2.2. minor modification of these guidelines in accordance with South African law and realities;

10.2.3. the allocation of rand values to each diagnosis and level;

10.2.4. a fair and reasonable method to calculate general damages related to multiple outcome diagnoses;

10.2.5. an initial notification report to be completed by persons other than medical practitioners or psychologists in circumstances that neither is available;

10.2.6. the method by which the outcome psychology report will be used to generate an appropriate offer for non-pecuniary damages related to psychological impairment;

10.2.7. development of a digital cloud based injury reporting system;

10.2.8. access of compromised injured persons to reporting, treatment, rehabilitation and care, as well as to fair and reasonable compensation for general damages; and

10.2.9. legally sound methods to limit the costs of legal representation and medico-legal reports, without infringing on the rights of individuals to reasonable representation and assistance.

10.3. The purpose of this preliminary report is to inform the soon to be established legal-, finance- and intergovernmental committees about the vision and concepts of the medical committee, and more particularly to refer to them the outstanding issues listed above for their consideration, action, creative thinking, feedback and integration.

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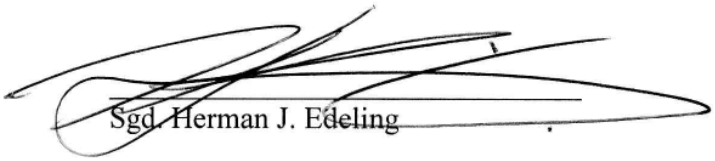

20 March 2016

Chairperson, APRAV Medical Committee.

Annexures : -

A. APRAV-FirstInjuryReportContent-Draft
B. APRAV-FirstInjuryReportForm-Draft
C. APRAV-ProgressInjuryReportContent-Draft
D. APRAV-PainDisabilitySelfReport-Jacobs-Draft
E. APRAV-MMI-OutcomeInjuryReportContent-Draft
F. APRAV-PsychologyPath-Reynolds-Draft

