The American Medical Association's "Guides to the Evaluation of Permanent Impairment" in Australia: the Standard, and Departures from the Standard

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Personal injury and Illness — Appraisal — American Medical Association's "Guides to the Evaluation of Permanent Impairment" ("Guides") — "Guides" adopted/adapted in Australia — Victorian workers compensation — Impairment — Impairment evaluation — Activities of daily living — Doctor's role in evaluation — Interpretation of "Guides".

Introduction

In 1962, Sir Geoffrey Newman-Morris noticed the lack of a single standard by which the medical profession could help to estimate the extent of disabilities suffered by injured people.[1] In the USA, at that time, a committee of the American Medical Association had begun to consider problems associated with evaluating permanent physical and mental impairments and, in 1971, the American Medical Association published the *Guides to the Evaluation of Permanent Impairment*.[2] The evaluation was "an appraisal of the nature and extent of the patient's illness or injury as it affects his personal efficiency in one or more of the activities of daily living".[3] After 1971, the *Guides* have been published in several editions, and have represented a standard which, previously, the medical profession lacked.

In Australia, during the past decade, legislatures occasionally have adopted or adapted the American Medical Association's Guides: see generally the Victorian Transport Accident laws, the former New South Wales Transcover scheme, the Victorian WorkCover system, workers' compensation legislation in South Australia, Queensland and the Northern Territory, and the Commonwealth Comcare scheme. In Australia, though the *Guides* have no special authority, they may be endorsed by federal or state legislation. If so endorsed, the precise application of the *Guides* will depend upon the actual terms of the particular legislation. Because the existing pieces of legislation are not uniform, the *Guides* may (and probably will) produce results which differ from one regime to another, even when applied to identical factual circumstances. Thus, differing standards flow from a common source and, to

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† This article was originally received for publication in April 1996, and, accordingly, takes no account of developments after that date.

1 See his paper on "The Assessment of Post-Traumatic Disability" in *The proceedings of the Medicolegal Society of Victoria*, vol 10, 1962, p 28.

2 1971, American Medical Association, Chicago, USA.

3 1971 edition, p (iii). In 1971, those activities were "self care, communication, normal living

an extent, the attempt to devise a single standard has been thwarted. That has occurred because various legislatures have not adopted the *Guides* but, instead, have adapted them, and not in uniform ways.

The following discussion centres upon the use of the American Medical Association's *Guides*, in the context of the Victorian WorkCover legislation, for workers' compensation purposes. So used, the *Guides* affect a significant proportion of the Australian workforce. If the past decade shows a trend, the *Guides* may tend to become more generally applied across Australia. Some of the *Guides'* broad concepts, and some of the learning surrounding their use in Australia, are discussed. The discussion draws attention to some current developments concerning the standard (where adopted) and departures from the standard (where it has been adapted). The purpose is to assist doctors called upon to use the *Guides* to evaluate medical impairments, claims officers who deal with the resulting medical reports, lawyers whose clients' fates depend upon the *Guides*, and legislators intending to adopt/adapt the *Guides*.

"Serious Injury" Under Victorian WorkCover Legislation

Somewhat confusingly, the Victorian Accident Compensation Act 1985[4] refers to "serious injury" in two contexts which concern, first, statutory compensation and, second, common law damages. The two contexts received differing treatments in the legislation, and must be kept separate.The following discussion concerns impairments which amount to "serious injury" in the sole context of statutory compensation, and as the expression is defined in s 93B(5) of the Victorian Act.[5]

Workcover Compensation: Serious Injury Defined by Statute

Serious injury is defined in the Victorian Act s 93B(5)[6] so as to refer to the AMA *Guides* in the following way:

> In this section, "serious injury" in relation to a worker means an injury which entitles the worker to compensation under this Act and in respect of which the worker would, if assessed by the Authority, authorised insurer or selfinsurer according to the methods specified in the American Medical Association's *Guides to the Evaluation of Permanent Impairment* (second edition or a subsequent prescribed edition) have a level of impairment of 30 per cent or more.[7]

4 Reprints 5 and 6.

5 It follows that the present discussion has no necessary bearing upon "serious injury" in the context of common law damages, as referred to elsewhere in the Victorian Accident Compensation Act 1985 (reprints 5 and 6), s 135A(2)(a) and (b); ss 135A(3), (4) and (6); and s 135A(19).

6 Accident Compensation Act 1985 (Vic) (reprints 5 and 6).

7 It seems odd that the Victorian legislature still relies upon the second edition published in 1984, when it has long been superseded by several later editions published in 1988, 1990 and 1993. The American Medical Association "strongly discourages" the use of any but the most recent edition of the *Guides*, because the information in it would not be based on the

WorkCover Compensation: Circumstances Where "Serious Injury" is Relevant

In the present narrow context, if a worker has an impairment of 30% or more, that is a relevant circumstance:

(a) After the first 26 weeks of incapacity.[8] As the statute shows, a worker with that degree of impairment obtains favoured treatment: the rate of weekly payments is higher.

(b) After the worker has been incapacitated for 104 weeks.[9] After 104 weeks, the worker's entitlement to weekly payments ceases altogether, unless the worker has an impairment of 30% or more, or is totally and permanently incapacitated.

(c) In considering whether a worker continues to be eligible for compensation in the form of medical and like expenses.[10] If the worker has the required degree of impairment, that compensation does not cease (as it might otherwise do) after 52 weeks after the entitlement to weekly payments ceases.[11]

(d) In considering whether a worker may be eligible for a settlement.[12][13]

The Present Context: AMA *Guides*

The present discussion refers principally to the AMA *Guides* (2nd ed)[14] as adopted/adapted by s 93B(5).

As mentioned earlier, the precise application of the *Guides* depends upon the actual terms of the particular legislation which adopts or adapts the *Guides*. Because existing pieces of legislation are not uniform in Australia, different outcomes could occur from one regime to another, even in identical factual circumstances. Accordingly, the present discussion of a particular legislative use of the *Guides* is not necessarily transferable to another use of them. For example, different considerations might apply to:

(i) the identical AMA *Guides* (2nd ed), when referred to in different statutory contexts, eg the Victorian WorkCover Table of Maims;[15] the former NSW Transcover scheme;[16] or the Victorian Transport Accident scheme;[17]

(ii) a later edition of the AMA *Guides*, eg the AMA *Guides* (3rd ed revised)[18] referred to in South Australia's workers compensation

8 s 93B(1)(a).
9 s 93B(3)(a).
10 s 99(14)(a)(iii).
11 s 99(11).
12 s 115(1)(a)(ii).
13 Serious injury is also relevant when a worker ceases to reside in Australia: ss 97(2) and (3), but it is not clear what amounts to serious injury in that circumstance.
14 1984, American Medical Association, Chicago, USA.
15 Annexed to the Victorian Accident Compensation Act 1985 s 98 (reprints 5 and 6).
16 The former Transport Accidents Compensation Act 1987 (NSW) s 106.
17 Victorian Transport Accident (Impairment) Regulations 1988, reg 6.

legislation;[19] an unspecified edition in Queensland;[20] the *Guides* (4th ed)[21] referred to in the Northern Territory;[22]

(iii) the AMA *Guides* when used as a reference of last resort as permitted by the 1989 Comcare Guide.[23]

Focus: the AMA *Guides* as Adopted/Adapted by Section 93B(5)

In assessing whether there is impairment amounting to a "serious injury" under s 93B(5) of the Victorian Act by reference to the AMA *Guides*, medical practitioners and others should take into account at least the matters which follow.

All Impairments Consequent Upon, or Secondary to, Injury are Relevant

It is the worker who is being assessed, and not the particular injury of the worker. For example, though a quadriplegic's injury is to the neck, a proper assessment of impairment is not confined to the neck. Properly assessed, the impairments of the worker's arms, legs and many other bodily functions, consequent upon or secondary to the neck injury, must be taken into account. That is so, notwithstanding that the worker's arms, legs etc received no direct injury. Were it otherwise, the assessment would ignore the whole person, ie would deal with part only of the person.[24] The principle is important. The AMA *Guides* focus upon impairments consequent upon or secondary to injury,[25] not the injury itself.

Perhaps it is arguable that the assessment should ignore the whole person, and deal only with the injured part of the person. The argument arises not from the *Guides* themselves, but from ambiguity perceived within s 93B(5). That statutory provision commences by focusing upon "injury", presumably to part of the body. If that focus remains undisturbed, and does not shift to the whole person, curious consequences ensue. Thus, a worker whose little finger was

19 South Australia Workers Rehabilitation and Compensation Act 1986, Sch 3 cll 4, 5; Workers Rehabilitation and Compensation (General) Regulations 1987, reg 16.
20 Queensland Workers' Compensation Regulation 1992, reg 4, which may refer to the fourth edition though the regulation does not in terms say so.
21 1993, American Medical Association, Chicago, USA.
22 Work Health Act 1986 (NT), ss 3(1), 70; Work Health Regulations 1986 (NT), reg 9.
23 The Commission for the Safety Rehabilitation and Compensation of Commonwealth Employees, *Guide to the assessment of the degree of permanent impairment*, AGPS, Canberra, 1989, p 5. The Comcare Guide, of course, derives from the AMA *Guides*.
24 In contrast to "serious injury" under s 93B(5), it seems possible that, assessed under the different regime found in s 98(1), the degree of impairment of the back, neck or pelvis might concentrate upon the relevant part of the worker, rather than the whole person. But this point need not here be determined.
25 A question remains whether s 93B(5) refers to impairments having a lesser connection with the injury than is suggested by the writer's loose expression "consequent upon or secondary to" the injury. That question arises because s 93B(5) does not use words of causation, but words of association. Section 93B(5) speaks of injury "in respect of which" the worker would have a specified level of impairment. The question, however intriguing, is not here

amputated would have a level of impairment of the little finger beyond 30% and, presumably, would fall within the statutory description. But the writer prefers an interpretation which assesses the impairment of the worker, considered as a whole person. It seems to flow inevitably from the statute.

Impairment Need Not be Permanent

In this respect, the Victorian statute has adapted, not adopted, the AMA *Guides*, and the question is not what is the permanent impairment. That conclusion flows from the statutory framework, ie the express and implied provisions of the Victorian Act, the inferences of legislative intention to be drawn from the circumstances to which the Act is directed, and from its subject matter.[26] So far as the *Guides* are inconsistent, the statute must prevail over the *Guides*. For good reason, the statute recognises that impairment may represent a temporary effect of an earlier injury. Of course, it is only the impairment which may be temporary; at the time of assessment the injury itself would necessarily be well established.

Thus, a worker might, at one point in time, be assessed as having impairments amounting to a serious injury and, at another time, be assessed differently. For example, after the first 26 weeks of incapacity referred to earlier,[27] a worker might still be very disabled and merely on the way towards ultimate recovery[28] and, so, might then be assessed as having a sufficient degree of impairment. Yet, some time later, as the worker progressed towards recovery, the worker might cease to have a serious impairment. Conversely, a worker might initially seem to make an uneventful recovery but, later, might require major surgery.[29] In such a case, the worker may have no impairment amounting to "serious injury" until the later time.

Though there seems good reason why impairment need not necessarily be permanent, that factor causes some confusion when an assessor resorts to the AMA *Guides* to measure the degree of impairment. The confusion arises because the *Guides* relate to permanent impairments and lack detailed reference to impairments which are temporary. Notwithstanding that difficulty, the degree of impairment must be evaluated. To that purpose, the *Guides* must be modified to accommodate the statutory departure.[30]

Understanding of "Impairment" is Crucial

The question is, what is the "impairment"? The AMA *Guides* give the answer. Impairment is the loss of, loss of use of, or derangement of any body part,

26 Cf *Mobil Oil Aust Pty Ltd v Federal Commissioner of Taxation* (1963) 113 CLR 475 at 504, Kitto J.
27 See n 8 above.
28 Eg, worker badly burned in bushfire.
29 Eg, worker whose serious condition initially went unrecognised.
30 The *Guides* must also be modified to accommodate s 93B(5) in other ways. The statute requires assessment by a non-medical person, while the *Guides* contemplate assessment by a doctor. Another departure is suggested by Judge Rendit's decision in *Villagram v VWA* (29 July 1994, County Court (Vic), unreported). If the *Guides* seek to establish a whole person impairment from whatever source including a non work-related ulcer condition, the *Guides* must be modified to accommodate s 93B(5) which has a different approach, namely to

system or function. That is the definition set out in the *Guides*.[31] The definition prevails over any other notion. The definition seems widely drawn, as should be expected of an expression designed to cater for the huge variety of circumstances which may present themselves for assessment.

To the same effect, the *Guides* require, as well as a medical evaluation, "an analysis of the history, and clinical and laboratory findings *to determine the nature and extent of the loss, loss of use of, or derangement of the affected body parts, systems or functions*" (emphasis added).[32]

The *Guides* assist a greater understanding of "impairment" by frequently relating impairment to the worker's "health status".[33] That is a wide as well as a vague expression, which should not be interpreted narrowly or reduced to too much precision. It shows the breadth of the area which the *Guides* seek to cover.

Impairment Evaluated by Reference to AMA *Guides* as a Whole

The extent of a worker's impairment is a question to be resolved by reference to the AMA *Guides* as a whole. In many cases, that question will not be resolved satisfactorily by reference solely to a single table, or even a single chapter. Of course, in some simple cases, a particular worker's impairment may fully and adequately be comprehended by reference solely to an isolated portion of the *Guides*. In such a simple case, the medical practitioner need go no further. A simple case occurs "when a single permanent impairment is present". In such a case, "the percent of impairment may be read directly from the text or it can be related to part of the body or to the 'whole person' by referring to appropriate tables".[34]

More often, the doctor's inquiries (including a careful history) will show that there is more than a single impairment, and that the overall impairments are not fully or adequately ascertained by reference to a specific chapter. In this respect, a thorough and detailed history remains important. As well as other factors, the *Guides* require the taking of a history and then an analysis of the history to determine the nature and extent of the loss, loss of use of, or derangement of the affected body parts, systems or functions.[35] To assess the various impairments revealed by the history, the medical practitioner must often go beyond a particular chapter and venture into the *Guides* as a whole.

A familiar example occurs with some scarring disfigurements. In such a case, as shown in the *Guides* (2nd ed),[36] a proper assessment may require several diverse approaches, including the effect on the activities of daily living, any loss of motion under Ch 1, any loss under Ch 2, any effect on the chest wall under Ch 3, any change of behaviour under Ch 12. Those several approaches are necessary to take "into account all relevant considerations in

31 See the glossary (2nd ed) p 225 and cf p (viii); (4th ed) p 315, and cf pp 1-2, 9.
32 2nd ed preface p (viii); cf 4th ed pp 315, 1-2, 9.
33 2nd ed preface pp (vii), (ix), (x) and 225; 4th ed pp 1, 2, 10, 316.
34 2nd ed preface p (viii), cf 1st ed p (iv).
35 2nd ed preface pp (vii), (viii), cf 4th ed p 8.

order to reach a 'whole person' impairment rating".[37] Because of that necessity, several approaches constitute the norm, rather than the exception.

In circumstances where there is present more than a single impairment, or where the worker's impairments seem not fully or adequately described by reference to a particular table or chapter, the medical practitioner should say so. Further, if assessment of some of the worker's impairments is considered beyond the medical practitioner's own field of expertise, the doctor should say so. Conversely, if within that field, the medical practitioner should then proceed to assess the overall impairments by reference to considerations which appear in or by reasonable inference from the *Guides* as a whole.

Always, the overriding consideration is to assess the loss of, loss of use of, or derangement of all body parts systems or functions. Particular aspects of that proposition are now discussed.

If the patient whose impairment is being assessed suffers from some relatively uncommon illness or disorder[38] not specifically referred to in the AMA *Guides*, eg reflex sympathetic dystrophy,[39] Q-fever or a bowed tibia, it nevertheless remains the doctor's duty to assess the "impairment" as defined in the *Guides*. It is not open to the doctor to assess the impairment at zero or at an unsatisfactorily low level simply because the AMA *Guides* contain no easily discernible reference to the worker's particular disease, illness or injury, or any simple method of evaluating the impairment. In those circumstances, the doctor must do the best he or she can to assess the impairment, as defined and understood in the *Guides*, and measure the impairment by reference to the *Guides* as a whole, drawing such analogies as can reasonably be made. Mere difficulty of measurement should not be regarded as an insuperable obstacle. Thus, for example, the chapter on Ear, Nose, Throat and Related Structures[40] notes that such disturbances of the ear as chronic otorrhea, otalgia and tinnitus "are not measurable and, therefore, the physician should assign a degree of impairment that is based on severity and importance and is consistent with established values".[41] This approach conforms to notions of justice. A right to compensation is not to be restricted or denied because of difficulties in fitting the *Guides* to the circumstances of a particular case. Put another way, where it is evident that some degree of impairment exists, difficulties in assessing the extent of impairment do not displace the decision-maker's obligation to make an assessment as best he or she can.

If, in a case involving injury to the back, or an arm or a leg, inquiries show that the worker's impairments are not properly and adequately described by

37 2nd ed preface p (viii); cf 4th ed pp 9, 278. As to other examples, cf the *Guides*, 2nd ed, at p 2 (consideration must also be given to loss of sensation); p 47 (neurological) involvement also should be evaluated); p 69 (necessary to determine extent of loss of function due to sensory deficit, pain or discomfort, loss of muscle strength, altered fine motor control of muscle); pp 131-3 (combining Ch 1 with Ch 4).

38 Cf 4th ed p 3.

39 As to reflex sympathetic dystrophy: see 4th ed pp 56, 89, 313. So, too, the fourth edition deals expressly with matters such as pain, organ transplantation, and the adverse effects of pharmaceuticals.

40 2nd ed ch 7; cf 4th ed ch 9.

41 2nd ed p 153; 4th ed p 224 and cf p 3. See also J V Luck, D W Florence "A brief history [illegible] comparative analysis of disability systems and impairment rating guides", *Orthop Clin*

means of a goniometer,[42] the doctor must measure the impairments by other means, in addition to the goniometer. The doctor must go to the *Guides* as a whole for assistance, and then make such assessment of the impairments as appears to the doctor to be proper and adequate. A worker's impairments will not be assessable by reference solely to a particular chapter if there are impairments beyond those measured by the means found in that chapter, as is shown by several examples found in the *Guides*.[43]

One important factor which should be taken into account is the impairment constituted by the effect of the injury on the various "activities of daily living", listed and described in the AMA *Guides*.[44] This is considered in more detail, below.

The *Guides* suggest that another relevant consideration may arise if the patient needs continuous therapy or medication.[45] That consideration is often overlooked.

Role of the AMA *Guides*

If the doctor's task is always to determine what is the "impairment", as defined in the AMA *Guides*, it follows that the *Guides* as a whole should be seen as something that assists in the proper assessment of impairment and not as something that hinders a proper evaluation. In other words, the *Guides* are what they purport to be: they are no more than guides for evaluating impairment. The *Guides* are not designed as a set of blinkers which prevents full regard being given to the worker's impairments. Instead, the *Guides* claim to "provide a structured set of medical criteria that comprises a reference with which to establish well-formulated medical ratings of permanent impairment".[46] Properly understood, the *Guides'* criteria do not exist to exclude consideration of impairments but, on the contrary, to ensure that all impairments receive attention.

The point is exemplified when the *Guides* (2nd ed) consider a particular instance of muscle weakness. The *Guides* go to extraordinary lengths to take that impairment into account. In the example,[47] a knee injury gives rise to weakness of the quadriceps muscle, the main muscle controlling the knee. The resultant loss of strength constitutes an impairment, and must be assessed. The example invites the doctor to assess that aspect of the impairment by reference to the femoral nerve, which is the nerve that supplies the quadriceps muscle. The weakness/loss of strength is assessed as an impairment of the femoral nerve, though the nerve itself was not injured at all and perhaps remains unimpaired.

42 The goniometer, referred to in (2nd ed) Ch 1, suffices as an instrument of measurement only in limited circumstances, namely where the particular worker has no impairment beyond (eg) loss of motion/abnormal angle of fixation of a joint, measurable by means of the goniometer.

43 Cf 2nd ed pp 2, 64, 69, 74, 131-3, 191, 204; cf 4th ed pp 9-10, 94.

44 2nd ed p 225; cf 4th ed pp 317, 1; cf 1st ed p (iii).

45 Cf 2nd ed pp 138, 169, 179, 191, 208; cf 4th ed p 9. Cf *Turner v Love and Transport Accident Comm* (4 April 1995, SC(Vic) appeal division, unreported).

46 2nd ed preface, p (vii); cf 4th ed pp 1, 7.

The *Guides* represent an imperfect tool.[48] Even amongst doctors using the *Guides* overseas, there seem no universally accepted criteria for evaluating impairments, and rating practices vary from doctor to doctor in assessing impairment due to, eg, low back disorders and deafness.[49] Another example has emerged during the course of several court cases in Victoria, where many specialist psychiatrists have given widely diverging evidence concerning the proper interpretation of the *Guides* (2nd ed) chapter on "Mental and Behavioural Disorders".[50] The divergence has concerned crucial considerations, eg the weight which should be attached to the various subjects used in the evaluation of psychiatric impairment listed at (2nd ed) p 220 in Table 1.[51] The specialist psychiatrists seem united, however, in attributing the divergence to uncertainties found in the *Guides* themselves, which in the second edition require the evaluator to use the now superseded[52] *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed), commonly known as "DSM III". But criticism of the *Guides* is beyond the scope of this article.[53]

Importance of "Activities of Daily Living"

Put shortly, impairment evaluation *requires*, amongst other things, an assessment of the activities of daily living. To that extent, the writer agrees with Professor Pryor.[54]

The original AMA *Guides*, published in 1971, described the evaluation of impairment as "an appraisal of the nature and extent of the patient's illness or injury as it affects his personal efficiency in one or more of the activities of daily living".[55] In 1983, the NSW Law Reform Commission regarded the original *Guides* as concentrating "upon the victim's general capacity to

48 The *Guides* do not claim perfection, cf the changes from edition to edition and the express statement at p 3 of the fourth edition.

49 D S Gloss, M G Wardle "Reliability and validity of American Medical Association's guide to ratings of permanent impairment", *Jour Amer Med Assoc*, vol 248, 1982, pp 2292-6; R A Brand, T R Lehman "Low-back impairment ratings of orthopaedic surgeons", *Spine* vol 8 no 1, Jan-Feb 1983, pp 75-8; D Ward "The American Medical Association/American Academy of Otolaryngology formula for determination of hearing handicap", *Audiology*, vol 22 no 4, 1983, pp 313-24; W Noble "Evaluation of hearing handicap: a critique of Ward's position", *Audiology*, vol 27 no 1, 1988, pp 53-64; J V Luck, D W Florence "A brief history and comparative analysis of disability systems and impairment rating guides", *Orthop Clin North America*, vol 19 no 4, 1988, pp 839-44.

50 2nd ed ch 12; cf 4th ed ch 14.

51 Cf 4th ed p 301.

52 The fourth edition conforms to the terminology of the later DSM-III-R (American Psychiatric Association, 1987, Washington DC).

53 See eg, E Pryor "Flawed promises: a critical evaluation of the American Medical Association's Guides to the evaluation of permanent impairment" *Harvard Law Rev*, vol 103, 1990, pp 964-76; L A Le Leu, E M Shanahan "Guidelines to the evaluation of permanent impairment" (letter), *Med Jour Aust*, vol 160, 1994, p 310; J A Streeton (further letter), *Med Jour Aust*, vol 160, 1994, p 658; M T Pathe, P E Mullen "The Dangerousness of the DSM-III-R", *Jour of Law and Med*, vol 1, 1993, p 47; the papers referred to at n 49.

54 E Pryor "Flawed promises: A critical evaluation of the American Medical Association's Guides to the evaluation of permanent impairment", *Harvard Law Rev*, vol 103, 1990, p 964 at 972 (n 22). More narrowly, the Victorian s 93B(5), which requires assessment according to the methods specified in the *Guides*, thereby requires an assessment of the activities of daily living

undertake activities, rather than his or her ability to work". According to the NSW Law Reform Commission, the *Guides* "do not take account of the effect of the disability on fitness for work, except insofar as restrictions on mobility or the capacity to perform day-to-day activities limit a person's capacity for paid employment".[56]

The emphasis upon the activities of daily living is continued in the AMA *Guides* (2nd ed). The preface states[57] that:

> . . . the purpose of the *Guides* is to make clear these distinctions in such a way as to meet the needs of all people whose health impairments have caused impairment of their capacities to engage in the activities of daily living and to meet their personal, social or occupational demands.

To understand the *Guides'* thrust, its glossary is important. "The user of the *Guides* must give careful attention to the definitions listed in the Glossary".[58] The glossary[59] refers to a range of "activities of daily living" which (as the *Guides* state) is a term related to impairment. In the second edition, that term refers to several activities, namely self care and personal hygiene; communication; normal living postures; ambulation; travel; non-specialised hand activities; sexual function; sleep; and social and recreational activities. The text gives examples of every activity. Any significant restriction on or interference with those activities constitutes an impairment which should be taken into account: the worker's overall impairments are not fully and adequately described if any such restriction or interference is ignored. This approach would seem to conform to the *Guides'* intention. The approach allows for differing losses to be assessed between differing workers who may have the same physical injury.

By way of illustration, a worker who has a particular physical injury and has all the deficits referred to under the heading "activities of daily living", should be assessed as having a greater impairment than a worker with the same physical injury but none of the deficits referred to under the heading activities of daily living. These two workers must have different impairment levels, just as a worker suffering two deranged lumbar discs has a greater impairment than another worker suffering only one deranged disc. If the impairment levels are not assessed differently, the assessor fails to do what the *Guides* demand, ie assess the "impairment" as defined[60] in the *Guides*.

The *Guides* contain many examples[61] which show the importance placed upon limitations in the performance of the activities of daily living. The degree of impairment is affected by the extent to which a person is able/unable to carry out, engage in or perform some or all of the activities of daily living, as the various examples show. The impact of the worker's injuries upon the worker's activities of daily living must be considered. For example, a bowed

56 See *A Transport Accident Scheme for NSW*, NSW Law Reform Commission, May 1983, p 134.

57 2nd ed p (viii); cf 4th ed pp 1-2, 9.

58 2nd ed preface, p (vii), cf also p (viii); cf 4th ed pp 14, 139, 153, 169, 201, 210, 223, 264 etc.

59 2nd ed p 225; cf 4th ed p 317; 1st ed p (iii).

60 2nd ed p 225 and repeated at p (viii); 4th ed pp 315, 1.

61 Cf 2nd ed pp 63-4, 158, 173, 204, 208-9, cf 4th ed pp 14, 139, 153, 169, 201, 210, 235, 249,

tibia is insufficiently assessed if a goniometer is used as the sole determinant of the level of impairment, in circumstances where the bowed tibia has wider impairing consequences for the particular worker. As a further example, a lumbar disc derangement is inadequately assessed if the assessment takes no account of impairment of the worker's anatomically normal but functionally abnormal leg, the efficient use of which is restricted by reference to the lumbar disc derangement.[62]

The point is emphasised by the matters identified in the *Guides* as constituting the kinds of information that should be contained in the doctor's report. Thus, the analysis of the doctor's findings should include an "explanation of the impact of the medical conditions on life activities" and, also, two other specific explanations concerning the activities of daily living.[63] A medical report which lacks that data must be open to the substantial criticism that the medical assessor has failed to consider all that should have been considered. Put another way, a medical report lacking some data is not the complete report that, the *Guides* state,[64] is essential to support a rating of permanent impairment.

All of this may be familiar ground to some. It receives reference here because, at least in Victoria, these concepts seem not as widely understood as they might be. Thus, in the case of a back injury for instance, some Victorian doctors have concentrated upon Ch's 1 and 2, ignoring the rest of the *Guides* (2nd ed). But, of course, even when the impairment is well localised, its consequences cannot be understood without taking an individual's activities into account.[65]

The Doctor's Role

Ultimately, the doctor's role is to provide to the authority, authorised insurer or self-insurer as the case may be (or to the court in the event of dispute), expert information which better equips those non-medical people to assess whether the level of impairment is, or is not, 30% or more. That is so because s 93B(5) expressly invokes the assessment of "the Authority, authorised insurer or selfinsurer" and not "an oracular pronouncement by an expert".[66] Here, too, the statute departs from the *Guides* and, again, with good reason.

In general, it seems sensible that the assessment is made by a non-medical person. A similar point was noticed by Professor Ison[67] who said, "it is important to recognise that only part of a medical opinion or medical memo will reflect a judgment on a matter of medical science. Commonly the report

62 Cf the reasoning of the NSW Court of Appeal in *Department of Public Works v Morrow* (1986) 5 NSWLR 166, and *Owsten Nominees (No 2) Pty Ltd v Gardner* (4 September 1995, SC(NSW) Court of Appeal, CA 40049/94, unreported).

63 2nd ed p 223; cf 2nd ed foreword p (iii) which urges all users to read the Preface and the appendices on report preparation and terminology before using the *Guides*; cf 4th ed pp 1, 10, 315.

64 2nd ed p 223; 4th ed p 10.

65 That proposition seems self-evident. It is explicit in the fourth edition, p 10.

66 To use the words of Lord President Cooper in *Davie v Edinburgh Magistrates* [1953] SC 34 at 40.

will also reflect, overtly or implicitly, assumptions about the nonmedical facts, assumptions about the position to be assumed in the absence of evidence, and about the legal criteria applicable, including the burden and standard of proof. These are all matters appropriate for decision by a claims officer. Moreover, part of the reasoning in a medical report is often ordinary logic, and that too can be checked by a layman. Even with regard to those parts of a medical opinion expressing a judgment on a matter of medical science, a well-trained and experienced claims officer can still put to himself, and to the advising doctor, some pertinent questions, such as whether the doctor had a sufficient opportunity to form a reliable opinion, and whether the appropriate procedures were carried out for the opinion to be soundly based".

Furthermore, the ultimate assessment must usually take into account and settle the various views advanced by several doctors, each taking histories of varying thoroughness or accuracy, and each emphasising factors relevant to his or her own field of expertise. In the case of a head injury, for instance, "opinions may have to be sought from neurologist and neurosurgeon, ophthalmologist and general surgeon, physician and psychiatrist", as Sir Geoffrey Newman-Morris has remarked.[68] Only rarely will a single medical practitioner have the breadth of expertise to evaluate conclusively the level of impairment. The non-medical assessor has an important role, to see that all relevant circumstances, arising from the several available medical and non-medical sources, are accommodated.

Usually a medical assessment of impairment will describe the impairment as found at the time when the doctor examined the patient. That proposition seems unremarkable, until it is realised that that time may not be the relevant time. Rights and liabilities, as constructed by the statute, may well depend upon the impairment as assessed at some *earlier* time. In such a case, the doctor's later assessment is not necessarily rendered irrelevant. It may well contain information which assists. But, clearly enough, the later assessment must be treated with some care. The non-medical assessor's role includes an accommodation of that circumstance.

The *Guides* recognise that non-medical factors must be taken into account, and that those factors go beyond the proper province of both the *Guides* and the doctor using the *Guides*.[69]

In this setting, the doctor assumes the role of an expert witness. According to the authors of *Cross on Evidence*,[70] it is desirable to have as clear as possible an idea of the functions of expert witnesses, and those were succinctly described by Lord President Cooper[71] when he said, "Their duty is to furnish the judge or jury with the necessary scientific criteria for testing the accuracy of their conclusions, so as to enable the judge or jury to form their own independent judgment by the application of these criteria to the facts proved in evidence".

The special position of an expert witness was noticed by Sir Gerald

68 G Newman-Morris "The Assessment of Post-Traumatic Disability", *The Proceedings of the Medicolegal Society of Victoria*, vol 10, 1962, p 28 at 36.

69 2nd ed pp (vii), 225, 226, 227; 4th ed, pp 4-5, 316, 318.

70 *Cross on Evidence*, 4th Australian ed, Butterworths, 1991, p 785; cf *Freckelton & Selby on*

Thesiger[72] when he said, "Now let us be clear as to the distinction between the expert and the ordinary witness. A failure to appreciate the distinction causes misunderstanding. An ordinary witness is called to tell, and is only allowed to tell, the Judge or Jury what he himself actually perceived. That is to say saw, heard, smelt, tasted or felt. He should not express an opinion, so far as he can be prevented from doing so. That is to say he is not supposed to draw an inference from the facts that he observed. That is for the court. An expert witness may, however, draw an inference from facts that he observed himself, or assumes to be true if he did not himself observe them. But it is always for the Judge or Jury to decide if those facts are true".

If the doctor purports to give expert guidance upon matters which are within the ordinary capacity of non-medical people to determine, the doctor usurps the role of an expert.[73] Sir Owen Dixon has said[74] that the rule of evidence relating to the admissibility of expert testimony (as it affected the case) cannot be put better than it was by J W Smith in 1876.[75] "On the one hand" that author wrote, "it appears to be admitted that the opinion of witnesses possessing peculiar skill is admissible whenever the subject-matter of inquiry is such that inexperienced persons are unlikely to prove capable of forming a correct judgment upon it without such assistance, in other words, when it so far partakes of the nature of a science as to require a course of previous habit, or study, in order to the attainment of a knowledge of it". Then after the citation of authority the author proceeds: "While on the other hand, it does not seem to be contended that the opinions of witnesses can be received when the inquiry is into a subject-matter the nature of which is not such as to require any peculiar habits or study in order to qualify a man to understand it".

These principles may place a doctor in a difficult position. The doctor might well regard some factors as important to an impairment assessment, eg factual circumstances which (if accepted) demonstrate restrictions upon or interference with the worker's activities of daily living or which (if not accepted) demonstrate no such thing; or which tend to show that an alleged factor (which could have caused the impairment) did or did not in fact cause the impairment; or which suggest the likelihood or unlikelihood of a particular proposition. Nonetheless, those factors might be regarded as matters that are within the ordinary capacity of non-medical people to determine. Should the doctor's assessment refer to and rely upon those factors?

In a sense, the doctor is damned if the doctor does, and damned if he or she does not. The quandary might be resolved, in practice, in the following way. On the one hand, if the doctor purports to make an overall assessment of all the impairments, the doctor should explicitly say that he or she does so and that, in doing so, the doctor has intended to include all relevant factors, even if some of those factors might go beyond the strict province of an expert medical witness. In that event, the doctor should draw attention to the particular factors which have influenced the assessment. On the other hand, if

72 Thesiger, "The Judge and the Expert witness", *Med Sci Law*, vol 15, no 1, 1975, p 3 at 4.
73 *Clark v Ryan* (1960) 103 CLR 486 at 492.
74 *Clark v Ryan* (1960) 103 CLR 486 at 491.
75 In the notes to *Carter v Boehm* 1 Smith LC 7 ed (1876) 577 adopted by Harding ACJ in

the doctor's assessment is more narrowly based, so as to exclude those factors from consideration, the doctor should say so and should state that, to that extent, the assessment does not necessarily take into account all factors which conceivably might be relevant. In that event, the doctor should draw attention to the particular factors which were excluded from consideration but which, had they been considered, might have influenced the assessment. In that connection, doctors should notice that the *Guides*[76] require medical reports to refer to the absence of, or to the examiner's inability to obtain, pertinent data.

Circumstances will vary from case to case. In some cases, a doctor may feel more comfortable with the first of those approaches and, in other cases, the second. Of course, the doctor might make two separate assessments, adopting each of the two approaches.

It is true that the *AMA Guides* refer to "a patient's medical impairment, which is an alteration of health status assessed by medical means"; and state that "only a physician may carry out an authoritative medical evaluation that assesses an individual's health".[77] But the statute, in contrast, requires that the level of impairment be "assessed by the (Victorian WorkCover) Authority, authorised insurer or selfinsurer" according to the methods specified in the *AMA Guides*: see the terms of s 93B(5). As noticed earlier,[78] the *Guides* must be modified to accommodate the legislative demands of s 93B(5) in this and other respects.

In general, a worker is entitled to a proper assessment of the worker's impairment, based upon the whole of the evidence which is accepted. In analogous circumstances, many authorities show that the assessment may properly go beyond the percentages suggested by medical practitioners or scientific tests.[79] Indeed Meagher JA recently observed that it did not matter that no medical witness gave a figure equal to that chosen by the trial judge, whose task it was to arrive at a determination of the loss by reference to all the evidence, and who was not the captive of the doctors.[80]

Interpretation of AMA *Guides*

The proper interpretation of the *Guides* is a question of law. It is not a question of medical opinion.

As was said by Ormiston JA in 1995,[81] "the task of determining impairment and the like given to medical panels cannot be described as a mere inquiry of fact as it would ordinarily involve, to a greater or lesser extent, questions of law such as the proper interpretation of the (*Guides*) and their legal application under the (legislation)". Of course, Ormiston JA's observation is simply a particular instance of the general rule that the construction of a written

76 2nd ed p 223; cf 4th ed p 10.
77 2nd ed preface at p (vii); cf 4th ed pp 1, 2.
78 See n 30 above.
79 *Buwalda v SEC* (1973) 4 WCBD (Vic) 329 (Judge Just); *Hugyecz v City of Camberwell* (1974) 4 WCBD (Vic) 406 (Judge Harris); *Thomas & Coffey Aust Pty Ltd v Batista* (1995) 11 NSWCCR 437 (CA(NSW)); *Kayell Pty Ltd v Fahey* (1995) 11 NSWCCR 442 (CA(NSW)).
80 *Manning Valley Senior Citizens Homes Ltd v Cleveland* (29 August 1995, CA(NSW), CA 40262/93, unreported)

instrument is a question of law.[82] So seen, the *Guides* must be construed as a whole. This means collecting the general intention from the instrument as a whole and inferring the intention from the instrument's general frame. The *Guides* must be read and interpreted as a whole in order to extract the meaning of any particular part or expression.[83]

Thus a judge has construed (2nd ed) Ch 12 (Mental and Behavioural Disorders) as intending an "averaging method" of assessment in preference to a "median method".[84] So, too, a judge has interpreted the *Guides* to require, as a matter of logic and fairness, that a worker suffering two deranged lumbar discs has a greater impairment than another worker suffering only one deranged disc.[85]

The *AMA Guides* are not to be construed narrowly. Not only are they merely guides, but they have work to do in a large variety of cases which might give rise to "impairments". Of necessity, the *Guides* must be interpreted in a liberal and practical manner, so as to achieve the purpose of evaluating impairments in all circumstances which might occur.

Thus, in a *Comcare* case the Federal Court rejected a narrow interpretation of one of the "activities of daily living" namely "feeding".[86]

Furthermore, if the *Guides* contain ambiguity so that two interpretations are reasonably open, a beneficial construction should be preferred, with the result that the construction favourable to the worker should be adopted. .

Medical evidence given before Victorian courts suggests that, in some areas, these principles have not always been sufficiently appreciated or applied. Some doctors have tended to assert that the *Guides* require particular impairments to be disregarded. According to the assertion, the *Guides'* silence concerning particular impairments, or lack of specific reference to particular impairments, brings about the result that some impairments must be disregarded. Upon this approach, for example, impairments constituted by loss of strength, loss of sexual function, or sleep disorders have been excluded, save in the several circumstances where the *Guides* positively demand that they be assessed. Such an approach is unjustified and lacks proper foundation. It fails to view the *Guides* as a whole. The clear language, necessary to justify such an approach, is not present in the *Guides*. The approach proceeds upon the unlikely basis that the *Guides* seek to exclude some impairments from consideration, and to exclude them arbitrarily. That basis lacks warrant or support in the *Guides'* language or purpose. Properly understood, the *Guides* do not seek to exclude any impairment from consideration but, on the contrary, intend that every impairment should be taken into account and assessed.

Conclusion

In Australia, the American Medical Association's *Guides to the Evaluation of Permanent Impairment* seem likely to be used more and more by the various

82 Cf *J & P Hutchison v McKinnon* [1916] 1 AC 471 per Lord Atkinson at 476.

83 See generally Odgers' *Construction of Deeds and Statutes*, 5th ed, Sweet & Maxwell, London, 1967, p 55.

84 In *Vasilopoulos v VWA* (30 March 1995, Judge Higgins, County Court (Vic), unreported).

Commonwealth, State and Territory governments. The *Guides* seem most useful if the *Guides* represent a single, authoritative and well-understood standard, alike to all who use the *Guides* across Australia. This goal requires the various Australian legislatures to adopt the *Guides* in uniform ways, so as to maintain as far as possible a single standard for use Australia-wide. So far, this goal has not been achieved, and the *Guides'* purpose has been undermined. The present non-uniform uses and the piecemeal adaptations of the *Guides*[87] are to be deplored, and are a proper subject for concerted legislative reform. In the absence of reform, there is available no single and authoritative standard but, rather, a series of differing and confusing standards. Nonetheless, even the differing standards contain core material which, together with other learning surrounding that material, needs to be understood if the *Guides* are to achieve some of their aims, when used in Australia.

87 The present non-uniform uses include reliance upon the second edition in Victoria, the third edition (revised) in South Australia, an unspecified edition (perhaps the fourth edition) in Queensland, the fourth edition in the Northern Territory, and a derivative in the Comcare system, as well as several separate pieces of legislation that employ differing methods to adopt/adapt the *Guides*. Western Australia uses a particular document published by the WA branch of the Australian Medical Assoc Inc, see WA Workers Compensation and Rehabilitation Act 1981 s 93A, and see Dr Le Leu and Dr Shanahan's letter in *Med Jour*