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Dwight M. Palmer

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Evaluation of physical impairment is a procedure involving purely medical considerations. Rating of disability, on the other hand, involves a host of psychological, sociological, and economic factors. However, dectors, who are especially qualified to rate impairment, are often called upon to evaluate disability, for which function they are not so qualified. Dr. Palmer discusses the prevailing confusion between these two concepts, and sets out the work and proposals of the A.M.A. in this area.

There has been considerable dissatisfaction with evaluations in the area of rating the medical impairment of the sick and injured. Recognizing the existence of this discontent and desiring to contribute to a solution the American Medical Association several years ago formed a committee[1] for the purpose of developing guides for the evaluation of physical impairment. These guides are intended to apply not only in the rating of impairment sustained in the course of employment but also in other areas, such as the evaluation of impairment associated with aging, or of the impairment of those seeking disability benefits under the social security laws or other disability programs.

The committee, in reviewing the work that had been done in this area and in considering the dissatisfaction with the existing approach to disability rating, decided that it would be desirable (1) to put the doctor in the position of rating medical impairment, and (2) to distinguish impairment from disability, which involves non-medical considerations such as sociological conditions, occupations, skills, and financial resources. It was thought that the rating of disability might be better handled by persons or bodies outside the medical profession, such as judges, juries, boards, referees, arbitrators, etc. These people would take into consideration those sociological, occupational, and financial factors which, along with medical impairment, constitute disability.

When asked to appear on the program that led to this Symposium,

*M.D., Columbus, Ohio. Diplomate of the American Board of Psychiatry and Neurology. Member, American Medical Association Committee on Medical Rating of Physical Impairment. This article is based upon a speech given at the Institute on Employee Injuries held at the Vanderbilt University School of Law in November of 1962.

1. Committee on Medical Rating of Physical Impairment.

I agreed to speak on the subject of the medical rating of impairment, but when I arrived, I found that the program as printed included the subjects of both impairment and disability. This exemplifies the odds faced in attempting to distinguish between these two concepts. A simple illustration of this distinction is here appropriate. Consider a person who has made his entire living with a given part of his body, say his right hand. Suppose further that the hand is amputated. From the standpoint of medical impairment, this person is not one hundred per cent impaired. He still has a left hand, a head, and a trunk. Thus there are many avenues of living for this man. Nevertheless, he may be one hundred per cent disabled for the only occupational ability he has ever had. Consequently it might be said in this case that the medical impairment would be fifty-five per cent of the whole man, but the disability would be one hundred per cent.

The Committee on Medical Rating of Physical Impairment is preparing a set of guides which provide criteria only for the rating of impairment, thus restricting the doctor's role to the making of a purely medical judgment. It is very probably true that many people will continue to want the doctor to rate disability. Conversely, many people—and, paradoxically, sometimes the same people—will berate the doctor for having rated disability at a certain value. However, the committee firmly believes that the doctor will be most effective if he limits himself to the medical discipline and rates impairment rather than disability. This committee has been working for several years and thus far has produced four guides, which have been published in the *Journal of the American Medical Association*;[2] four additional guides are now in preparation and others may be promulgated in the future.

A great amount of time has been spent by the committee, of which I am a member, in discussing these guides and in questioning leading practitioners in the various fields of medicine about physical impairment of the various regions of the body. A general principle that has guided our thinking is that we should deal only with permanent impairment. This means that a patient should have had the advantages of good medical care—the best available. An attempt should have been made to reverse the course of his sickness or to build up in his body compensations which serve to partially or totally rehabilitate him from his illness or injury. The patient should be in such a state of medical management at the time of evaluation that his condition is stable and non-progressive, and also non-regressive. Another guiding principle, already mentioned, is that the sociological background of

2. Reprints of these guides may be obtained from the American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

the patient, his age, sex, special training, education, and economic status, are not a part of the medical rating of impairment. These factors do, of course, enter into the consideration of disability.

Our basic approach is to evaluate medical impairment on a basis of interference with the daily living of the patient. This involves the ability of the person to take care of himself, to communicate with others, to stand and walk about, and to use all of his members, with particular reference to his capacity to use his hands; it does *not* include the acquired skills which may constitute his trade or vocation.

These ratings have been applied to the concept of the whole man; thus it is necessary to state them in terms of percentage of impairment of the whole man. Under this approach a one hundred per cent medical impairment would be equivalent to death. If a person has impairments of more than one system of his body, these are to be combined by the use of established combining tables rather than by adding the impairment values for the different systems. If they were merely added it would be entirely possible to arrive at figures above one hundred per cent.

The committee is striving to produce a series of guides with consistent values. For example, if a person is blind for reasons of eye disease, the value should not be different from that state resulting from a complete lesion of the optic nerve. Obviously consistency is difficult to achieve, and considerable effort must be devoted to that end.

I will now repeat my thesis for emphasis. The opinion of the American Medical Association Committee on Medical Rating of Physical Impairment is that a doctor contributes most effectively when he attends to medical matters, such as, in the present context, the rating of impairment. The committee considers that though a doctor may be better qualified than the average layman to rate disability, nevertheless he is in a non-medical area when he must consider such factors as how much money a person is losing because of a medical impairment. Therefore, the guides that are being produced deal with impairment, and not with disability.

At the present time workmen's compensation boards, insurance companies, welfare agencies, and courts commonly ask doctors to rate disability as well as impairment; this is particularly true in the industrial compensation field. All that is requested is the percentage of *disability* the doctor finds. Thus a dual problem of education presents itself as it is sought to implement the ideas herein discussed. Both the doctor and those who would use the doctor's services must be brought to an understanding of this concept of the doctor's proper role. However, in spite of these difficulties we feel that in the end the doctor will command more respect if he remains a doctor and rates only

impairment rather than attempting to do something for which he is not preeminently qualified, namely, the correlating of impairment and the other relevant factors to determine disability.

To illustrate the distinction sought to be made, it is felt that there should not be much disagreement among doctors in any community, or in any of the fifty states, as to impairment. A patient in Maine should have essentially the same medical impairment rating as one in Hawaii or Texas if each has an identical illness or injury. Disability is quite a different matter. Factors of a sociological and economic nature enter into the concept of disability. If this can be made clear, it will tend to lessen conflict, not only between law and medicine, but among groups within medicine and among people who are in neither field, but serve as administrators.

It has been very interesting to the members of the Committee on Medical Rating of Physical Impairment to consult another doctor and to educate him to think in terms of impairment rather than disability. The process takes two or three hours. A dramatic situation is utilized to illustrate the point, such as the case of a concert violinist who enjoys a high income because of his great skill. As he is walking down the street a brick falls from the top of a building and strikes him on the head, fracturing his skull and giving him a blood clot over his non-dominant cerebral hemisphere. As a result of this accident, even after the best treatment, he loses his ability for fine movements. He can talk, walk, and read, but he has lost the fine movements of his left hand, and will never again play the violin well. What is that man's disability? As a concert violinist I think all would agree that his disability is one hundred per cent. But the medical impairment is not one hundred per cent, since he is still able to carry out the ordinary activities of daily living to some degree. Admittedly he is not going to be a successful violinist, but there are many, many things he can do.

Only recently someone was telling me about a man who is totally paraplegic, that is, he has lost the use of both lower limbs, as well as the control of his bladder and bowels. He has to wear a diaper and a urinal and must live in a wheelchair, but he is actually operating a large business. For many occupations, and perhaps for his previous occupation, he undoubtedly would have been rated one hundred per cent disabled, but for what he is doing now, as a whole man, in terms of a living member of the community, he is certainly not one hundred per cent disabled. So the interpretation of disability varies vastly in different social and economic situations. This individual was never one hundred per cent physically impaired, but his impairment was the same while he was in his first economic situation as it is in his present one. So, in his case, the questions of impairment are: How

impaired is a person with the loss of both lower extremities? How impaired is a person with the loss of bladder and rectal control? These impairment percentages will be combined and the value obtained will be less than one hundred per cent.

It should be emphasized that the American Medical Association has not told any physician that he cannot rate disability. Doctors frequently do rate disability. However, we are working toward a situation wherein the doctor who rates disability will so state, and will make a parallel statement concerning medical impairment. For example, the doctor might state that the medical impairment of a given patient is twenty-five per cent, but after also considering such factors as the patient's educational and employment background, his attitude, the economic situation in the locality, and the prospects for future employment, the disability value assigned may vary significantly. It is our belief that the adoption of this distinction will be of value both to the medical profession, and to the public generally.