Disability — Is it Permanent?

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• Too often cases of industrial injuries are submitted for permanent disability rating before maximum recovery is attained and the condition is permanent and stationary.

This is frequently a situation that is detrimental to the injured working man, since his physical disability might be further reduced by additional treatment, and his future earning power and economic status thus be improved. Also it may be detrimental to the insurance carrier and/or employer, since in some instances it results in increased permanent disability award payments for portions of the condition which are not truly permanent.

Inadequate medical reports also are a frequent cause of unfair awards. The necessary factors used to arrive at proper conclusions, the errors that have been observed and the importance of this problem are discussed.

BEFORE ONE APPROACHES the problem of reports on permanent disability, the condition under consideration should be permanent and stationary, meaning that maximum improvement has been obtained and the residual factors of disability will continue unchanged for the remaining life of the patient. Unfortunately, too many cases are reported as permanent and submitted for rating too soon after injury, with many resulting conflicts between the patient and insurance carrier (or employer), unnecessary litigation expense, and adverse psychological reactions on the part of the patient which may further compound the problem involved. Hence, it is to be hoped that all physicians who deal with patients who have industrial injuries will think twice and, before recommending final disposition of the case at hand, will ask themselves, "Is it permanent?"

In order to emphasize the importance of the overall subject, certain facts should be brought forth. During the fiscal year 1955-56 in California there were completed 11,682 permanent disability ratings. In addition there were 6,962 compromise and release cases which fundamentally require the same factors of information. Since approximately half of these ratings involve disability of an upper extremity, and four-fifths of the half involve the area of the hand, most of the problems to be discussed will refer to this portion of the body. Taking the year 1954, the average settlement in 16,052 permanent disability cases was slightly more than $2,300, or in total an expenditure by workmen's compensation carriers of $37,531,000 for permanent disability settlements. This excludes the expense incurred by approximately 250 self-insured employers.[2] Since in any case of this type premature rating may increase the amount of award and often will result in overpayment of some hundreds of dollars, inaccuracies of rating could sharply raise the cost of settlement. The resultant rise in insurance costs would have to be absorbed in higher prices for products of industry, and eventually be paid for by all purchasers—the general public, including the patient.

Perhaps the most frequent cause of error in rating is submission for rating at too early a date. Just as important as the already mentioned overpayment for factors of disability which are not truly permanent, is the fact that the injured person might be improved or further rehabilitated by additional treatment if his condition were not considered "permanent." To deprive him of obtaining a better result and improved function with which to compete in the labor market is certainly unjustified and unfair to the patient. The commonest faults in this respect are: (1) Dismissal of patients who have had amputation while the stump is so tender and painful as to interfere with function, although such conditions can usually be corrected by treatment, (2) dismissal of patients with excessive weakness or excessive grasp loss which can be improved by proper exercise, (3) dismissal of patients with limitation of function which can be reduced by adequate physical therapy (not merely the common practice of heat lamp or diathermy treatments unaccompanied by additional measures), and (4) too early rating of cases in which reconstructive or rehabilitative operation can produce beneficial results.

The problem of excessive grasp loss deserves considerable attention, for when loss is excessive it raises the percentage of disability rating, but when consistent with the function loss and other factors of an injury it does not affect the rating. The mechanics of the California rating system, which are more comprehensive than in other states, are designed to take into account that amount of grasp loss expected from the residuals of hand injuries. For example, if the rating of disability for an amputated finger comes to 6 per cent, the award is

Presented before a Joint Meeting of the Sections on General Practice and Industrial Medicine and Surgery at the 86th Annual Session of the California Medical Association, Los Angeles, April 28 to May 1, 1957.

calculated to include a grasp loss consistent with the amputation (in this case approximately 25 per cent loss of grip). If the percentage loss calculated for the grasp loss alone exceeds the amputation rating (or function loss rating where amputation has not occurred) then the larger rating percentage is used and the monetary settlement becomes increased. The accompanying chart may serve as guide as to what constitutes grasp loss commensurate with the function loss. The estimates of loss shown on the chart are slightly modified from those presented by Kirkpatrick,[4] giving figures of higher allowable percentage loss in some instances, which are felt to be commensurate with the amputations or motion losses shown. (All physicians doing industrial injury work should study the excellent article of Kirkpatrick regarding grasp loss.) Experience has shown that excessive grasp loss is rarely a permanent factor and rating as such is seldom justified.

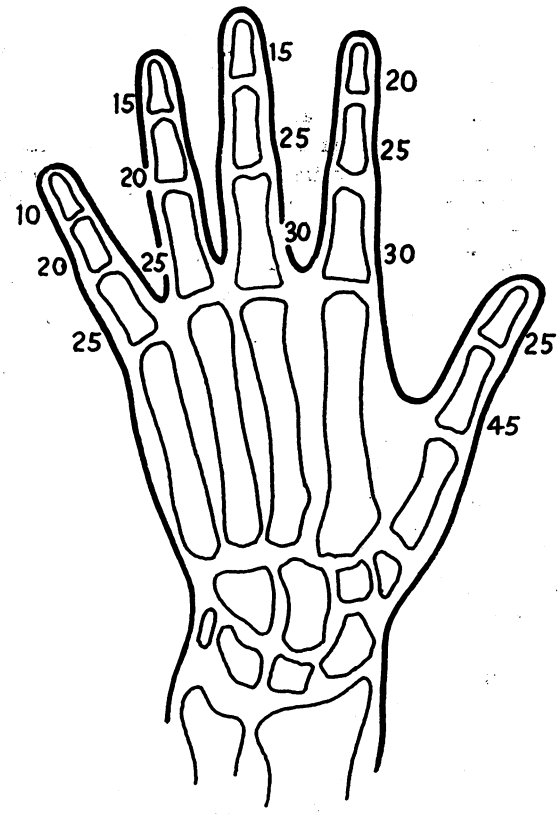
It is quite common for a case to be submitted for rating in which the physician indicates permanent disability consists of amputation of the middle finger, gives figures which represent 50 to 60 per cent grasp loss, and states that the condition is now permanent and static and ready for rating. Reference to the accompanying chart would show immediately that such an opinion is in error.

Another frequent difficulty is the presentation of permanent disability reports containing inadequate information regarding the disability which exists. Incomplete measurements of function loss, improper description of amputation level (which should be based on bone length and not soft tissue level), absence of measurements of atrophy, lack of recording of grasping power in upper extremity injuries, failure to describe shortening or deformities secondary to fracture or other injury, and lack of description of instability and the degree of instability are common. This prevents accurate rating and usually results in the injured person's receiving a lesser compensation award for his handicap than is just. He then either accepts an inadequate award—perhaps not knowing it is inadequate—or becomes involved in litigation, with expense, delay and often bitter reaction.

One further shortcoming of many reports by physicians is failure to cover the problem of subjective complaints, which in California are just as important as factors of rating as are objective findings. In some cases, particularly in cases of injury to the back, the subjective factors may far exceed in rating weight the factors of limited motion. Subjective disability without objective findings may result in a permanent total disability award in some instances. Therefore, subjective complaints should be thoroughly described. An excellent article by Barritt,[1] which includes the present standard of classification, should be available to industrial physicians when such problems arise.

The following suggestions may be of help to a physician in the preparation of permanent disability reports.

PER CENT GRASP LOSS COMMENSURATE WITH AMPUTATION LEVEL



PER CENT GRASP LOSS COMMENSURATE WITH DISTANCE FINGERTIP MISSES MIDPALM ON FLEXION

Finger	Distance (inches) fingertip misses mid-palm				
	½	1	1½-2	2½	3
	PER CENT				
Index	10	15	20	20	25
Middle	15	20	25	25	30
Ring	10	15	20	20	25
Little	10	15	20	20	25

The most accurate method to determine when a patient's condition is truly permanent and stationary is repeated examination at intervals varying from one to three months, making sufficiently detailed descriptions of the complaints and findings and accurate measurements of function in each report to permit comparison and evaluation of the progress of the case. When it is apparent the condition has ceased to fluctuate, either in improvement or retrogression and the findings are medically consistent with the injury, it is then the proper time for submission for rating. This period is seldom less than six months following injury in the simpler cases, and may be as long as three or four years—sometimes longer—in complex cases. In cases of major hand injury maximum recovery rarely is reached in less than one year. If an upper extremity is involved, the reports should always give results of repeated tests of grasping power, for in some cases there is steady improvement in this respect until final disposition is near, and then suddenly strength seems to vanish. Adequate repeated reports in such cases go far to assist the physician in substantiating his final evaluation of the degree of grasp loss.

When the final report is to be formulated, the following factors should be included:

1. Subjective complaints should be listed in full, as given by the patient, and classified by the accepted standard as to degree.

2. Deformities, scars and other cosmetic disfigurement should be described.

3. Objective findings—such as atrophy and shortening—should be carefully and completely covered.

4. Descriptions of impairment of function should follow the accepted standard of measurement given in *Evaluation of Industrial Disability*, Oxford University Press, 1950.

5. Grasp loss should be shown by three comparative tests.

6. Preexistent disabilities in the area involved should be segregated from the results of the injury, or, if they overlap, the examiner should apportion the amount due to the injury being considered.

7. Where the opposite side has been involved in preexistent disability (preventing its use as a normal for comparison), or bilateral disabilities occur from the same injury, it is necessary for the examiner to establish estimated normals for the particular individual in order to fairly reveal the disability that has resulted.

8. The examiner should offer his own best evaluation as to the handicap resulting from subjective complaints—which may differ in degree from the patient's interpretation. Likewise in the event of excessive grasp loss or evidence of other exaggeration, he should give his opinion as to the degree to which these factors are present and reasons to substantiate his questioning of the validity of the findings.

9. The physician should make no attempt to state a percentage of disability as is done in some other states.

In conclusion there is much that can be done by the physician to accomplish accurate and fair permanent disability awards to the injured patient, prevent unnecessary expense to insurance carriers, and reduce litigation which is an expense and delay to both parties, if attention is devoted to the necessary details of this subject.

"The evaluation of disability of an injured employee is an art comparable to that of the clinician in medical practice."[3]

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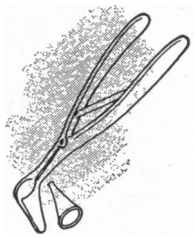
REFERENCES

1. Barritt, J. L.: The evaluation of subjective disability, Ind. Med. and Surg., 417-19, Sept. 1956.

2. Gershonson, Maurice I.: Division of Labor Statistics and Research: Personal communication, Feb. 1957.

3. Homblad, Edward C.: The essentials of medical reports for employees care, Illinois Med. Jour., July 1956.

4. Kirkpatrick, John E.: Evaluation of grip loss, Calif. Med., 85:314-320, Nov. 1956.