Submission No 55

INQUIRY INTO PERSONAL INJURY COMPENSATION LEGISLATION

Organisation: Premier Orthopaedics

Name: Dr Ian Harris

Position: Orthopaedic Trauma Surgeon

Telephone: 9553 9655

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Subject:

Summary

IAN HARRIS

M.B., B.S., F.R.A.C.S. (Orth)
ORTHOPAEDIC TRAUMA SURGEON

19 April 2005

Director
General Purpose Standing Committee No. 1
Legislative Council
Parliament House
SYDNEY NSW 2000
Fax: 9230 3416

Re: Inquiry into personal injury compensation legislation

Dear Sir/Madam,

Thank you for accepting this late submission to the Parliamentary Inquiry into personal injury compensation legislation. I have read with interest the submissions already taken.

Through my submission, I hope to make the enquiry aware of the negative health and social effects associated with compensation. The effect of compensation on health and surgical outcomes is my current area of research interest.

BACKGROUND

I am an orthopaedic surgeon in practice in Liverpool and Kogarah in New South Wales. I am the head of the Orthopaedic Department at Liverpool Hospital and maintain both a private and public practice, as well as participating in clinical research. I am a Conjoint Senior Lecturer at the University of New South Wales.

I completed my medical degree from the University of New South Wales and completed my orthopaedic training on the Sydney orthopaedic training program. I am a Fellow of the Australasian College of Surgeons. I am the Australian Trustee of the AO Organisation, the international orthopaedic group. I am President of the Australasian Orthopaedic Trauma Society. I am an Editor of the journal Orthopaedic Knowledge Update. I am a reviewer for multiple orthopaedic and trauma journals.

Regarding my research, I recently completed a Masters of Medicine in Clinical Epidemiology at the University of Sydney and am currently completing a PhD in Surgery; the title of my thesis is “The effect of compensation on outcome after surgery and trauma”. The first part of my PhD thesis, “A meta-analysis of the effect of compensation on outcome after surgery”, was recently published in JAMA, the Journal

ORTHOPAEDIC DEPARTMENT
SOUTH ENTRANCE
LIVERPOOL HOSPITAL
CNR ELIZABETH & GOULBURN ST
LIVERPOOL NSW 2170
☎ 61-2- 8777 5228
FAX: 61-2- 8777 5221

✉ ADDRESS ALL CORRESPONDENCE TO:
PO BOX 906
CARINGBAH NSW 2229

PREMIER ORTHOPAEDICS
55 MONTGOMERY STREET
KOGARAH NSW 2217
☎ 61-2 9553 9655
FAX: 61-2 9587 7214

of the American Medical Association. A copy of the article is attached, along with a report lodged by a health journalist affiliated with the New York Times, commenting on the JAMA article.

The other parts of my thesis have not been completed. They concern the association between compensation status and outcome after road trauma or major trauma.

I chose to undertake this research because I was interested in studying the reasons why compensated patients did so poorly after injuries. This is a well known phenomenon amongst orthopaedic surgeons and other specialists who treat compensated patients regularly.

WHAT IS KNOWN ABOUT THE EFFECT OF COMPENSATION

Compensation is clearly associated with poor health. Across a myriad of conditions, most noticeably low back pain, neck pain, RSI and chronic pain, compensation is associated with poor outcome. This association stands, whether the outcome is measured by general health status, chronicity of symptoms, return to work rates, return to work times, or severity of symptoms. My meta-analysis (attached) shows that compensated patients have nearly four times the odds of having a poor outcome after surgical intervention compared to non compensated patients. This association stands despite the country involved, the type of compensation, the length of follow up, the outcome measure used, or the type of surgical intervention. The same association has been previously shown in meta-analyses of patients with chronic pain and patients with head injury.

This association works against the intentions of the compensation system. Instead of compensation improving a patients condition, it makes it worse. The mechanism for this association is also the subject of my thesis and would require extensive discussion. Suffice it to say, it is rarely due to conscious deception on behalf of the patient but is related to concepts of blame and fault, and to financial incentives and other forms of secondary gain.

For some conditions, the very diagnosis made by doctors is in question. Perhaps the most famous example of this is whiplash, where, in some societies, whiplash is not known and studies have shown that the rate of chronic neck pain after motor vehicle collision is no higher than the background rate of neck pain in age and sex match controls who have not suffered motor vehicle collisions. Similarly, the stark differences in the incidence of chronic back pain and chronic neck pain between societies is best explained by social and cultural factors, rather than to any difference in the incidence of “injuries” or trauma to the spine. In fact, the “injury model” of back pain and neck pain is poorly supported in the scientific literature and, in my opinion, has a lot to answer for.

The other example which is well known to Australia researchers is RSI; a condition which became an epidemic, had no pathological basis, and was ‘cured when compensation was withdrawn.

RECOMMENDATIONS

1. ***Remove compensation for pain and suffering.***
   Many studies have shown that compensation for pain and suffering increases pain and suffering. This is most clearly shown by falls in the rates of chronic pain and disability with reductions in compensation for pain and suffering.

2. Minimise legal involvement.

Use of an adversarial legal system and retention of a lawyer are both associated with poor outcomes after injury. The adversarial system results in a paradoxical situation where patients are expected to get better, yet, at the same time, repeatedly prove that they are ill.

3. As much as possible, base compensation on objective criteria.

This is an extension to the idea of removing compensation for pain and suffering. Compensation for subjective complaints such as pain and suffering are extremely sensitive to financial incentives. I also propose removing compensation for chronic back and neck pain. These conditions are very poorly related to "injury" and multiple large scale studies have shown that chronic back pain and in the workplace is more strongly associated with job satisfaction and other psycho-social factors than any physical components of the work. I note that the 5Th Edition of the AMA Guides to the Assessment of Permanent Impairment have moved towards more objective criteria for back and neck pain and I agree with this.

I note that several of the submissions suggest that the AMA Guides are not suitable for assessing permanent impairment. I agree that there are problems with the Guides but they are the most objective criteria that we currently have and they improve with each edition. Furthermore, the WorkCover amendments to the AMA Guides are also improvements.

SUMMARY

While I agree that compensation for loss of wages and medical expenses is fair; giving individuals money for pain and suffering, or conditions associated with chronic pain (such as chronic back pain and chronic neck pain), does not make them better. To the contrary, it makes them worse and this has been repeatedly shown in the medical literature.

Yours sincerely

Ian Harris

Enclosures:

1. Worker's comp can keep injuries lingering: Patients, doctors, lawyers implicated, experts say. E.J. Mundell *(Health Day Reporter)*

2. Association between compensation status and outcome after surgery: A Meta-analysis. I. Harris, J Mulford, M Solomon, J van Gelder, J Young. *JAMA, April 6, 2005; Vol 293; No.13; page 1644-1652.*