

Discussion

DR. JOHN YOUNG (*U.S.A.*). It is known that the court can only award dollars in quantities of dollars for disability. In our country the greater the disability the more severely the person is injured and the more money he gets. I would ask Mr. Golman, in his new scheme of things, what substitute can be offered to replace the quantum awards and give the person more dignity in living?

MR. GOLMAN. The quantum dollar award is that it is usually excessive because the individual has not been returned to his optimum situation. We are getting to the adverse situation where at least the plaintiff's attempts to prove the great disability, the numerical quantum of award of course will be excessive. We are trying to get down to a base-line which establishes an equity of award. In most instances the catastrophically injured person is not capable of being restored to a vocational economic level. We are mainly dealing with marginal people—people who are marginal in the basic pre-mortal state, who now have this security. We are essentially trying to take the waste out of the economic quantum award. It is an acceptable substitute. If we do not raise the harshness of the adverse situation—and may I go just one point further with respect to that—is that it then creates very strong and powerful motivation forces. These forces, if properly handled, can be controlled, I think, basically by management from the viewpoint of the law. I do not know whether I have completely answered it, but this is the best substitute we have, at this moment, to reduce the waste so that society can afford to treat its catastrophically injured people appropriately.

DR. J. SILVER (*G.B.*). I think the situation in Israel is quite interesting. They have started a new spinal unit and after several wars, when there was a tremendous feeling for the soldiers, they were given unlimited money. But after the last war they felt this was not satisfactory because the money was being wasted. This time, they have said that they will give unlimited money for vocational training, if it is a soldier, to get him back to work so there is no room for money ill-spent. Otherwise, they give less money, or sufficient money, as other countries do. They will not give unlimited money, as they have been giving formerly. With regard to getting the people back to work, when they are employable, they have said that, if a person is classified as 100 per cent disabled, then he will pay no income tax if he works. Israel, I think, carries the highest taxes in the world. This is very forward thinking: unlimited money for vocational training and if the person is back to work he pays no income tax. I think that tends to reduce the adverse situation and concentrates on getting the person back to work.

SIDNEY EICHENVENS (*U.S.A.*). I would like to ask the speaker if he has any opinion as to the role of the contingency fee in fostering or hindering a fair and proper legal judgement.

MR. GOLMAN. Perhaps I should explain what a contingency fee is. A contingency fee is the portion of the award the lawyer will receive if he is successful. If he is not successful he will receive no award. Now this is contrary to most of the other systems in the world. The contingency fee—you have to understand its historical development in the United States to know its meaning—permits representation where the individual wanting representation has what we call a relatively valid claim, but does not have the economic means of guaranteeing a solicitor ordinance fee. It has its purpose in the United States. It also, depending on the individuals on the plaintiff side who are receiving this fee, has the tendency to enlarge the amount of money to be received. However, it does, in a sense prolong or extract the optimum out of the case.

The real problem in the United States lies with the defence, who are paid *per diem*, and who, like the English solicitor, must prove his fee. So, the longer the case is hung out the greater the fee. The larger the amount of paperwork produced does not solve the problem but the heavier the paper the more the defence bill. The plaintiff's attorney is really interested in getting in, getting the job done and getting out, because he makes

no money from procrastination, while the defence lawyer makes his living by procrastination.

In England, the lawyers are paid for the amount of time they spend, not the quality of the time. Consequently there is this tremendous delay in the English system, which premeates the country, Australia, New Zealand, and all its former dominions. I have run into this several times and it has been very disconcerting to try to solve the problem where both counsels must be rewarded for the time they have spent.

DR. H. TALBOT (*U.S.A.*). The classical example, of course, of continued procrastination is in Dickens' *Bleak House*, where we have the situation of three generations wasted—three generations of a family devoted to their famous legal case.

I wanted to ask you whether you thought that this undesirable level of adverse relationship in these cases, the tendency to, through no fault of insurance since a great many of our cases derive from traffic accidents, extend into personal liability. As far as I know, it has been used largely in terms of property damage, but the basic principle and basic ethic of no-fault insurance might not help alleviate the situation of a strictly adverse relationship between the two sides rather than some sort of judicial arbitration where it could be just in both ways. Regarding Dr. Frankel's remarks, I would like to point out one result of our increasing concern with the human rights of the subject of our clinical investigation. At present, as a profession, we tend to be arrogant and say we know what we are doing and do not have to tell the patient too much, we know what is good for him and so on and so forth. But it seems to me that in the last ten or fifteen years we've been more and more preoccupied with the necessity, both ethical and legal, of securing the patient's consent and taking him into our confidence. We found in such a service as this here and of Dr. Rossier's in Boston, where you have a rather sophisticated patient constituency, people who by fairly prolonged hospitalisation have learned something about what is going on. A result of their being taken into your confidence is that they can help you a great deal in your research; they make intelligent observations, they know what you are looking for and frequently make informed suggestions and contributions. If you wish to object that their contributions are going to be subjectively insular, well, so are our own judgements too.

PROF. M. WEISS (*Poland*). I would like to make a few remarks to both speakers. Perhaps you are interested in the situation in our conditions, because from a legislative point of view we are a little different, as probably you all are. We are now in a very difficult situation all round the world (I am speaking now on behalf of W.H.O.). In travelling through poor countries, the Middle East or Far East as I have done very frequently, you are faced with severe confrontations. Look at the situation in severe high tetraplegics. Shall we go as far as possible with curative treatment, procedures of saving of life, when we know that it is impossible to reconstruct his social independence, even life. When a prognosis is bad, as in a very high severe lesion and the case is not getting better because of pulmonary complications, we fight for two or three weeks with life-saving procedures. If his social prognosis is bad, we cease to save his life by all means, and we think that this procedure is ethical. We are in a very difficult situation here because the same proposal given to the counsel would condemn the family or himself to death. The second problem concerns money and compensation. In Poland we make a very detailed study about how far the legislation destroys possibilities of further rehabilitation and how far it stops motivation for the rehabilitation. In particular we found this in coal miners. They do not like to continue the rehabilitation programme, including vocational training. We built a big hospital, beautifully equipped for vocational rehabilitation in Silesia, where we not have different types of workers but not very many miners. Coal miners receive high compensation. They are afraid to be without this money and they do not like to change their vocation because it is a very heroic, a very much appreciated vocation in our country. From this point of view we have now suggested, as a result of this critical review of legislation, that a vocational approach, as our colleague

from Israel suggested, should be the basic one. We have to give them unlimited possibility for further work plus compensation which means that the money he would receive would be insured for him but that he must work, because when anyone is without work they would be psychologically destroyed.

DR. CHAHAL (*India*). I support fully what Dr. Weiss has said. Another one of the problems in a developing country like India is that I am often asked by medical administrators, colleagues and friends what justification I have to occupy the hospital beds with total tetraplegics for one year, then one and a half years in rehabilitation, when we know that ultimately we will be unable to give them any vocational training. Another problem is that in vocational motivation for patients with high lesions, the financial background always comes in and that they find that if they are trained, they are likely to lose the compensation or the help which the State or the people are going to give. They do not want to go in for any effort because they find they are already totally incapacitated.

MR. GOLMAN. If I may just continue. First to Dr. Chahal. I am very much opposed to any definitive legislation standardising awards to people of different capacities. I think this is one of the failures in an over-all insurance system. It does, however, in two or three States in the United States, provide unlimited medical care which again is explained for other reasons. The basic thing is to try to avoid this exploitation, but how do we do it? I think the only way we can, is on an individual basis, not a broad consensus (persons dealing with each other to solve a particular problem within a framework of the broad concepts of the law). Conversely, I would like to make a comment with respect to the doctor and Professor Weiss, that I quite agree that there is a moral ethical consideration with respect to the saving of the life of a quite catastrophically injured person who has no potential whatsoever to make a contribution to society after you have saved it. With regard to this, it is unfortunate when we see the effort devoted to the life of an individual who, before his injury lay starving on the street, there would be no compassion for him or no ability to take care of him. We are interested, as I see it, only in salvaging—and I need to say it because we're going to come to this dichotomy eventually. We're going to have to face it within the next twenty to twenty-five years, to salvage those who are competent, and we have to let those who are incompetent go. Man has to make this decision because, if he does not, the competent will be destroyed in the process. With respect to people in Israel—they are unique, they have a different problem. In our country, in Britain and the other developed countries in the world we have a surfeit of people for whom we have no place in the economic scheme of things, and we talk about vocational rehabilitation. Yet there is no job for them and there is also no job for the able person. This is a large and continually broadening area. We have to consider these things in this whole field of rehabilitation and social consideration.

DR. H. TALBOT. I must say my piece about this. You speak about the potential to make a contribution to society. I say we have no more right to demand that of a man who is disabled than we do of demanding of each other, our own families and people we know most, people who talk around with their lives happily or unhappily, who make no particular contribution to society and feel no obligation and on whom we pose no such obligation but that we only ask them to live decently and not to spit in someone else's pathway. I think that this is not a subject that we're going to solve here. But I don't believe in the second place that we can look at someone who has been injured and say whether or not he has this potential. We all have had experiences of people who before their injury were pretty marginal sort of specimens, to use your words, but who turned out after injury to be well competent of considerable rehabilitation. They had no rehabilitation in the first place, but having been injured, they got rehabilitated. So, in the first place I don't think we have a right to impose this obligation to be useful to society, only to live out their individual lives in dignity and satisfaction. We do have an obligation to help them or to give them a chance to do that. In the second place, I don't think we're capable of judging in a given case whether or not an individual has

this potential. From time to time we may see cases for which there is obviously a job in one way or another. If society can't make another job for people it seems to me that society's answer is that society ought to have the ingenuity to figure out some way to make a job, or perhaps better yet to limit the number of people who are born in the first place. It seems to me that we're getting involved in a lot of complex problems. As a physician I cannot consent to this responsibility of deciding that this man should be allowed to die as long as I have any potential to keep him alive.

SIR LUDWIG GUTTMANN (*G.B.*). We have to realise that both medical and legal professions are today in a more difficult position than was the case 30 years ago, because at that time, even the paraplegic, let alone the tetraplegic, was considered as a hopeless case with a very short duration of life. It was very simple to assess his life expectancy and his pension, as then the life expectation was generally considered no longer than two to five years. We know now that the life expectancy is so much increased, indeed in many cases of paraplegia practically as normal as that of able-bodied people. It is now more difficult for both the medical adviser and the legal counsel on both the defendant's and the plaintiff's side. We doctors certainly have no right to condemn even high tetraplegics to die by stopping life saving measures after a few weeks and by not giving him the chance of social and professional rehabilitation.

There is another point I would like to mention here. I have been quite often in courts as medical adviser, and there are always two questions: what is the life expectancy and whether the man is able to take up employment and to return as a useful member to society?

With regard to Sid Golman's remark that in England there is a long delay in settling the case, one of the reasons is to decide in paraplegics and tetraplegics who show functional recovery when the optimum is reached, which naturally is important for the working capability of the injured, *i.e.* full-time or part-time, and the type of employment he may be able to take up, especially whether or not he can return to his former job. It may take one to two years and even longer until a final medical assessment is possible following repeated check-ups. In complete and also certain incomplete lesions the assessment of life expectancy depends often on the risks of complications developing after discharge from hospital, in particular infection and dysfunction of the urinary tract. There is no doubt that in some litigation cases the working capability of the plaintiff is difficult to assess as a result of aggravation of the symptomatology due to neurotic overlay. In this connection some solicitors dissuade their clients, who otherwise would be capable of taking up employment, not to do so before the case is settled. Whenever I come across this attitude I never hesitate to warn the plaintiff that this may just have an adverse effect on the court's decision. The conclusion from all this is that every litigation case has to be considered individually on its merits.

MR. KRISHNAN (*G.B.*). With reference to Dr. Chahal's statement, I think it must be very clear that this problem is not confined to a developing country. This problem we face, though in a diminutive manner. In the place in this country, where I work, where the employment possibility is very small, we find that two things happen: Firstly, if the patient is heavily compensated he invariably loses all impetus for working and unless he is essentially a man who is interested in working—just because he's a paraplegic and sits in a wheelchair he doesn't overnight turn into a sort of a firebrand who wants to go out dashing about working. It doesn't happen, it depends on his personality and on the persuasion which the doctors and the people concerned can offer. Now, the second group are the people who had unfortunately sports injuries or who are self-employed, who were not paying enough stamps so that they can receive industrial disability. Now, these people are in an extremely pitiable condition, and the State must do a tremendous amount of rethinking how in fact these people can be compensated. If they are criminally injured, the Criminal Injury Compensation Board does pay a certain amount. But I have two very young rugby football players in my unit at the moment who had great

potential for promotion in service and are highly intelligent people. Both these people are reduced to extreme helplessness, and I would hate to think what's going to happen to them, unless they have private incomes, or I can generate such melodrama in the local region where some kind man is going to give me a lot of money to look after them. So, this problem is not essentially a problem of developing countries. In a relative manner, it is a problem of a highly sophisticated National Health Service, where we still have serious anachronisms.

DR. F. W. MEINECKE (*Germany*). First of all, may I say from all that I have heard this morning about home care, I am a little jealous about what can be done in other countries and what we can't do in our country. I think there was one point which I'd like to mention. Most of the home care is done in towns and their environments, and the difficulty we have is with patients living in the country and I feel that we should have an international programme how to deal with those paraplegics and tetraplegics. Another point I want to mention is the possibility of training the relatives in the nursing and care of a paralysed person, while he is in hospital. I know there are some centres where they are able to do so, but I feel we should have that in mind when setting up new centres. The last point I want to mention is the possibility for clinical staff to visit the families and explore the situation at home. In our country this is possible, as far as patients with industrial accidents and the care of Workmen's Compensation are concerned. But, they have a lot of difficulties and have trouble with the local social workers and the other insurances. And I would be interested to hear whether this problem occurs in other countries too.

DR. MASALAWALA (*India*). I would like to ask Mrs. Richards whether, from experience, she has roughly divided the people into two groups—those who have settled in and recovered their jobs or started new ones and those who have a sense of grievance. Was there any sort of correlation between these two groups and in the sense that one group had suffered their injuries as a result of either industrial accident or a third party was involved and the other, who were injured in sport or got their injuries by driving their own cars or something like that. Was there any correlation in these numbers and, if so, can anything be added to in the way of early settlement of claims.

MRS. RICHARDS. No, I didn't go into details about the claim, my numbers in fact don't show how the accidents happened, although one might have found this out by looking through notes. But I think you have certain people who are successful, naturally—they have been successful in life before they were disabled and they remain on the whole successful after disability. But you have those, as you say, because perhaps the accident was their own fault, who are much more bitter and resentful and they don't settle down readily when they go home. I think that, possibly, they are the ones with inadequate personalities who don't succeed anyway, they can't cope with their problems and their families, and this is I think where we fail, because we don't see enough of those patients who really do need our help, that we don't get out to see them afterwards. They feel isolated and left alone, and, you know, we've taken them so far but we don't take them far enough. As I've said, I think this is a question of time and distance, and if there were more of us in the team we could probably help the unsuccessful a great deal more.

BERNARD ENGELER—Lawyer (*G.B.*). I would like to ask Mrs. Richards a question following on Mr. Golman's talk earlier this morning. Do you feel that more funds for this home care would make for a better job. What I have in mind is that if there is a case with third-party liability, which exists in any case these days, if the insurers could be persuaded to fund a home-care rehabilitation service do you feel you could offer a better job?

MRS. RICHARDS. I think, in a way, money's the least of one's problems. On the whole, the social service is very good at producing money, but there are occasions, for example, when interim payments would be extremely helpful in order to get a patient and family into a bungalow now, not four years later when their case is heard. A young

girl or a young man would like a car, not an Invacar: this is where I think money should come out of litigation, if it could be made available more quickly.

B. ENGELER. You know that there is a facility for obtaining an interim payment in the course of litigation?

MRS. RICHARDS. Indeed; I think Dr. Frankel here is very good at doing it.

DR. J. YEO (*Australia*). If I may comment on Professor Ascoli's paper. I was very interested to hear your comments on the urological care at home. We, like you, have difficulty sometimes in convincing patients what they should do at home. We have found one helpful method is to use cystometry as an almost routine procedure before the patient leaves, partly from the point of view of confirming diagnosis as to what type of neurogenic bladder but also to demonstrate to the patient, to his relatives and to the nurse what happens with the fluid in the tube. And we found that the patient himself is prepared to accept a technique of management of bladder if he sees what happens when he taps or presses. I wonder if the professor would comment as to whether cystometry has been used at all in that way.

PROFESSOR ASCOLI. Of course, it is a general principle to show to the patient many days before his discharge, how and what he must do once at home.

PROFESSOR M. WEISS. I feel this session on social aspects is extremely important. Because this is our goal—the continuity of care must be now our basic point of strategy—to ensure local continuity of care. From this point of view I would like to present to you a few of our suggestions which we are now doing. The first is that we decided to admit a member of the family at the end stage of the rehabilitation into the hospital as a patient. Secondly, we decided to train a local doctor. Any local doctor gets a pamphlet which gives points he must observe when a patient is discharged. This local doctor is responsible also to send us some observations when he finds a special symptom which is alarming. The third proposal is to buy a few normal apartments, and in these apartments we place our personnel, and one of our doctors would be responsible for 20 cases discharged from hospital who spend there a programme of normal housing conditions. We have there an engineer to study what facilities can be proposed and some technicians to make these facilities. We planned to keep these cases there for two up to six weeks, and then they would be discharged from these apartments. Many duties you leave to a responsible nurse and the family member would go to the shops, buy the food and cook it. I feel that with such a programme, living in normal apartment conditions, we can achieve our goal and ensure proper results of our medical efforts.

PROF. ASCOLI. I don't know how the situation is in Poland, but in Italy it is impossible to have a correlation with the local organisations. They don't know about paraplegics—they know nothing about catheterisation, or decubitus. And for this reason the situation is completely different in the town where centres are as compared with the rest of the country.

DR. LINDEN (*U.S.A.*). I would like to ask Dr. Ascoli what instructions he gives his patients regarding the fluid intake. Surely it is the volume inside the bladder rather than the face of the clock which determines when the bladder will empty. This is sometimes very difficult to regulate with patients who are employed.

PROF. ASCOLI. Of course, we must regulate the quantity of fluid intake with the output.

DR. R. LINDEN. This was my point. You said the patients are supposed to void by the clock, but they're not really voiding by the clock.

PROF. ASCOLI. Some patients must urinate every three hours, some every four hours, some every two hours. You must take an individual case and establish how often by the clock and how much he must drink.

DR. J. CIBEIRA (*Argentina*). Well, I will insist on one point, that when we get an acute injury in our institute in Buenos Aires we consider right away more or less the prognosis, and we think of the team work at the beginning. It sometimes happens that

we are too much medically minded, we are really thinking on the scientific part of the situation, but we forget sometimes to get in touch with the patient's family, with his friends, and to prepare everything to discharge the patient with success. I am sure if we are thinking at the beginning about the discharge of the patient, we will know the psychological situation before and after the accident, what type of family he has, and the home care will be better and is successful many times.