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;

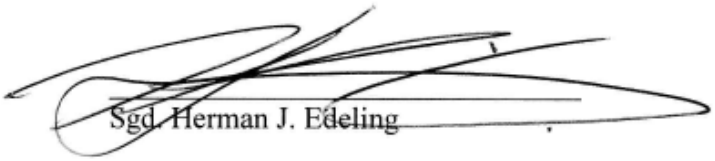
10.2.7. development of a digital cloud based injury reporting system;

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.

[*NOTE. Until the time of publication of these proposals, the intellectual property rights and copyright vest in the authors, Edeling, Engelbrecht, Enslin, Jacobs, Reynolds, Klopper and APRAV. The report and its annexures may be distributed only with the written consent of the authors, and then only in their entirety without any amendments.*]



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

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.

STICKER

PATIENT DETAILS:

Name: _____ Surname: _____

ID _____

ACCIDENT DETAILS:

Date: _____ Place: _____

Driver ☐ Passenger ☐ Cyclist ☐ Pedestrian ☐

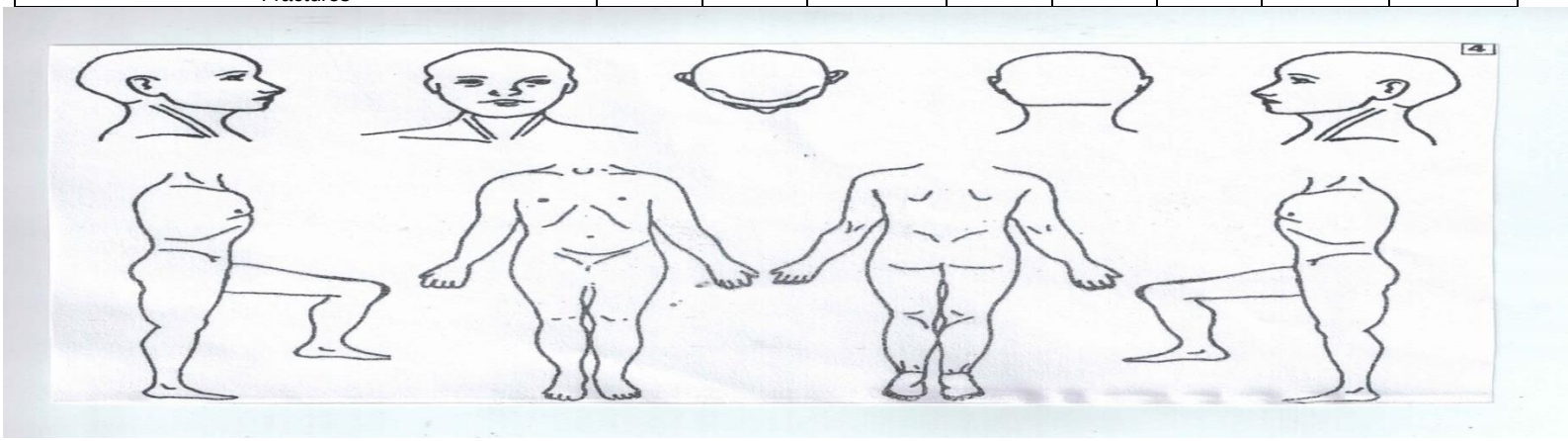
Car ☐ Truck ☐ Motorbike ☐ Taxi ☐ Bus ☐ Other ☐

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

Annexure D.

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 sequelea 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 sequelea. 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, 2008[4], 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.*

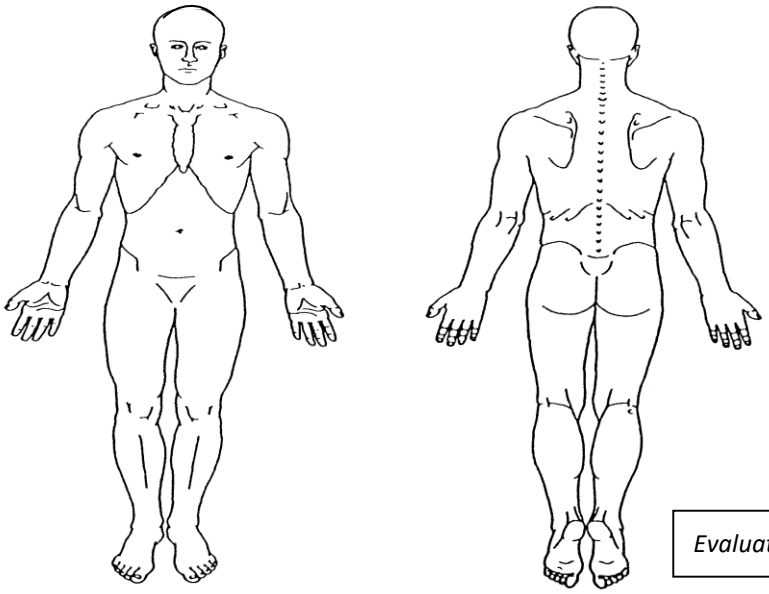
FUNCTIONAL LIMITATIONS SELF-REPORT QUESTIONNAIRE (FLSRQ)

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)*		
NOW	**HIGHEST**	**LOWEST**			
10	**10**	**10**	Excruciating, Maximum Pain Possible	VERY SEVERE (VS)	
9	**9**	**9**	Very Severe and Sharp Pain		
8	**8**	**8**	Severe and Sharp Pain	SEVERE (S)	
7	**7**	**7**	Very, Very Strong Pain or Aching		
6	**6**	**6**	Very Strong Pain or Aching		
5	**5**	**5**	Strong Pain, Aching or Pressure	MODERATE (MOD)	
4	**4**	**4**	Mildly Strong Pain, Aching or Pressure		
3	**3**	**3**	Moderate Pain, Aching or Pressure		
2	**2**	**2**	Mild Pain, Aching or Pressure	MILD (M)	
1	**1**	**1**	Very Mild Pain, Aching or Pressure		
0	**0**	**0**	No Pain or Aching, Feels Normal	NO	

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 *all* my personal care
	0 1 2 3 4 5 6 7 8 9 10	
	No | Mild | Moderate | Severe | Very Severe	

2.

Sleep without any problems	**Sleeping or sleeping position**	Cannot sleep *at all*
	0 1 2 3 4 5 6 7 8 9 10	
	No | Mild | Moderate | Severe | Very Severe	

3.

Travel without any problems	**Travelling: driving own vehicle or using public transport**	Cannot travel *at all* without assistance
	0 1 2 3 4 5 6 7 8 9 10	
	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 *all* tasks
	0 1 2 3 4 5 6 7 8 9 10	
	No | Mild | Moderate | Severe | Very Severe	

5.

No problem to walk/sit/stand	**Walking / sitting / standing**	*Cannot sit/ stand/walk at all*
	0 1 2 3 4 5 6 7 8 9 10	
	No | Mild | Moderate | Severe | Very Severe	

6.

No problem to participate	**Hobbies/recreational activities and/or sport**	Lost *all* interest/have *no* ability
	0 1 2 3 4 5 6 7 8 9 10	
	No | Mild | Moderate | Severe | Very Severe	

7.

No problem to work	**Formal or informal job**	Lost *all* interest/have *no* ability
	0 1 2 3 4 5 6 7 8 9 10	
	No | Mild | Moderate | Severe | Very Severe	

8.

No problem to interact	**Socialising or interacting with other people**	Lost *all* interest/have *no* ability
	0 1 2 3 4 5 6 7 8 9 10	
	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 10	
	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 10	
	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 30days) are matched against the corresponding five descriptors of severity as used in The Guides to the Evaluation of Permanent Impairment, 6th Ed., AMA, 2008[4], 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, 2008[4], 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:	*Progress report* DATE:				*Progress report* DATE:				*Progress report* 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

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***
Pain behaviors are exaggerated, non-physiologic	*Pain behaviors are mixed or ambiguous*	*Pain behavior are appropriate and tend to confirm other clinical findings*

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