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ACCIDENT COMPENSATION

*Terence Ison**

ETIOLOGICAL CLASSIFICATIONS IN COMPENSATION SYSTEMS

My topic is etiological classifications, and particularly the distinction between injury and disease. It's a distinction that we have seen pervading all compensation systems, or at least most systems, except some basic social insurance and social security systems. We find in discussion in the legal profession and among academic lawyers that we are constantly using etiological classifications, referring to them almost as if they exist in nature, and we tend to refer to them with a sort of tacit approval.

There are several explanations. Probably the most cogent is the historical one that most of us first came into contact with compensation systems through tort liability, and of course that's an etiological based system, so that it became normal for us to think in terms of cause. Then of course the profession has a financial interest in that type of structure which may have an influence on certain occasions. In the law schools there is also an academic interest in the philosophical or moral issues that can be debated around questions of cause, and perhaps potential disappointment if those issues were to disappear.

Probably the most pervasive influence is that lawyers tend to see nothing wrong with the use of etiological classifications. They tend to see nothing wrong, for example, with focussing on the victims of crime, the victims of automobile accidents, the victims of negligence, or the victims of something else. What I want to do this afternoon is to suggest that there is something very gravely wrong with that, and that we are not really performing a public service or making useful contributions when we start the debate by assuming the legitimacy of these classifications.

One thing that tends to pervade legal and parliamentary debate, and even royal commission reports sometimes, is an assumption of the feasibility of administering these classifications. There is an assumption that human disabilities can be classified in that way. This would seem alright if we visualise what you may call a normal person who is suddenly afflicted by some traumatic event and then has clearly diagnosed consequences, including ascertainable economic consequences. But of course we all know when we think about it that that is not the way the world really is. People come in diverse shapes and sizes with diverse physical, emotional and psychological makeups, and with all kinds of weaknesses and defects before any particular event operates on them, and a subsequent disability may not be the result of one particular event but the combination of a multitude of events and circumstances that affect the individual. At any subsequent point in time, a current disability may have resulted from a range of things that happened throughout life, including of course natural aging.

In tort liability, these problems are probably least profound, because it's common in tort claims that we can establish certain injuries as

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resulting from a certain event. Problems of etiological classification do come up though, even in tort claims, and they come up usually on the measure of damages. They involve whether certain consequences are attributable to a particular injury, or whether the disability is better or worse because of something else happening to the individual. In workers' compensation it is an enormous problem; not only the distinction between injury and disease, but also the classification of disease etiology, distinguishing diseases that result from employment from those that result from other causes.

The use of etiological classifications results in two major problems. One is what one might call the moral dilemma; the difficulty of justifying compensation for certain categories of disablement and not for others. The other problem, which is of even greater concern to me, is that not only do we exclude people who in moral terms may be just as deserving but we also exclude from compensation people who, under the terms of the system, are covered. We do so particularly in systems, such as workers' compensation or the accident compensation scheme in New Zealand, which cover certain diseases but not most diseases.

The reason why this happens is that some of the largest volume disease categories are those in which the cause of the disease is unknown or unascertainable, at least in the particular case. If you take, for example cancer, one of the largest volume categories of serious disease, we know a certain amount about the causes of cancer. We know that a fair amount of it is caused by smoking. We know also that a fair amount of it is caused by industrial exposures. We know also that a certain amount of it is caused by exposures to carcinogenic substances which may be absorbed through food, or from the general atmosphere. Often we can determine causes in aggregate, but not in individual cases. If you take coke oven workers, for example, it may not be difficult for an epidemiologist to say that: "The incidence of cancer among coke oven workers is so much higher than among the general population, and among the cancer victims who were coke oven workers, I can tell you that X portion probably had their cancers as a result of working with coke ovens, while Y portion would be attributable to more general causes, including smoking". Then you may say to him, "Yes, but I do not want aggregate figures. I need to know what caused the cancer in this case". He can't tell you. Epidemiological data will not usually persuade a court or tribunal to reach a positive conclusion on etiology in the particular case.

What happens of course is that once we use etiological classifications we start insisting on proof of causation in each case. I did some rough figuring on this in regard to workers' compensation in Canada. I took the available statistical data and then extrapolated from that using pure guesswork. My feeling was that if we try to guess as best we can at what proportion of people who are disabled as a result of employment actually receive workers' compensation it could be as low as 20%. Maybe it's as high as 40%; maybe 50%; but it is very doubtful if it is 60%, and it is certainly nowhere near 80%. My best guess is that somewhere in the range of 20/40% of those who are disabled as a result of employment actually receive workers' compensation.

By far the biggest problem is the difficulty in establishing disease etiology. In New Zealand this comes up a fair amount, and more than is commonly recognised. When I was there the difficulty of distinguishing

injury from disease was not a matter of great discussion among officials of the ACC, but the first hand evidence indicates very substantial problems of distinguishing injury from disease under the accident compensation scheme in New Zealand. With regard to every case that came to my attention, I put to myself this question: "Is there a problem of disease etiology in this case?" I found it was very much higher than was recognised.

One reason why the problem is not recognised more often is that it tends to be concealed. In New Zealand, for example, it tends to be concealed in the medical certificates. A doctor is asked to certify whether a disability resulted from personal injury by accident or other cause, tick box (a) or explain the other cause. Thus the difficult questions of etiology may lie concealed behind the certificate. Apart from looking at individual cases, if we look at the aggregated data in New Zealand, for example, at the time when I looked 13.2% of the claims were for bad backs. While a significant proportion of those would be short term muscle strains, there was also a significant proportion which were serious; ones where the pain does not relieve within about six weeks. Those cases almost inevitably involve medical reports referring to a traumatic experience plus spondylosis or other disease terms relating to pre-existing conditions in the back. Then there are sometimes subsequent events, including possibly disablement from a subsequent disease or subsequent aging.

Then there are all the sprains and the strains, and the heart attacks. If you think of what heart attacks are and look, for example, at the definition in the Accident Compensation Act of New Zealand, it says that personal injury by accident does not include damage to the body or mind caused by a cardio-vascular or cerebro-vascular episode unless the episode is a result of effort, strain or stress that is abnormal, excessive or unusual for the person suffering it, and the effort, strain, or stress arises out of and in the course of the employment of that person. But what are the sort of circumstances in which people actually sustain heart attacks? Often when they are trying to do something that is too much for them. When do people try to do something that is too much for them? Often when there is nobody around to help; when someone is working on his own. If someone is working on his own and has a heart attack and it is fatal, where are the witnesses? Thus even a scheme as broad as New Zealand's has problems of etiological classification.

It's commonly thought that these sort of problems do not arise under motor vehicle schemes, but that is an illusion. We have serious problems of distinguishing traumas and diseases even in motor vehicle schemes. A large proportion of motor vehicle accidents involve, for example, whiplash. With whiplash cases we have a traumatic experience operating on the muscles of the neck, but when it comes to the time required for healing and certainly when it comes to residual problems, there may well be uncertainty. For example, at the time of the accident the patient complained only of pain in the neck because that's where the big pain was; but six months later the patient is complaining of pain in the back. Now the question is did that result from the automobile accident or was it something that would have occurred in any event?

Motor vehicle cases can also involve heart attacks. We may know from subsequent evidence that the automobile went off the road. We know that the person suffered cardiac infarction, and the cause of death stated

on the death certificate is heart failure; but did he have a heart attack because he was going off the road, or did he go off the road because he was having a heart attack? The truth is that nobody will ever know; and yet eligibility for compensation depends upon an answer to that question under several systems, perhaps including accident compensation in New Zealand.

The problems become aggravated if we switch from lump sums to periodic payments. I'm not suggesting this as a reason for not doing it. There are reasons for doing it that far outweigh this one. Nevertheless, when one does switch from lump sums to periodic payments, there is an increased difficulty in handling distinctions between injury and disease. Take the ordinary trauma case, perhaps a motor vehicle case, where somebody is run over or involved in a collision. There are injuries which involve a joint. Perhaps six months later the person is back at work and appears to have recovered. Benefits terminate; but then nine or ten years later he suddenly appears again and complains of arthritis. Somebody says: "Well, that's not a traumatic disability, that's a disease". The claimant replies that: "My arthritis results from that traumatic experience". The question may then arise of whether this person would have had arthritis in that location regardless of the traumatic experience, or whether it was a result of the trauma. Thus these problems do arise even in the context of systems which may appear to be only systems of compensation for trauma.

A concern mentioned above is that the majority of victims of disease do not recover compensation, even under systems in which they are eligible, because of the difficulties in establishing etiology case by case. For example if we compare the cancer claims under workers' compensation systems with aggregated data drawn from epidemiological studies indicating what we would expect to be the incidence of cancer as a result of employment, the differences are fantastic. The actual incidence of cancer from employment could be anywhere up to forty times, some people estimate even a hundred times, the number of compensation claims.

One assumption sometimes made is that this situation will improve with advancing medical research. It is often assumed that we will discover more about the etiology of disease. We know now, for example, of about 13 to 18 carcinogens that we never knew of twenty years ago. The assumption is a mistake. It's not going to work out that way because other changes in society take place at a much faster pace than medical research. Medical research moves at a snails pace compared with the introduction of new chemicals into industry, into water supplies, into food chains, and into the atmosphere, and new uses of chemical compounds, new mixtures, and new applications. There is no way that the medical profession can keep up with the significance of all of those substances and their varied uses. For many of them we haven't even done the research to determine whether they are toxic at all, let alone to determine degrees of significance. Thus the problems of etiological classification are not going to become easier with the passage of time. They are going to become more difficult because causation is going to become more obscure. Knowledge of etiology advances at the perimeters, but it becomes obsolete in the centre core at a faster rate so that we are going to have increasing rather than decreasing difficulties in establishing the etiology of human disablement. This means that as long as we rely

on etiologically based systems of compensation we will have increasing injustice rather than a reducing incidence of injustice.

A related concern is that in most societies most of the time, it's unrealistic to expect that uncertainty will result in compensation. I'm not thinking here of New Zealand so much as Canada, the United States, the U.K., and Australia. The prevailing practice is that uncertainty about the etiology of a disease is deemed to warrant a negative assumption. It's a dominant fault in the medical profession and there are various reasons for it. The prevailing view in the medical profession, or at least among those whose opinions tend to prevail in compensation systems, is that the affirmative has to be demonstrated, and it doesn't matter what the statutes say about burden of proof. The dominant view in the medical profession is that the absence of positive data warrants a negative assumption. As long as that view prevails, and it does tend to prevail except where there is a strong tribunal that can divert them from it, uncertainty about the etiology of a disease operates against the acceptance of a claim.

Disease is very important. People can go through law school assuming that accidents are what cause disablement and death, and of course accidents do cause some of it, but only minority categories. When I looked at deaths occurring in New Zealand in 1975 among what you might call the workforce age bracket, that is 20 to 59 years, only 17% were classified as resulting from accidents, poisoning or violence. Looking at morbidity data, the best morbidity data that I could find related to discharges from New Zealand hospitals, only 12.5% were classified as cases involving accident, poisoning or violence. All the rest were disease cases. So as long as we focus on trauma oriented systems we are looking at minority causes of disablement.

It is more than just injustice that concerns me here, it is also therapeutic damage. It has long been obvious to me that etiological classifications involve delay, they involve a lot of expense, they involve a great deal of waste, they involve a diversion of resources away from compensation towards administrative structures, legal processes, insurance processes, and so on. They involve delay while people are being classified into one etiological classification or another, and delays in compensation decisions are often associated with delays in the commencement of rehabilitation. That has long been obvious. What has become more apparent to me in recent years is that these delays in rehabilitation can involve permanent damage to rehabilitation prospects and not merely a delay in commencement.

In a research project that I undertook recently I was concerned with the significance of the structural options in organising compensation systems on the way doctors diagnose, the way they prescribe, the way they treat, on patients responses to treatment and so on. An overall conclusion was that in the majority of cases, compensation structures probably do not make a significant difference, but they do make a significant difference in some cases, and certainly delay in the processing of compensation claims is a cause of therapeutic damage. It causes damage in two ways, first by extending the anxiety time and by delaying the commencement of compensation, and secondly by adding medical examinations that would not otherwise be needed. There seems to be a consensus on this among the medical profession, or at least among those who have thought about it, that medical examinations beyond those that

are necessary for basic diagnostic and treatment purposes are *per se* a cause of therapeutic harm. As long as we keep sending people to doctors, and the adversary system is the worse where you may have people examined by doctors on both sides, those medical examinations are themselves a cause of therapeutic damage. (See "The Therapeutic Significance of Compensation Structures", forthcoming in the *University of Toronto Law Journal*).

Perhaps the point that I will wind up on is that apart from the harm is the difficulty of trying to justify the use of etiological classifications. When we look at New Zealand, for example, there are various explanations of why in the first place the system was set up to deal predominantly with trauma and not for disease. But when we look for reasons for the continuation of that structure there are none that will seriously stand a few moments of reflection.

There are two other comments that I will make with regard to the moral difficulties of the distinction. If we are really concerned about distinguishing the deserving from the undeserving (and I don't like thinking in those terms when it comes to compensation for human disablement) probably in aggregate the victims of disease are more deserving than the victims of trauma. Probably the incidence of contributory negligence is less among disease victims than it is among trauma victims. So if we are really looking for the most deserving categories we are more likely to find them among disease victims than among trauma victims. The other point in moral terms struck me clearly when I visited a hospice for seriously disabled people, mostly quadraplegics and paraplegics. They were at the post-acute stage where the disease victims and the accident victims with very very similar catastrophic disabilities were now together in one almost permanent residence. I asked one of the administrators whether any of the patients had any views on the accident compensation system. He told me that one patient was very articulate about this, and so I went to interview her, and spent about half an hour with her. These comments are my paraphrase of what she said:

The Government has got the priorities wrong by using loose and ambiguous language. Their perception of accident is a physical impact concept that ignores most victims of 'accident' in the moral sense of that word. If a drunken driver injures himself hitting a telegraph pole they call that an accident. I call it a self-inflicted injury. If a rugby player becomes a paraplegic from impact in the scrum, they call that an accident. I call it a planned risk. If a small child runs into a street because there is no fence to stop him and is hit by a car, they call that an accident. I call it a predictable consequence. If someone is crippled by multiple sclerosis there is nothing he could possibly have done to prevent that. We don't know what causes it, so he could not possibly have avoided it. I call that a true accident. But they say he is not covered.

That brings out very graphically the moral dilemma in trying to perpetuate this distinction between injury and disease.