

INTEGRATED SYSTEM of PROCEDURES for VICTIMS of ROAD ACCIDENTS wrt**Medical Reporting, Access to Healthcare & Data Management.****Parallel Psychological Assessment & Reporting.****Scientificallly-Based Sliding Scale Offers for General Damages.*****(Alternative Procedures in case of Limitation of Awards to "Serious Injuries")*****Subsequent Procedure wrt Medical Assessment for Patrimonial Damages****1. INTRODUCTION AND PURPOSE**

- 1.1. Recognising the high costs generated by wasteful and counterproductive practices in medico-legal evaluation and reporting, as well as flaws in the existing RAF legislation, APRAV's medical committee has conducted further investigation, including a national consultative process, to develop an improved system of medical reporting and data management for persons injured in road accidents.
- 1.2. The primary purpose of the proposed system is to facilitate and promote early referrals and access to physical healthcare, mental healthcare, rehabilitation and case management services as and when necessary, and to promote communication and understanding between healthcare practitioners, RAF claims handlers and legal representatives.
- 1.3. Such improved methods should reduce effort and time for all stakeholders; should result in cost-savings; and should provide a sound medical basis for the subsequent determination of patrimonial (pecuniary) and general (non-pecuniary) damages.
- 1.4. The secondary purpose of the proposed system is to determine appropriate awards of compensation for general damages, to all road accident victims with permanent disability, according to a sliding scale that is based on a rational medical determination of the seriousness of the permanent sequelae of such injuries.

2. PROPOSED PRINCIPLES

2.1. The system is designed to generate offers of compensation for general damages that : -

2.1.1. are fair and in line with principles of disability assessment, common law and constitutional values;

2.1.2. will substantially reduce the need for legal representation;

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

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

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

2.3. 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, to all road accident victims whose injuries result in permanent disability, greater for more serious disability and lesser for less serious disability.

2.4. Awards for general damages should be based on the levels permanent disability and suffering resulting from injuries after MMI (maximal medical improvement).

2.4.1. 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).

2.4.2. The outcome diagnosis (permanent impairment), considered in the light of the circumstances of the injured person, should provide understanding of the level of permanent disability and suffering, thereby enabling automatic generation of an appropriate offer of compensation for general damages.

2.5. In order to establish the nexus between an outcome diagnosis (permanent impairment) and the injury sustained in 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.

2.6. Because general damage awards are intended to compensate for non-pecuniary disability, in the form of 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.

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

3. COMMENT ON CLINICAL MEDICAL REPORTS, MEDICO-LEGAL REPORTS AND RAF4 REPORTS

3.1. 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.

3.2. 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.

- 3.3. 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 (causation), apportionment in cases of co-morbidity, retirement age, life expectancy and/or general damages.
- 3.4. All registered medical practitioners should be competent to provide adequate clinical medical reports.
- 3.5. 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.
- 3.6. 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 "Narrative Test".
- 3.7. The American Board of Independent Medical Examiners (ABIME) provides post-graduate training in South Africa that is limited to the determination of WPI according to the AMA Guides 6th Edition.
- 3.8. The Faculty of the South African Medico-Legal Association (SAMLA) provides comprehensive multi-disciplinary post-graduate medico-legal training in South Africa, which includes training in the application of the "Narrative Test" inter alia.

4. BRIEF OVERVIEW OF PROPOSALS

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

- 4.2. At regular intervals after the accident, no less than one month, six months and thereafter every six months until MMI, any chosen medical practitioner will be consulted for completion of a simple "Progress Injury Report", as part and parcel of routine clinical follow-up consultations.
- 4.3. The most vital purpose of the progress injury reports will be the early referral of injured persons to necessary further treatment, investigation, rehabilitation and/or case management.
- 4.4. 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 training and experience.
- 4.5. Once MMI has been reached, which in many cases may be as soon as 6 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 superior in terms of providing useful information to the medico-legal compensation system.
- 4.6. 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.
- 4.7. On the basis of the envisaged MMI Outcome Injury Report, the administrative system of the RAF will (automatically) generate an appropriate offer for general damages.
- 4.8. Medical practitioners should have the option of providing reports either on paper or in digital form from a computer, tablet or smartphone.

5. PROPOSED IMPLEMENTATION OF INTEGRATED SYSTEM OF MEDICAL REPORTING, ACCESS TO HEALTHCARE AND DATA MANAGEMENT PROCEDURES

5.1. First Injury Report

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

5.1.2. The committee has 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”.

5.1.2.1. 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-First Injury Report Content” and “APRAV-First Injury Report Form”.

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

5.1.2.3. 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 (permanent impairment) after MMI.

5.1.3. 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.

5.2. Progress Injury Reports (Multiple)

5.2.1. Injured persons will be required to attend follow-up clinical assessments at regular intervals after the accident, as recommended by the treating medical practitioners, but no less than one month, six months and thereafter every six months until the injuries have stabilised, i.e. MMI has been reached.

5.2.2. At each follow-up clinical consultation a progress injury report will be provided by the attending medical practitioner.

5.2.2.1. The required content for each progress injury report is set out in the attached annexure "APRAV-Progress Injury Report Content". At the appropriate time the APRAV Medical Committee will format this content into a form for ease of use.

5.2.2.2. Each progress injury report will be supplemented by a pain/disability self-report questionnaire, to be completed by the injured person. Please refer to the attached document "APRAV-Pain Disability Self Report-Jacobs" for a brief description of the reasons and methodology, together with the proposed questionnaires relating to pain and disability.

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

5.2.2.3.1. 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;

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

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

5.2.2.4. It is evident that that the envisaged progress injury 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.

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

5.2.3. Major features and benefits of the proposed system of progress injury report are : -

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

5.2.3.2. Description of treatment received since the accident or previous report.

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

5.2.3.4. Determination of any evidence of complications.

5.2.3.5. 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.

- 5.2.3.6. Determination of whether MMI has been reached.
 - 5.2.3.7. Recommendations for further treatment if required.
 - 5.2.3.8. Recommendations for rehabilitation if required.
 - 5.2.3.9. Recommendations for case management if required.
- 5.2.4. A vital component of this system is the early referral for necessary treatment, rehabilitation and/or case management, i.e. appropriate access to healthcare.
- 5.2.4.1. The recommendations recorded on the progress injury report should be communicated (automatically) to the RAF, injured person and authorised representatives, so that injured persons can be referred timeously for necessary treatment, rehabilitation and/or case management.
 - 5.2.4.2. The relevant non-medical committees (i.e. legal / finance / intergovernmental) should consider practical implementation of such access to healthcare recommendations.
 - 5.2.4.3. On medical grounds it is anticipated that appropriate and early access to healthcare, as promoted and facilitated by this system, will reduce the extent and costs of permanent disability and suffering, will return greater numbers of injured individuals to the productive workforce, and will reduce the amounts of compensation to be awarded.

6. PROPOSED IMPLEMENTATION OF OUTCOME MEDICAL ASSESSMENT AND SCIENTIFICALLY-BASED SLIDING SCALE OFFERS OF COMPENSATION FOR GENERAL DAMAGES

6.1. Outcome Injury Report After MMI

6.1.1. 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.

6.1.1.1. The required content for this report is set out in the attached annexure “MMI - Outcome Injury Report”. At the appropriate time the APRAV Medical Committee will format this content into a form for ease of use.

6.1.1.2. This 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.

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

6.1.1.2.2. The training should ideally be provided by an independent body of suitably experienced experts.

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

6.1.2. 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.

6.1.2.1. 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.

6.1.2.2. In South Africa, where there is a major need to avoid litigation and unnecessary burden on the courts, this “Integrated System of Medical Reporting, Access to Healthcare and Data Management Procedures” should generate fair offers without the need for recourse to the courts in the majority of cases.

6.1.2.3. Therefore, for each diagnosis that is determined according to these guidelines, 3 ZAR values for general damages compensation will be determined by Prof Klopper, in conjunction with the legal and finance committees of APRAV, and on the basis of South African case law, in order to offer fair compensation for each of 3 levels of severity, namely (a) upper or more severe level, (b) average level and (c) lower or less severe level.

6.1.2.4. At the time of assessment after MMI, 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. (a) upper (b) average or (c) lower level. The medical report will contain no reference to any monetary value.

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

6.1.2.6. 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.

6.2. Generation of Offers of Compensation for General damages

6.2.1. On the basis of the MMI Outcome Injury Report, 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 general damages.

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

6.2.1.2. 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 are likely to be accepted by the majority of injured persons.

6.2.1.3. 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, by their nature, are relatively simple to define according to objective criteria.

6.2.2. Whereas the intention of this system is that literate claimants of sound mind, who have access to electronic communication, should 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.

6.2.3. 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-Psychology Path-Reynolds" 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 general 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 negotiation, mediation and/or litigation.

8.3. It is anticipated that disputed claims, whether they are dealt with by way of negotiation, 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 claims for general damages and patrimonial damages (see below).

9. SUBSEQUENT PROCEDURE WITH RESPECT TO MEDICAL ASSESSMENT FOR 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 (causation), 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 experts, such as clinical/neuro psychologists, speech therapists, educational psychologists, physiotherapists, occupational therapists, industrial psychologists and/or actuaries.
- 9.4. Multidisciplinary summary reports, in the form of joint minutes between the medical specialist/s and quantifying experts, would facilitate the administrative and legal determination of damages.
- 9.5. There is a major need for methods to limit the costs of legal representation and medico-legal reports to those that are necessary and reasonable, without infringing on the Constitutional rights of individuals to representation and assistance. Recommendations in this regard include : -
- 9.5.1. Direct settlement negotiations and/or 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 patrimonial 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 ethically, and if the medico-legal experts report ethically (factually, 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 opposing 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. ALTERNATIVE PROCEDURES IN CASE OF RETENTION OF LIMITATION OF AWARDS FOR GENERAL DAMAGES TO PERSONS WITH "SERIOUS INJURIES"

10.1. *The purpose of these alternative recommendations is to :-*

- 10.1.1. *Improve the existing RAF4 system of "serious injury" determination, in the event that it is decided by Parliament not to alter the limitation of awards for general damages to persons with "serious injuries".*

10.2. *The need for these recommendations arises from :-*

- 10.2.1. *Shortcomings of the AMA Guides (Fabricius Judgment - SAMLA Faculty), particularly with respect to the failure to recognise the circumstances of injured persons, as well as inability to measure abstract impairments.*
- 10.2.2. *Failure of reporting medical practitioners and appeal tribunals to comply with Narrative Test Guidelines published by the HPCSA in the SAMJ.*

10.2.3. *Lack of competence and independence of HPCSA personnel (SAMPLA correspondence and meeting with Ministers of Health and Transport).*

10.2.4. *Abuse of human rights of permanently disabled persons by delaying tactics, frivolous rejection of claims and failures of appeal tribunals to comply with PAJA duties.*

10.3. These shortcomings, failures and abuses can be remedied by :-

10.3.1. *Establishment of an appropriate and competent Independent Oversight Body and an appropriate and competent Independent Administrative Body.*

10.3.2. *Publish Regulations (Guidelines and Protocol) for serious injury assessment, with particular attention to the rational application of the Narrative Test for determination of serious injuries.*

10.3.3. *Publish Regulations (Guidelines and Protocol) for functioning of Appeal Tribunals, with particular attention to selection criteria, duties and remuneration of Appeal Tribunal members.*

10.3.4. *Provide training for senior healthcare practitioners i.r.o. medical and legal requirements of the administrative action exercised by Appeal Tribunal members, in line with the Promotion of Administrative Justice Act.*

10.3.5. *Publish an improved and more rational RAF 4 medical report form;*

10.3.6. *Establish a just and equitable mechanism to hear appeals against the findings of tribunals.*

11. FINAL COMMENT

11.1. I wish to express my sincere appreciation and gratitude to each member of the APRAV Medical Committee, as well as the coordinators and committee members of each of the 6 sub-streams that were engaged in the National Consultative Process, for their constructive and creative work, given in a spirit of friendly and selfless service to the community.

11.2. The work of the APRAV Medical Committee continues. The principal outstanding issues that require further action and/or development are : -

11.2.1. development of a digital cloud based injury reporting and data management system;

11.2.2. development of the administrative system to enable access of injured persons to treatment, rehabilitation, case management and reporting;

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

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

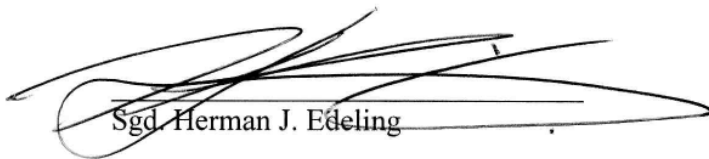
11.2.5. minor modification of these British Guidelines in accordance with South African law and realities;

11.2.6. the allocation of fair and reasonable rand values to each diagnosis and level;

11.2.7. development of the method by which the outcome psychology report will be used to generate an appropriate offer for general damages related to psychological impairment;

11.2.8. development of the administrative system to provide fair and reasonable compensation for general damages in accordance with MMI Outcome Injury Reports; and

11.2.9. development of 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.



Sgd. Herman J. Edeling

27 October 2020

Chairperson, APRAV Medical Committee.

Annexures : -

- A. APRAV-First Injury Report Content
- B. APRAV-First Injury Report Form
- C. APRAV-Progress Injury Report Content
- D. APRAV-Pain Disability Self Report Content and Forms-Jacobs
- E. APRAV-MMI Outcome Injury Report Content
- F. APRAV-Psychology Path-Reynolds

A. PATIENT AND ACCIDENT DETAILS

Name / Surname / ID number

Date of accident / Place of accident

Driver / Passenger / Cyclist / Pedestrian

Car / Taxi / Bus / Truck / Motorbike / Other

Fatalities : Yes / No / Patient / Family members / Non-family members

B. INJURY DIAGNOSIS

Injury diagnosis classification grid (mark with “X” - see example on form)

Region/s of injury/injuries

Head – Chest – Abdomen – Back – Neck – Upper limbs – Lower limbs
– Pelvis.

Injured tissue layer of each region

Superficial soft tissues (e.g. lacerations / abrasions / bruises).

Deep soft tissues (e.g. degloving / muscles / ligaments / joints).

Bones (fractures).

Internal organs (e.g. brain / spinal cord / nerves / lungs / heart / liver / spleen / kidneys / gastro-intestinal tract / uro-genital tract).

Diagrammatic representation of injuries (rough sketch - see example on form)

Diagnosis of injuries (description in words)

(e.g. Fracture of left femur. Concussion. Soft tissue neck injury. Pulmonary contusion. Ruptured spleen. Crush injury of right leg.)

C. DETAILS OF REPORTING PRACTITIONER

Print name / Date / Place / Contact number

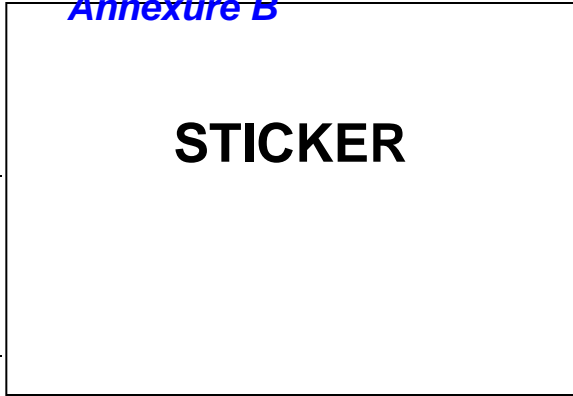
Medical practitioner / Psychologist / Nurse / Paramedic / Other

Designation / Professional registration number

Signature

RAF - FIRST INJURY REPORT

Annexure B



PATIENT DETAILS:

Name: _____ Surname: _____

ID _____

ACCIDENT DETAILS:

Date: _____ Place: _____

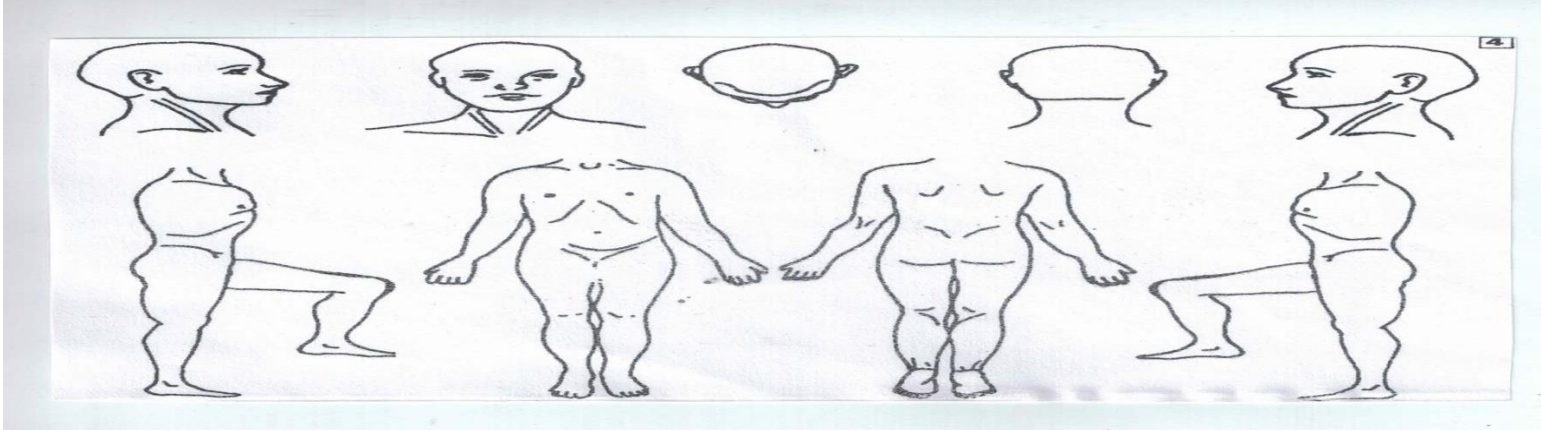
- Driver Passenger Cyclist Pedestrian
 Car Truck Motorbike Taxi Bus Other

FATALITIES:

- YES NO PATIENT FAMILY MEMBERS NON-FAMILY MEMBERS

INJURIES

Injured Tissue Layers	Head	Chest	Abdomen	Back	Neck	Upper limbs	Lower limbs	Pelvis
Superficial soft tissues (eg. lacerations / bruises)								
Deep soft tissues (degloving, muscles, joints / ligaments)								
internal organs (e.g. brain/ spinal cord/ nerves/ Lungs/ heart/ liver/ spleen/ kidneys/ gastro-intestinal tract/ uro-genital tract)								
Vascular or nerve structures								
Fractures								



Describe injuries (use back of page if necessary)

SIGNATURE: _____ PRINT NAME _____ DATE: _____

CONTACT NUMBER: _____ PLACE: _____

- MEDICAL PRACTITIONER NURSE PARAMEDIC PSYCHOLOGIST OTHER

PROFESSIONAL REGISTRATION NUMBER: _____ DESIGNATION: _____

A. PATIENT AND ACCIDENT DETAILS

Name / Surname / ID number

Date of accident / RAF claim number

B. UPDATED INJURY DIAGNOSIS

Injury diagnosis classification grid (mark with “X” – refer to first injury report and confirm, revise and/or add)

Region/s of injury/injuries

Head – Chest – Abdomen – Back – Neck – Upper limbs – Lower limbs – Pelvis.

Injured tissue layer of each region

Superficial soft tissues (e.g. lacerations / abrasions / bruises).

Deep soft tissues (e.g. degloving / muscles / ligaments / joints).

Bones (fractures).

Internal organs (e.g. brain / spinal cord / nerves / lungs / heart / liver / spleen / kidneys / gastro-intestinal tract / uro-genital tract).

Diagnosis of injuries (description in words - refer to first injury report and confirm, revise and/or add)

(e.g. Fracture of left femur. Concussion. Soft tissue neck injury. Pulmonary contusion. Ruptured spleen. Crush injury of right leg.)

C. TREATMENT TO DATE

First progress report

Hospital admission/s – Name of hospital/s. Dates of admission and discharge.

Describe treatment **since accident** (e.g. investigations / admission to ICU / ventilation / operations / procedures / medication / therapy).

Subsequent progress reports

Describe treatment **since previous progress report** (e.g. admission to hospital / ICU / investigations / ventilation / operations / procedures / medication / therapy / rehabilitation).

D. PROGRESS TO DATE

Are the injuries responding to treatment and healing according to medical expectation? (Yes / No).

If No please comment.

Is there any evidence of complications? (Yes / No).

If Yes please describe the complication/s.

Have the injuries reached MMI (Maximal Medical Improvement) as defined? (Yes / No).

If No then complete this report and remind the person to return for

further follow-up after 6 months.

If Yes then complete this report and arrange referral for a final assessment and outcome report.

E. COMMENT ON SELF-REPORT QUESTIONNAIRE

Reported pain experience (None / Mild / Moderate / Severe / Very Severe). Opinion of examiner (Credible / Inappropriate exaggeration / Inappropriate underreporting).

Reported functional limitations (Total score between 0 and 100). Opinion of examiner (Credible / Inappropriate exaggeration / Inappropriate underreporting).

(In case of perceived inappropriate exaggeration or underreporting, please record and explain relevant observations.)

F. RECOMMENDATIONS

Is any further treatment required? (Yes / No).

If Yes please indicate (medication / investigation / referral to a specialist / operation / procedure / referral to therapist). Please provide detailed recommendations.

Is rehabilitation required? (Yes / No).

If Yes please indicate (admission to rehabilitation centre / out-patient rehabilitation / physiotherapy / occupational therapy / speech therapy

/ cognitive therapy / psychotherapy / mobility aids). Please provide detailed recommendations.

Is personal care and/or supervision required? (Yes / No).

If Yes please indicate (full time nursing care / part time nursing care / care giver / supervisor). Please provide detailed recommendations.

G. DETAILS OF REPORTING PRACTITIONER

Print name / Date / Place / Contact number

Medical practitioner / Psychologist / Nurse / Paramedic / Other

Designation / Professional registration number

Signature

The Functional Limitations Self-Report Questionnaire (FLSRQ) concerning quantifying pain and suffering within the medico-legal industry in the SA context

1. *Background for developing a questionnaire/screening tool to aid quantification of pain and suffering:*

When quantifying pain and suffering, it is not only the nature and extent of the injuries and physical symptoms that need to be considered, but also the impact on the plaintiff's conduct and lifestyle. Factors such as the severity and duration of the pain, disability/physical impairment, physical disfigurement, emotional suffering, loss or enjoyment of life, family, marital and social relationships, impairment of physical and mental abilities and loss of lifestyle all form part of the calculation for general damages.

A self-report questionnaire was therefore developed to guarantee inclusiveness of all related factors. In order to aid the meaningful, reliable, objective and fair measurement of pain and suffering, the client's subjective experiences are considered a vital component in the process.

Where the physician/medical expert attempts to provide an objective clinical/medical opinion based on medical, empirical facts, this questionnaire gives the client the opportunity to express his/her subjective experience of functional limitations: who better to provide feedback on pain response and functional impairment than the person experiencing it. In a sincere individual such self-report can provide valuable information.

2. *Overview:*

This questionnaire covers a much wider field than merely physical pain and physical discomfort/impairment. Although it does not deal with the problem/s in detail, it deals with the functional sequelae of the accident. Thus, it asks the client to rate his/her perception of functional impairment, and in this case it can mean impairment due to physical, mental, psychological or psycho-social sequelae. Its intent is NOT to go into depth, as this will require specific expert assessment, but to merely provide an overview/screening of the client's perception of functional impairment, where after more in-depth and need-specific assessments can be arranged if necessary. The questionnaire is completed more than once to give an indication of possible changes in functioning over time. This might assist the physician/medical expert in determining the seriousness of the condition, the course of the condition, aspects relating to prognosis, etc.

Care was taken to create an uncomplicated, time-efficient tool that is simple to administer and score.

3. Background on selection of assessment methods and areas to be assessed/screened:

3.1 In assessing/screening pain, it was decided to use a three-way approach in order to ensure that clients with different intellectual capacities have the best chance of comprehending what is expected of them. When assessing “pain”, it should be acknowledged that pain severity is always subjective, even if the neuroreceptors register an objective “quantity” of pain. This is because there is always an emotional component to a person’s perception of pain due to the interpretation of the pain signal in the central nervous system. Therefore, a person’s specific pain perception is of importance to gain an understanding of how they interpret their situation. It was decided to evaluate the pain using a simple tool like an NRS (Numerical Rating Scale) with uncomplicated, yet detailed word descriptors anchored to each number to provide clarity and comprehensiveness. On the right side of the Pain Scale are the five descriptors of the severity of the client’s problem used in The Guides to the Evaluation of Permanent Impairment, 6th Ed., AMA, 2008⁴, None (NO), Mild (M), Moderate (MOD), Severe (S) and Very Severe (VS). This was done to create consistency throughout the entire process of assessing/testing within the medico-legal industry in the SA context. The “Faces Pain Scale” was additionally included for clients who cannot read or who have, for one or another reason, difficulty to understand the NRS/word descriptor scale. The pain drawing also forms part of the pain assessment/screening. This is mainly to determine the client’s perception of pain location.

3.2 The Difficulty Scale was developed to screen the most important areas where the client might experience functional difficulty as sequelae of the accident in question. Areas include: personal care (ADL), sleeping, travelling, home maintenance/domestic tasks/gardening, walking/sitting/standing, leisure time spending, social interaction, emotional experiences and intellectual capacity. Similar to the assessment/screening of pain (and for the same reasons), the five descriptors of the severity of the client’s problem used in The Guides to the Evaluation of Permanent Impairment, are also applicable here.









*Below find the **FLSRQ** – the questionnaire consists of two pages which the client completes on his/her own or with assistance (if required). It is a self-report questionnaire and thus reflects the client’s perception and not the evaluator’s opinion (However, the evaluator does indicate at the bottom of each page, whether the reported symptoms are credible, inappropriately exaggerated or underreported considering objective medical findings). Then you will find the section where the **purpose of each test module, administration and scoring** is explained to the evaluator. Next you’ll find the “**sheet for exit process**” which is the scoring sheet that should be completed by the evaluator on the last visit or point of exit.*

FUNCTIONAL LIMITATIONS SELF-REPORT QUESTIONNAIRE (FLSRQ)

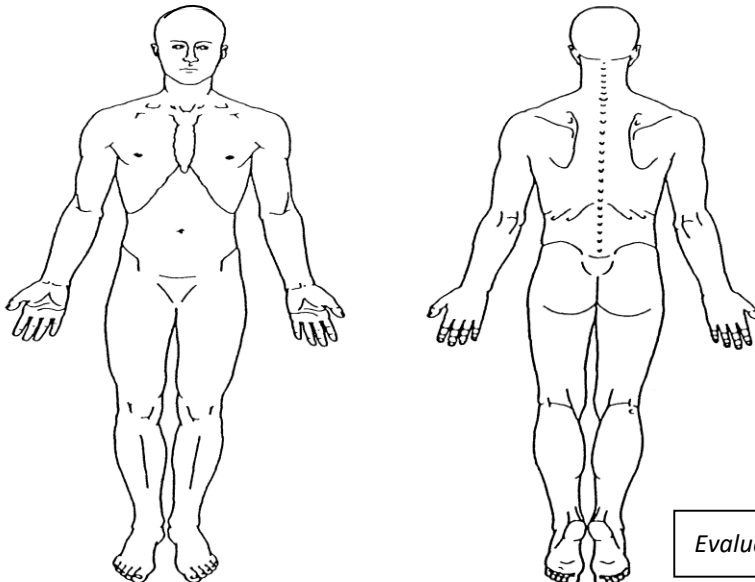
NAME: _____

DATE: _____

Instructions: You may experience symptoms such as pain and/or physical-, emotional-, or intellectual difficulties as a result of your involvement in the accident. These symptoms may cause you to struggle with your day-to-day activities, interaction with others, work and free time pursuits. By completing this questionnaire, you can show us how these difficulties have influenced you. Please circle your choice. Let's start with your **pain experience**:

RATE YOUR PAIN			Please rate your pain on a scale from zero to 10 (columns on the left). Zero means you have no pain at all and ten means the worst possible pain you can imagine. What number would you give your pain at the moment (NOW) ? What number was your HIGHEST and LOWEST pain in the last 30 days? (The "word descriptors" and "faces" may help you with your choice, but you only need to circle the numbers)		
N O W	H I G H E S T	L O W E S T			
10	10	10	Excruciating, Maximum Pain Possible	VERY SEVERE (VS)	
9	9	9	Very Severe and Sharp Pain	SEVERE (S)	
8	8	8	Severe and Sharp Pain	MODERATE (MOD)	
7	7	7	Very, Very Strong Pain or Aching		
6	6	6	Very Strong Pain or Aching	MILD (M)	
5	5	5	Strong Pain, Aching or Pressure		
4	4	4	Mildly Strong Pain, Aching or Pressure	NO	
3	3	3	Moderate Pain, Aching or Pressure		
2	2	2	Mild Pain, Aching or Pressure		
1	1	1	Very Mild Pain, Aching or Pressure		
0	0	0	No Pain or Aching, Feels Normal		

Show where your pain is located. Do not show any pain that is not related to your current injury.



Evaluator signature: C I E U

Now show us your **other difficulties**. Please rate your difficulties on a scale from zero to 10. Zero means you have no difficulty at all and ten means as bad as it can be.

1.

Take care of myself completely	Personal care tasks, such as washing, dressing, eating, etc.										Need help with <i>all</i> my personal care
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

2.

Sleep without any problems	Sleeping or sleeping position										Cannot sleep at <i>all</i>
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

3.

Travel without any problems	Travelling: driving own vehicle or using public transport										Cannot travel at <i>all</i> without assistance
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

4.

Take care of tasks completely	Everyday tasks, such as house work in the home and work outside the home in the garden or yard										Need help with <i>all</i> tasks
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

5.

No problem to walk/sit/stand	Walking / sitting / standing										Cannot sit/stand/walk at <i>all</i>
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

6.

No problem to participate	Hobbies/recreational activities and/or sport										Lost <i>all</i> interest/have <i>no</i> ability
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

7.

No problem to work	Formal or informal job										Lost <i>all</i> interest/have <i>no</i> ability
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

8.

No problem to interact	Socialising or interacting with other people										Lost <i>all</i> interest/have <i>no</i> ability
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

9.

No depression/tension/anger	Emotional experiences										Very severe depression/tension/anger
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

10.

No mental problems	Intellectual/mental ability (remember, concentrate, etc.)										Very severe mental problems
	0	1	2	3	4	5	6	7	8	9	
	No	Mild	Moderate	Severe	Very Severe						

Evaluator signature: **C I E U**

FUNCTIONAL LIMITATIONS SELF-REPORT QUESTIONNAIRE (FLSRQ)

PURPOSE OF THE FLSRQ:

The FLSRQ aims to involve the client in the decision-making process to quantify his/her pain and suffering. This will enhance the fairness of the process, as the claimant will have the opportunity to give feedback on his/her subjective experiences. This instrument does not only focus on physical pain and impairment as the client can also indicate social/emotional and mental difficulties. It is **a screening tool** with the purpose of quickly identifying possible problem areas which can be deferred to the appropriate experts for further testing.

The questionnaire is intended to be completed on more than one occasion in order to show the path of recovery and to compare results to aid the process of determining the outcome diagnosis and ultimately quantify the claim.

PURPOSE OF EACH TEST MODULE AND ADMINISTRATION:

Pain Scale – *The Pain Scale is used to gain a quick appreciation of the severity of the client's pain perception and to match his/her pain rating to objective medical findings.* The client is instructed to circle the number that best describe their pain between the extremes of "no pain" to "very severe pain" at present (now), their highest pain and their lowest pain over the last 30 days. The reason the question is asked about the client's high and low pain ratings over the last 30 days is because it is normal to experience pain fluctuation from low levels, or none at all, to higher levels occasionally and if there is no fluctuation there is reason for closer investigation. The "word descriptors" aim to guide the client to make an appropriate choice. The "faces" were added to aid the client who may experience difficulties with reading or comprehending of written instruction. However, generally speaking, the client only needs to circle the applicable number in the columns on the left, but for a client who has difficulty with this, the "faces" scale can be used instead.

Pain Drawing – *The Pain Drawing was originally designed by Ransford to be scored only for low back pain where the client is instructed to use the four modalities, stabbing, burning, pins and needles and numbness, to show the type and location of the symptoms they are experiencing. However, the pain drawing's purpose for this assessment is only to provide a quick appreciation of the location of pain for any type of injury.* The client is asked to indicate exactly where his/her pain (as sequelae of the accident in question) is located.

Difficulty Scale – *The Difficulty Scale aims to indicate the client's perception of the severity of functional limitations in his/her life as result of accident related sequelae regarding pain/physical limitation/emotional difficulties/intellectual difficulties, etc.* The client is asked to rate his/her difficulties on a scale from zero to 10 where zero means no difficulty at all and ten means as bad as it can be (very severe difficulty).

SCORING AND INTERPRETATION

Pain Scale – The client's scores on the ten-point scale regarding the three questions (now, highest and lowest in the last 30 days) are matched against the corresponding five descriptors of severity as used in The Guides to the Evaluation of Permanent Impairment, 6th Ed., AMA, 2008⁴, None (NO), Mild (M), Moderate (MOD), Severe (S) and Very Severe (VS). Pain ratings of 3 and above (MOD) suggest further investigation is necessary. If the client, for example, selects a 4, it falls into the Moderate (MOD) category and a 7 falls in the Severe (S) category and so on.

Pain Drawing – This is not scored, yet should correspond with the known medical findings/impairment.

Difficulty Scale - The client's scores on the ten-point scale regarding the ten areas are matched against the corresponding five descriptors of severity as used in The Guides to the Evaluation of Permanent Impairment, 6th Ed., AMA, 2008⁴, None (NO), Mild (M), Moderate (MOD), Severe (S) and Very Severe (VS). Difficulty ratings of 3 and above (MOD) suggest further investigation is necessary – probably more in-depth assessment by an occupational therapist. Regarding areas 8, 9 and 10 further investigation by a psychiatrist/clinical psychologist is indicated.

With each progress report, the evaluator should determine - after the client completed the form - whether pain/difficulties reports are credible (C), inappropriately exaggerated (IE) or underreported (U). Simply circle either the C, IE or U at the bottom of the form where it says: *evaluator signature*. Below are explanations for these concepts.

(C) Credible (the ideal client): *The objective findings are consistent with the client's reports of pain/difficulties and demonstrated behaviour.* In other words, pain/difficulties reports that are appropriate or reasonable considering the objective medical evidence at hand.

(IE) Inappropriate (severe) exaggerating: *The client's subjective reports are far greater than the objective findings.* Although some degree of symptom exaggeration may still be within acceptable boundaries, it becomes inappropriate when the reports of pain/difficulties are far out of proportion to medical findings and the client makes a deliberate attempt to exaggerate and/or distort his/her symptoms. Look out for high pain reports, but with normal facial affect and normal movement of the injured part, symptoms that are not medically logical, symptoms that are regional rather than specific, etc.

(U) Underreporting: *The client minimizes symptoms and the objective findings exceed the client's subjective reports.* This often happens in brain injured cases and stoic individuals that are highly motivated.

The scoring sheet for the exit process – specifically EVALUATOR NOTES - is only completed at the last visit (point of exit), yet progress reports on the FLSRQ can be updated after each visit. Scores of three and above (thus moderate, severe and very severe) suggest further investigation/referral. If the client indicated scores less than 3, yet the evaluator suspects underreporting, it is simply indicated on the form and further investigation should then also be recommended.

SHEET for EXIT PROCESS – Annexure to MMI report

Client name: _____

Date: _____

FLSRQ SCORES

Client score:	<i>Progress report</i> DATE: _____	<i>Progress report</i> DATE: _____	<i>Progress report</i> DATE: _____						
PAIN SCALE									
Now	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
Highest	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
Lowest	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS

Evaluator opinion:	C	IE	U	C	IE	U	C	IE	U
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PAIN DRAWING

Evaluator opinion:	C	IE	U	C	IE	U	C	IE	U
---------------------------	---	----	---	---	----	---	---	----	---

DIFFICULTY SCALE

1. Personal care	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
2. Sleep	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
3. Travel	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
4. Tasks	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
5. Walk, sit, stand	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
6. Sport, hobbies	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
7. Job	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
8. Socialise	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
9. Emotions	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS
10. Mental	NO/M	MOD	S VS	NO/M	MOD	S VS	NO/M	MOD	S VS

Evaluator opinion:	C	IE	U	C	IE	U	C	IE	U
---------------------------	---	----	---	---	----	---	---	----	---

EVALUATOR NOTES/SUMMARY

PAIN SCALE AND PAIN DRAWING

Do the client's scores indicate improvement over time:	YES	NO*
Did the client indicate fluctuation in pain level:	YES	NO*
Are pain reports medically logical considering the injuries/diagnosis:	YES	NO*
Are pain reports all in the none (NO) to mild (M) category:	YES	NO*
Does the client's drawing correspond with the known medical findings/impairment:	YES	NO*

DIFFICULTY SCALE

Do the client's scores indicate improvement over time:	YES	NO*
Is client version medically logical considering the injuries/diagnosis:	YES	NO*
Are problem reports all in the none (NO) to mild (M) category:	YES	NO*

*"NO" responses may indicate the need for further investigation

Further investigation required:

Medical expert/s:

Supplementary health expert/s (psychologist, occupational therapist, etc.):

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A. PATIENT AND ACCIDENT DETAILS

Name / Surname / ID number

Date of accident / RAF claim number

B. UPDATED INJURY DIAGNOSIS

Injury diagnosis classification grid (mark with “X” – refer to first injury report and confirm, revise and/or add)

Region/s of injury/injuries

Head – Chest – Abdomen – Back – Neck – Upper limbs – Lower limbs – Pelvis.

Injured tissue layer of each region

Superficial soft tissues (e.g. lacerations / abrasions / bruises).

Deep soft tissues (e.g. degloving / muscles / ligaments / joints).

Bones (fractures).

Internal organs (e.g. brain / spinal cord / nerves / lungs / heart / liver / spleen / kidneys / gastro-intestinal tract / uro-genital tract).

Diagnosis of injuries (description in words - refer to first injury report and confirm, revise and/or add)

(e.g. Fracture of left femur. Concussion. Soft tissue neck injury. Pulmonary contusion. Ruptured spleen. Crush injury of right leg.)

C. TREATMENT SINCE LAST PROGRESS REPORT

(e.g. admission to hospital / ICU / investigations / ventilation / operations / procedures / medication / therapy / rehabilitation).

D. PROGRESS TO DATE

Have the injuries reached MMI (Maximal Medical Improvement) as defined? (Yes / No).

If No then stop writing this report and replace with a further progress report.

Have the injuries responded to treatment, recovered and/or stabilised according to medical expectation? (Yes / No).

If No please comment.

Is there any evidence of complications? (Yes / No).

If Yes please describe the complication/s.

E. CIRCUMSTANCES OF INDIVIDUAL

Pre-accident age / home and family circumstances / educational status / occupation / recreational activities / any special circumstances.

Current (post-MMI) age / home and family circumstances / educational status / occupation / recreational activities / any special circumstances.

F. COMMENT ON SELF-REPORT QUESTIONNAIRE

Reported pain experience (None / Mild / Moderate / Severe / Very Severe). Opinion of examiner (Credible / Inappropriate exaggeration / Inappropriate underreporting).

Reported functional limitations (Total score between 0 and 100). Opinion of examiner (Credible / Inappropriate exaggeration / Inappropriate underreporting).

(In case of perceived inappropriate exaggeration or underreporting, please record and explain relevant observations – see annexure.)

G. OUTCOME DIAGNOSIS AFTER MMI

Provide the outcome diagnosis for any and all sequelae of the injuries according to the prescribed classification system (Adapted version of the British Guidelines for the Assessment of General Damages in Personal Injury Cases).

For each diagnosis allocate the patient's outcome to the upper level / average level / lower level.

Provide the concurrent diagnosis for any co-morbid condition/s that is/are unrelated to the injuries sustained in the accident in question.

Is each identified outcome diagnosis directly attributable to the injuries sustained in the accident in question? (Yes / No). If No please provide details of any identified unrelated but contributing condition or cause, and estimate an apportionment of damages attributable to the injuries sustained in the accident in question.

In estimating an apportionment, relevant factors to be taken into account include : -

Details of unrelated injuries, serious illnesses, chronic conditions and/or disabling conditions.

Details of unrelated treatment (doctors, operations, medication, and/or any other forms of therapy), at the time of this accident or thereafter.

Functional status immediately prior to this accident, wrt work, schooling, amenities, sports, recreational activities and relationships.

H. RECOMMENDATIONS

Is any further treatment required? (Yes / No).

If Yes please indicate (medication / investigation / referral to a specialist / operation / procedure / referral to therapist). Please provide detailed recommendations.

Is any further rehabilitation required? (Yes / No).

If Yes please indicate (admission to rehabilitation centre / out-patient rehabilitation / physiotherapy / occupational therapy / speech therapy / cognitive therapy / psychotherapy / mobility aids). Please provide detailed recommendations.

Is any further personal care and/or supervision required? (Yes / No).

If Yes please indicate (full time nursing care / part time nursing care / care giver / supervisor). Please provide detailed recommendations.

I. DETAILS OF REPORTING PRACTITIONER

Print name / Date / Place / Contact number

Medical practitioner / Psychologist / Nurse / Paramedic / Other

Designation / Professional registration number

SIGNATURE

ANNEXURE 1 TO INJURY OUTCOME REPORT

Inappropriate Pain Behaviour

In cases that present clinically with inappropriate pain behaviour, the physician should record and explain relevant observations. The physician may refer to any suitable literature, such as the following method as described in the Fifth Edition of the AMA Guides, Table 18/5 on P.580.

Factors to be considered include inappropriate -

History

Symptoms reported

Conflict with existing reports from hospitals, doctors and other experts.

NB.: The patient must be warned about the possibility that inappropriate pain behavior will affect his / her claim.

Table 18-5 *Assessment of Pain Behavior, 5th Edition of the AMA Guides*

Observable Pain Behaviors

Note the presence of any of the following behaviors during the interview and examination.

- 1. Facial grimacing*
- 2. Holding or supporting affected body part or area*
- 3. Limping or distorted gait*
- 4. Frequent shifting of posture or position*
- 5. Extremely slow movements*
- 6. Sitting with a rigid posture*
- 7. Moving in a guarded or protective fashion*
- 8. Moaning*

9. *Using a cane, cervical collar, or other device*

10. *Stooping while walking*

11. *Other:* _____

Based on the behaviors above and knowledge of the individual's diagnosis and organ dysfunction, rate the pain behaviors by giving them a score between +10 and -10. You may give any score between +10 and -10.

-10	0	+10
<i>Pain behaviors are exaggerated, non-physiologic</i>	<i>Pain behaviors are mixed or ambiguous</i>	<i>Pain behavior are appropriate and tend to confirm other clinical findings</i>

Global pain behavior score= _____

Private Investigator Report

(a) The examining doctor should consider the need for a private investigator's report in cases of suspected significant malingering.

(b) Alternate telephone numbers or e-mail addresses:

- Employer _____
- Family members _____
- Neighbors _____
- Treating GP and/or Treating Specialist _____

ANNEXURE 2 TO INJURY OUTCOME REPORT

Compliance Of RAF With Duties

Has he or she received the necessary support from RAF regarding the processing of the claim?

Has the RAF facilitated access to necessary treatment and rehabilitation? (medical specialist - private hospital - state hospital - rehabilitation centre - occupational therapist - physiotherapist – speech therapist – other).

Claim number.

E-mail address and telephone number of the Claim Handler.

E-mail address and telephone number of the Claim Handler's Supervisor.

Particulars of treatment modalities that have been approved and paid for by RABS.

The medical examiner should provide an opinion regarding the extent to which the RAF administration has been *helpful or otherwise* in facilitating access to treatment and rehabilitation to reduce the pain, suffering and disability of the road accident victim, from the time of the accident until the Outcome Report.

A percentage *could* be added to the non-pecuniary damages awarded to the victim (possibly 10% - 15% - 20%) if it is found that the RAF has not fulfilled its administrative, financial, operational and/or legal duties.

FAIR AND EQUITABLE COMPENSATION OF NON-PATRIMONIAL DAMAGES SUFFERED IN MOTOR VEHICLE ACCIDENTS – PSYCHOLOGICAL TRAUMA

Introduction

Historically, claims for compensation for non-patrimonial losses have been based on medical evidence confirming pain and suffering, and the reasonableness of the claim in that regard (nexus between the accident and symptoms). Indeed, the prescribed procedures, including documentation to be completed in support of claims against the RAF, are explicit with regard to the “medical” information required.

The unintended consequence of this is that there is not formal acknowledgement of the fact that victims of motor vehicle accidents may not only suffer physical injuries with psychological concomitants, but may also suffer psychological “injuries” in the absence of physical injuries. Consequently, victims of motor vehicle accidents who have suffered psychological injury without physical injury have been compelled to somaticize in order to claim physical injuries which would then facilitate the process of claim. This clearly places the burden on those healthcare practitioners who are encumbered with consultation because of the unintended consequences of the articulation of legislation. In other words, victims of motor vehicle accidents had to claim physical symptoms in order to access compensation, even when those physical symptoms were offered as an analogue for psychological injury; for example, the victim claiming lower back pain or persisting post-concussion syndrome, when those claims were clearly disproportionate with any injuries that may have been suffered in the accident under consideration.

Progressive practice has recognised that pain and suffering comprises both physical and psychological components, and the complex interaction between these. As a consequence, that interaction has been at least implicitly acknowledged and considered in the awarding of non-patrimonial damages.

However, the preponderance of evidence required in support of such claim has come from the medical experts. The courts appeared generally to have been guided by that evidence, and in doing so has accepted a pragmatic and broad definition of “medical” expertise to include not only that of medical practitioners, but also ancillary (paramedical) healthcare professionals and clinical psychologists, who are not ancillary healthcare professionals but healthcare professionals of first instance.

However, with the advent of the RAF Amendment Act 19 of 2005, which came into operation on 01 August 2008, the Courts have been conservative in definition of the

term “*medical practitioner*”. Such interpretation has resulted in increased burden on “those who are registered with the Health Professions Council of South Africa as medical practitioners” and who now, pragmatically, are required to act as gatekeepers for the expert opinion of not only ancillary healthcare professionals, but also for clinical psychologists.

The paradoxical effect of this is that rather than reducing costs of expertise in the case of victims of motor vehicle accidents who have suffered psychological injury without physical injury, costs are increased because the victim has to access medical opinion as well as clinical psychological opinion.

A proposed solution; the parallel pathway

The existing process for identifying, validating and quantifying non-patrimonial losses suffered by victims of motor vehicle accidents and who have suffered physical injury as well as psychological injury is in the process of revision. The proposed revision has process integrity, and is supported by the appropriate systems.

However, that process is inappropriate for victims of motor vehicle accidents who have suffered psychological injury without physical concomitants. To illustrate (graphically), a young mother is the driver of a motor vehicle that is involved in a collision. She does not suffer physical injury, apart from possibly some muscle stiffness because of the force of impact. However, her child who is a restrained passenger in the motor vehicle suffers critical injuries in that accident. The mother not only witnesses her severely injured child, but is powerless to intervene and save that child’s life. She has to stand by and watch as her child dies. She is profoundly traumatised and consults with a clinical psychologist in order to address the critical incident stress and, potentially, post-traumatic stress disorder. She undergoes appropriate psychotherapy, and clinical evaluation is that she does not require management by medical professionals. Notwithstanding appropriate psychotherapy, she remains symptomatic.

Current legislation and conservative interpretation of that legislation requires that in order to submit a claim she would have to consult with a medical practitioner who would then complete and submit the required documentation to the RAF. That medical practitioner would probably recommend clinical psychological opinion, which would then be submitted to the RAF. Current legislation does not allow for a clinical psychologist to submit founding documentation in support of claims against the RAF.

While revision of, or amendment to, current legislation would align intent and process, provision must be made for founding clinical psychological opinion in support of claims

against the RAF and where the victim has not suffered physical injury to be submitted to that institution.

Proposed process

1. Motor vehicle accident:

- 1.1. With no physical or psychological injury: No claim - process stops
- 1.2. With physical injury and possibly psychological “injury”: continue in prescribed medical process
- 1.3. Without physical injury, but with psychological “injury”: enter into parallel claim process for non-pecuniary damages

2. Clinical psychological claim process:

- 2.1. Consult with clinical psychologist
- 2.2. Clinical psychologist completes and submits “Initial Clinical Psychological Report”, including making recommendations for further management
- 2.3. Clinical psychologist completes and submits “Progress Clinical Psychological Report”
- 2.4. Clinical psychologist completes and submits “Outcome Clinical Psychological Report”
- 2.5. This process does not require that the same clinical psychologist examines, treats or reports on the initial, progress and outcome status of the victim of the road accident
- 2.6. this process also assumes appropriate professional management of the victim of the road accident

Information required in the Initial Clinical Psychological Report

1. Appropriate demographic detail

- 1.1. Name(s)
- 1.2. Surname
- 1.3. Date of birth
- 1.4. Identity number

2. Date of consultation

3. Accident detail

- 3.1. Date
- 3.2. Time

4. Particulars of the accident

- 4.1. Whether victim was driver or passenger
- 4.2. Number of occupants in the vehicle
- 4.3. Relationship of occupants to victim
- 4.4. Nature and severity of injuries sustained by occupants of the vehicle
- 4.5. Nature and severity of injuries sustained by other victims of the accident

5. Description of psychological sequelae of the accident

- 5.1. At the accident scene
- 5.2. within the 1st 72 hours
- 5.3. progression of sequelae
- 5.4. accessing appropriate counselling/intervention

6. Clinical psychological assessment of the victim

7. Referral as indicated

8. Identifying detail of the clinical psychologist

- 8.1. Signature
- 8.2. Full names
- 8.3. Professional registration number
- 8.4. Practice registration number

Information required in the Progress Clinical Psychological Report

1. Appropriate demographic detail

- 1.1. Name(s)
- 1.2. Surname
- 1.3. Date of birth
- 1.4. Identity number

2. Date of consultation

- 2.1. If possible, the number in the sequence of progress evaluations

3. Accident detail

- 3.1. Date
- 3.2. Time

4. Particulars of the accident

- 4.1. Whether victim was driver or passenger
- 4.2. Number of occupants in the vehicle
- 4.3. Relationship of occupants to victim
- 4.4. Nature and severity of injuries sustained by occupants of the vehicle
- 4.5. Nature and severity of injuries sustained by other victims of the accident

5. Description of psychological sequelae of the accident

- 5.1. At the accident scene
- 5.2. within the 1st 72 hours
- 5.3. progression of sequelae - how have the nature and severity of sequelae changed since the last report was completed? (Resolution/recovery, improvement, deterioration, new symptoms)
- 5.4. impact of appropriate counselling/intervention, if accessed

6. Clinical psychological assessment of the victim

7. Referral as indicated

8. Identifying detail of the clinical psychologist

- 8.1. Signature
- 8.2. Full names
- 8.3. Professional registration number
- 8.4. Practice registration number

Information required in the Outcome Clinical Psychological Report

1. Appropriate demographic detail

- 1.1. Name(s)
- 1.2. Surname
- 1.3. Date of birth
- 1.4. Identity number

2. Date of consultation

- 2.1. Identify whether initial and progress reports have been perused
- 2.2. if these have, specify which reports have been perused

3. Accident detail

- 3.1. Date
- 3.2. Time

4. Particulars of the accident

- 4.1. Whether victim was driver or passenger
- 4.2. Number of occupants in the vehicle
- 4.3. Relationship of occupants to victim
- 4.4. Nature and severity of injuries sustained by occupants of the vehicle
- 4.5. Nature and severity of injuries sustained by other victims of the accident

5. Description of psychological sequelae of the accident

- 5.1. At the accident scene
- 5.2. within the 1st 72 hours
- 5.3. progression of sequelae - how has the nature and severity of sequelae changed since the last report was completed? (Resolution/recovery, improvement, deterioration, new symptoms)
- 5.4. impact of appropriate counselling/intervention, is accessed

6. Clinical psychological assessment of the victim

7. Residual sequelae manifest at the outcome assessment:

- 7.1. Description of persisting sequelae
- 7.2. Severity of “permanent” sequelae* on the victim’s ability to maintain appropriate:
 - 7.2.1. Domestic, academic or employment autonomy
 - 7.2.2. relationships with family, friends, acquaintances and contacts
- 7.3. Need for further therapy/counselling
- 7.4. Future vulnerability

8. Identifying detail of the clinical psychologist

- 8.1. Signature
- 8.2. Full names
- 8.3. Professional registration number
- 8.4. Practice registration number

* these “permanent” sequelae would then form the basis of calculation of quantum