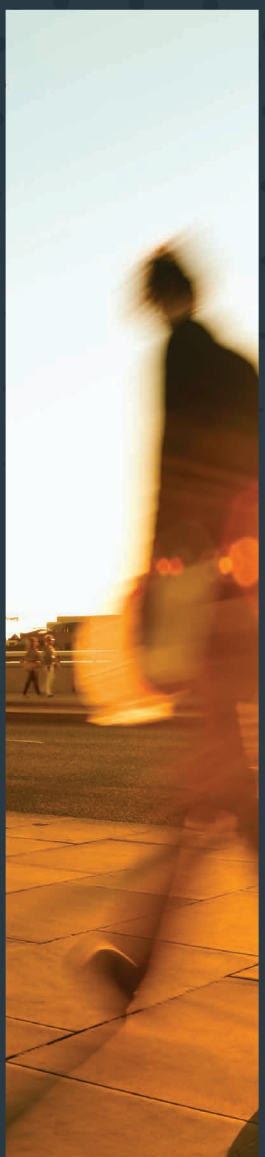
FIRST REPORT OF THE

Personal Injuries Commission



PIC | AN COIMISIÚN UM DHÍOBHÁLACHA PEARSANTA
PERSONAL INJURIES COMMISSION

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PART 1

Executive Summary and Recommendations

Foreword By Chairman Mr Justice Nicholas Kearns

On behalf of the Members of the Personal Injuries Commission, I present our first report to the Tánaiste and Minister for Business, Enterprise and Innovation, Ms Frances Fitzgerald T.D., and to the Minister of State with Special Responsibility for Financial Services and Insurance, Mr Michael D'Arcy T.D.

Significant public focus has been placed on the cost of insurance in recent years with the average price of motor car insurance premiums increasing by 70% between 2013 and 2016 (CSO data).

Against this background the Cost of Insurance Working Group (CIWG) was established in July 2016, chaired by former Minister of State at the Department of Finance, Mr Eoghan Murphy T.D. Its report published in January this year identified measures that could be introduced to help reduce the cost of motor insurance for consumers and businesses. In relation to personal injury claims the CIWG Report concluded that:

- Awards for Personal Injury claims represent a significant component of an insurance company's pricing model;
- Soft-tissue claims represent a significant component of personal injury (PI) claims;
- Severity in soft-tissue claims can be difficult to diagnose; and
- Approaches that link diagnosis, treatment, prognosis and awards of damages should be examined.

The CIWG recommended that a Personal Injuries Commission (PIC) be established to investigate some of these issues further.

Since its establishment in January of this year, the PIC has been actively engaged in delivering in accordance with the terms of reference of its work. A considerable amount of research into other jurisdictions has been carried out along with a consultation exercise with the medical community and key stakeholder groups. This research and consultation has informed the initial findings of the PIC which suggest that adopting a standardised and internationally recognised approach to diagnosis, treatment and reporting on soft-tissue injuries, by practitioners who are appropriately competent and trained, will improve the personal injuries environment in Ireland.

Our future reports will focus on looking at comparative systems and benchmarking compensation award levels internationally. Preliminary findings suggest that the frequency of soft-tissue injury claims in Ireland would appear to be significantly higher than a lot of other European countries. Commentators have claimed that award levels are higher in Ireland than in other jurisdictions and this is currently being researched by the PIC. It remains to be determined whether this could be a contributing factor in terms of claims frequency or exaggeration.

PIC is conscious that exaggerated and fraudulent claims contribute significantly in driving up insurance costs. Urgent measures are generally recognised as being required to combat these malpractices. This can be achieved though more rigorous enforcement of existing remedies, through the deployment of new technologies such as telematics, and through greater sharing of information regarding fraudulent claims. In this regard, the PIC recognises the overlap of its work in examining award levels and the issue of exaggerated and fraudulent claims which is being examined by CIWG, and consequently will work in close liaison with CIWG to ensure effective recommendations address these concerns.

I would like to express my thanks to the PIC Members for their commitment and detailed analysis of the issues we have examined, and to the secretariat for the extensive research they have carried out and for their support to the PIC. I would also like to thank the various bodies and individuals who have contributed to the work of the PIC, particularly Dr Noel McCaffrey and Dr Jean O'Sullivan who provided very helpful input at the initial stages of the Commission's work.

This is an important and complex area which affects many individuals and virtually all sectors of society both in terms of the impact of accidents on injured parties and the cost of insurance premiums which policyholders pay. It is important that the rights of individuals are protected but that an appropriate balance is struck between accident victims and policyholders who ultimately bear the financial cost of claims. I hope the analysis of international best practices, feedback from our consultation exercise and the ongoing complementary work of the CIWG lead to a better functioning personal injuries environment in the future.

Nicholas J. Kearns
Chairperson

November 2017

Executive Summary

Introduction

Significant public focus has been placed on the cost of insurance in recent years with average motor car insurance premiums increasing by 70% between 2013 and 2016. The Cost of Insurance Working Group (CIWG) identified measures, including the establishment of the Personal Injuries Commission (PIC), that could be introduced to reduce insurance costs. The CIWG report envisaged the PIC recommending enhancements to the claims process in Ireland, through examining other jurisdictions including those where scales or rating of soft-tissue injuries are used, by analysing international compensation levels and compensation mechanisms and by benchmarking international awards for personal injury cases. CIWG advocated that approaches (particularly those applying in common law jurisdictions) that clearly link the diagnosis, treatment, prognosis and the award of damages should be examined.

This first report from the PIC covers phase one of a three phase eighteen-month work programme. Considerable research has been carried out in addition to a consultation with the medical community and relevant stakeholders. This informs the initial findings of the PIC. Subsequent reports from the PIC will focus on internationally benchmarking compensation award levels and describing comparative systems.

Overview of Personal Injury (PI) System in Ireland

Ireland operates a fault-based (tort) system in relation to PI claims. The underpinning legislative/constitutional framework in Ireland is that the victim of an accident caused by the negligence of others is entitled to be compensated by the liable party. There is a limited period for claimants to bring a personal injury claim (limitation periods in Irish law are set out in a variety of statutes and judicial decisions). Compensation, usually paid as a lump sum, comprises general damages (pain and suffering) and special damages (financial loss).

Levels of general damages are not defined in legislation. The Book of Quantum is a set of guidelines based on actual pay outs that reflect the prevailing levels of compensation for various types of injury. Award levels are determined ultimately by judicial decisions.

In assessing damages medical information is considered. This is usually provided in the form of narrative style commentary relevant to diagnostic, prognostic and injury recovery period information, but not typically incorporating any specific injury severity scales. Medical practitioners in addition to giving expert evidence may also be a witness as to relevant facts.

The liable party for an accident is usually responsible for third party costs such as legal, medical, engineering, actuarial fees etc., which can vary across settlement channels. PIAB reports a delivery cost of less than 7% for cases they assess and data provided to CIWG indicates a 40% additional cost for cases resolved outside of PIAB.

Personal Injury Claim Resolution Channels

Personal injury claims generally arise from motor, workplace or public place accidents, or medical negligence incidents. They can be resolved through direct settlement between parties, through the Personal Injuries Assessment Board (PIAB) or through the Courts.

PIAB operates an administrative paper-based process, assessing damages on the same basis as the Courts, and with the aim of removing cases from unnecessary litigation. Claimants are typically required to attend an independent medical examination which provides for an up-to-date medical report. It does not address issues of liability. The introduction of PIAB has driven a move away from an adversarial system of resolving cases. In addition, PIAB has facilitated direct settlements between parties. Some commentators suggest direct settlements are as high as 60%-70% of all cases.

The right to litigate is a Constitutional right in Ireland. Under Article 34 of the Constitution, justice is usually administered in public, in Courts established by law and by judges appointed in accordance with the Constitution. Although a limited number of claims are determined by the judiciary they influence compensation levels throughout the system. Under the *Civil Liability and Courts Act 2004*, the judiciary are required to have regard to the Book of Quantum in assessing damages. Cases dealt with in Court are usually adversarial and conducted with plaintiffs and defendants relying on their own evidence and experts.

European Wide Frequency/Cost of Soft-Tissue ('Whiplash') Claims

Indications from commentators are that Ireland has a very high frequency of 'whiplash' claims compared to other jurisdictions and that compensation levels are significantly higher. Comparing frequency is problematic owing to the lack of data available generally and the individual nature and characteristics of different jurisdictions including the use of different definitions.

PIAB estimate that approximately 80% of motor personal injury claims currently reported are 'whiplash' related. Based on this estimate, it is reasonable to conclude that soft-tissue injuries (e.g. 'whiplash') account for a large proportion of claims by volume in Ireland.

Executive Summary (continued)

There are considerable variations in the frequency of 'whiplash' claims across Europe and based on the limited information available, Ireland's and the UK's incidence rate of such claims, appears significantly higher than those in other EU countries such as Germany and France. A comparison of costs is even more difficult where there can be different heads of damages for recoverable non-economic losses (e.g. general damages).

In some countries injury compensation levels are determined with the aid of tables. In others, case law precedents or guidelines assist courts and insurers. The PIC will report in more detail on international benchmarking of awards in its second report.

A high-level comparison of the cost of a 'whiplash' claim can be made between levels of damage in Ireland and England/Wales based on the respective versions of the Book of Quantum and the Judicial Studies Board Guidelines. Such a comparison indicates that less severe injuries in Ireland tend to attract higher levels of damages but that is less pronounced as the severity of injury increases. The provision of comprehensive data and settlement figures from insurers is a key element in facilitating a more detailed and useful comparison.

Role of Medical Experts Internationally in Personal Injury Claims

Medical experts are utilised in most European countries in evaluating personal injury claims and in the process, that leads to the quantification of compensation for non-economic losses such as pain and suffering. In some countries, the Courts rely on tables compiled by medical experts to determine the level of injury and its permanency. Differences between EU Member States exist regarding the appropriate qualifications and the exact roles of medical experts in evaluating claims.

In some countries, any doctor can act as a medical expert without specific requirements while in other countries medical experts must have a specific qualification or cannot be also acting as a claimant's own treating doctor. Different methods of injury evaluation are also employed.

International Scales for Assessment and Rating of Soft-Tissue Injuries

There is no universally recognised system of calculating impairment on a percentage basis. Some countries use systems of medical scoring or scales linked directly to compensation payments while others use tables as guides for amounts, similar to the process facilitated by use of the Book of Quantum.

The Whiplash Associated Disorder (WAD) scale as developed by the Quebec Task Force (QTF) is an objective scale based on severity of symptoms and associated physical signs, used and well recognised internationally, including in some European countries:

- Grade 0 (WAD 0) – no neck pain, stiffness, or any physical signs are noticed
- Grade 1 (WAD I) – neck complaints of pain, stiffness /tenderness but no physical signs
- Grade 2 (WAD II) – neck complaints and decreased range of motion and local tenderness in the neck
- Grade 3 (WAD III) – neck complaints plus neurological signs
- Grade 4 (WAD IV) – neck complaints and fracture, dislocation, or injury to the spinal cord

The scale helps determine the type and extent of medical care likely to be needed and has become the established norm in many parts of the world. The PIC has recognised that there are very significant advantages in adopting this scale.

Evaluation of Soft-Tissue Claims in Various European Jurisdictions

Ireland

Generally, injury medical reports that are used do not incorporate specific severity scales although the QTF WAD scale and International Classification of Disease coding (ICD-10) are occasionally referenced. Reporting is usually and particularly for 'whiplash' type injuries, by way of a submission of opinion (typically by an IMC registered GP or Orthopaedic Consultant) in the form of narrative style commentary relevant to diagnostic, prognostic and recovery period information. The Book of Quantum contains award level guidelines. Previous Court judgements are also considered.

UK

MedCo is a non-profit making organisation and operates as part of a new system introduced in the UK. The aim is to facilitate the sourcing of medical reports in soft-tissue injury claims brought under the Ministry of Justice's new Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents. The MedCo system requires registration of medical experts providing soft-tissue injury medical reports. It requires advance accreditation to a mandatory minimum level with a modular training programme covering areas such as professional obligations, clinical examination and legal content of reports. This training is delivered by MedCo itself.

France

Assessment of injuries is based on "The Nomenclature Dintilhac" which lists all recoverable damages and the methods of valuation. The nomenclature is not legally binding but it is referred to by the French Courts with its definitions being applied. Medical experts used in the assessment of bodily injuries must possess specific accreditation. The diagnosis of bodily injury is based on objective proof. Compensation is based on the percentage disability, whether this is permanent or temporary, and the age of the claimant. The medical expert must outline an opinion on the claimant's injury and medical sequelae. A medical report should provide information under the various headings of the nomenclature to allow for cross-referencing with tables produced by France's regional Courts.

Germany

The claimant must provide convincing evidence of the injury and once this is established prove that the injury is related to the accident. The injured party is responsible for obtaining medical evidence however, the presentation of a medical certificate from a GP or a hospital may sometimes suffice. Small injuries do not receive compensation. Compensation for pain and suffering is based on injury severity, duration of treatment and the age of the claimant. German Courts can appoint their own assisting experts. Disputed claims require an independent medical opinion along with the original opinion. A claimant is required to prove a certain level of 'whiplash' has been sustained to ensure payment of compensation for this type of injury.

Sweden

Sweden operates a strict liability (no fault; claimants having a right to compensation for bodily injuries) system for persons suffering personal injury because of a road traffic accident. If the victim's disability is greater than 10% the file must be submitted to the Road Traffic Injury Commission (TSN) which advises the parties. Non-monetary payments include amounts for pain and suffering based on tables and as recommended by the TSN. Entitlements depend on the seriousness of the injuries and the length of treatment. Payment is often made by way of diminishing monthly amounts. Sweden uses an adapted QTF classification system. When claiming compensation, a claimant's injury symptoms must generally occur within 3-4 days of an accident and be reported promptly. A claim can still be submitted in this time period without a medical report being obtained, however the claim will be much more difficult to prove.

Norway

Compensation for non-economic damages resulting from a road traffic accident is based on published tables. Compensation is state regulated and standardised based on the medical disability. The formula for calculation was developed with Norway's social welfare department and takes into account the seriousness of the injury and the injured party's age. Compensation for permanent injury is split into several groups depending on the degree of disability determined. Compensation is not paid for medical disability less than 15%. The diagnosing process for minor injury claims is carried out by independent doctors however such doctors are not considered "independent" if they are the claimant's own GP.

International Approaches to 'Whiplash' Diagnosis and Treatment

Internationally there are many similarities in the approach used to assess Whiplash Associated Disorder (WAD) injury and widespread reference to the QTF scale. Common and similar approaches across jurisdictions include history taking; widespread application of the Canadian C Spine rule (a decision making tool used to determine when radiography should be utilised in patients following trauma); observation of posture; palpation and cervical range of motion tests. Diagnostic scans are usually recommended for more serious WAD injuries, but a body of medical opinion considers the use of Magnetic Resonance Imaging scans (MRIs) as having a very limited role in the clinical management of less severe 'whiplash' injuries. Australian, French and UK guidelines refer to and use the Neck Disability Index (NDI) and a Visual Analogue Scale (VAS) for pain assessment. Other specific tests are used in certain jurisdictions including tests generally only recommended in cases where more severe symptoms are indicated.

Irish Context

A doctor wishing to practice medicine in Ireland must register with the Medical Council. Specialists also register with the Medical Council additional qualifications relevant to their area of specialisation. There is no specific accreditation required or benchmark standard for a doctor wishing to complete a medico-legal report in a personal injury claim.

Executive Summary (continued)

Expert Panel

The PIC was tasked with investigating the potential for the establishment of a panel of medical experts for use in Court which would restrict the parties in personal injury proceedings to using experts from a panel designated by the Courts. In certain jurisdictions courts can appoint their own experts to provide opinion and assist with relevant factual issues, rather than relying solely on the expert evidence presented by the parties. Current practice in Ireland for litigated cases is that separate reports from medical practitioners representing both parties are usually submitted and practitioners can be called upon to give evidence in court primarily as a witness rather than an "expert". The use of multiple medical experts by opposing parties can be costly and may ultimately impact insurance premiums.

Legal advice received by the Department of Justice and Equality and the Department of Jobs, Enterprise and Innovation from the Office of the Attorney General in relation to use of such an expert panel was that the proposal to prohibit parties from using their own witnesses would affect a claimant's right to fair procedures and access to the courts, and also their rights to present their own evidence and challenge that presented by the opposing party. The introduction of a mandatory panel of expert witnesses would be an impermissible interference with a claimant's constitutional rights.

Consultation Process

Ten key medical organisations were invited to respond to fifteen questions asked under five key headings; diagnosis, grading and scales, forms, training and accreditation and medical professional evidence. The consultation responses can be considered broadly supportive of the PIC's emerging recommendations and ultimately led to the final recommendations and action points arrived at by the PIC in this report. In general, there is agreement that the adoption by medical professionals of a standardised approach to the examination of soft-tissue ('whiplash') injuries will bring more consistency to medical reporting and diagnosis, that the standardised approach as proposed by the PIC is the preferred one and that the use of the QTF classification model is the preferred model for the grading of WAD injuries. The majority view reflected in the responses is that claimants as opposed to medical experts should complete any self-testing elements of injury evaluations. There is significant agreement that compulsory formal training, accreditation and qualification will improve the consistency and quality of reports (a Continuous Professional Development (CPD) based programme being the appropriate level of expertise required) and agreement that individual medical bodies, as opposed to independent training providers, should deliver the training courses. Respondents also provided examples regarding the proposed training content and various training delivery models.

Conclusions

The adoption by medical professionals of a standardised approach to the examination of soft-tissue ('whiplash') injuries and use of a standardised reporting template will bring more consistency to medical reporting and diagnosis. This standardised approach should be along the lines of South Australia Clinical guidelines for best practice management of acute and chronic WAD injuries.

WAD grading, the NDI and VAS are recommended for inclusion in all soft-tissue ('whiplash') examinations and reports (including templates) going forward. A self-testing element (by the injured party) should be used. The use of any additional tests and tools for the examination and evaluation of soft-tissue ('whiplash') injuries should be left to the discretion of the examining specialist.

Training and accreditation in soft-tissue ('whiplash') reporting is agreed as being a best practice requirement for those wishing to complete relevant reports and should be delivered to improve the consistency and quality of reporting.

Such training and accreditation should be introduced initially as part of a medical practitioner's CPD training programmes and overseen by an appropriate professional/ regulatory body. Comments on the possible training curriculum will be provided by PIC to training bodies to assist.

The use of an Independent medical panel in court proceedings which could impinge on the constitutional rights of claimants is not being recommended by the Commission at this point in time. The PIC prefers an approach combining a template for assessing soft-tissue ('whiplash') injuries with best practice guidelines and believes this can deliver significant improvements and greatly enhance the personal injury claims environment in Ireland.

Key Recommendations

Recommendation	**A Standardised Approach to examination of and reporting on soft-tissue injuries should be adopted.**
Suggested timeframe for implementation	**To allow for the changeover in examination and reporting procedures it is suggested that a timeframe of mid-2018 is appropriate.**
Action Points	1. The Quebec Task Force (QTF) Whiplash Associated Disorder (WAD) grading should be used going forward by all medical professionals reporting on relevant injuries.
	2. The Neck Disability Index (NDI) and Visual Analogue Scale (VAS) should be included going forward as part of personal injury medical reporting examinations.
	3. Additional tests should be at the discretion of the examining medical professional.
	4. The template form included in the appendix should be used by examining medical professionals in all relevant cases. 4(a) Insurers should ensure that all cases commissioned by them from medical examiners going forward are completed in line with the template form. 4(b) PIAB should redesign their Form B going forward to reflect the recommended standardised template. 4(c) Court Rules changes should be considered which would require reports to be produced using the standardised format. 4(d) The use of standardised Medical reports should be included in any pre-action protocol developed for personal injury claims.
	5. Relevant medical professional bodies to publish, as soon as possible, guidelines in respect of training for use by medical professionals.
Recommendation	**Training and Accreditation of medical professionals who complete personal injury medical reports should be promoted. This should become 'Best Practice' and training should be introduced at the CPD level.**
Suggested timeframe for implementation	**By end 2018**
Action Points	1. All those involved in commissioning reports should ensure the use of accredited medical professionals for completion of their personal injury medical reports, when the relevant training and accreditation programmes are in place.
	2. Members of the PIAB panel completing personal injury medical reports should in respect of completion of relevant injury medical reports, when the relevant training and accreditation programmes are in place, be accredited accordingly.
	3. The Accreditation requirement should be included in any pre-action protocol developed for personal injury claims.
	4. The quality of the training should be monitored from implementation in the same manner applicable to existing CPD programmes.
	5. The CPD training could be delivered by individual medical professional bodies to their members or by independent training providers to medical professional bodies and medical practitioners.

Executive Summary (continued)

Recommendation	**Link future publications of the Book of Quantum to the newly standardised examination and reporting injury categories i.e. 'whiplash' soft-tissue injuries/ QTF WAD scales. The Cost of Insurance Working Group report of January 2017 recommends that the next review of the Book of Quantum should take account of the output of the work of the PIC. This recommendation highlights the output of the initial PIC report in terms of its potential impact on this next review.**
Suggested timeframe for implementation	**2019 when the next Book of Quantum is due for publication.**
Action Points	1. PIAB to consider in the context of the next Book of Quantum.
Recommendation	**Relevant injury data should be collated and published by appropriate bodies.**
Suggested timeframe for implementation	**By end 2018**
Action Points	1. PIAB to produce information going forward relating to the incidence of 'whiplash' soft-tissue injuries.
	2. Other relevant bodies to publish data relating to the incidence of 'whiplash' soft-tissue injuries. There may be merit that such data available from insurers, forms part of the National Claims Information Database which is being developed by the Central Bank of Ireland and which needs consideration by the relevant parties involved.
Suggested timeframe for implementation	**By end 2018**

CHAPTER 1

Context, PIC Terms of Reference and Approach

Chapter 1: Context, PIC Terms of Reference and Approach

1.1 Introduction and Background

This is the first report from the PIC and covers phase one of a three phase eighteen-month work programme.

Pricing in the non-life insurance sector has been subject to a lot of volatility in recent years, from a point where some premiums appeared to be priced at an unsustainably low level to the more recent experience of large increases, particularly since 2014. Significant public focus has been placed on the cost of insurance as the average price of motor insurance premiums increased by 70% between 2013 and 2016.

It is against this background that the CIWG was established in July 2016 bringing together all the relevant government departments and offices and chaired by the then Minister of State at the Department of Finance Mr Eoghan Murphy T.D. CIWG was tasked with examining the factors contributing to the increasing cost of insurance and identifying what short, medium and long-term measures can be introduced to help reduce the cost of insurance for consumers and businesses. The initial focus of CIWG was the issue of rising motor insurance premiums. The CIWG has more recently been examining issues relating to employer and public liability insurance.

A report from the CIWG on the Cost of Motor Insurance (Department of Finance, January 2017) reached the following key conclusions:

- Awards for Personal Injury claims represent a significant component of an insurance company's pricing model;
- Soft-tissue claims represent a significant component of personal injury (PI) claims;
- Severity in soft-tissue claims can be difficult to diagnose; and
- Approaches that link diagnosis, treatment, prognosis and awards of damages should be examined.

The level of awards for personal injuries in Ireland is ultimately determined by the courts: precedents set by the courts are followed by the PIAB and influence also how insurers settle claims.

Addressing the personal injury resolution framework in Ireland is a complex task. Whilst the CIWG engaged in a preliminary analysis of possible options used in other jurisdictions that could augment the Irish system, it recommended that a Personal Injuries Commission (PIC) be established to investigate some of these issues further.

Stakeholders participating in CIWG had shared their concerns in terms of a perceived lack of consistency in personal injury claim award levels through direct settlements between insurer and claimant, the PIAB and litigation channels. Such a lack of consistency in award levels can reduce incentives to settle claims early as the parties involved are unsure of appropriate award levels. Conversely, consistent use of the Book of Quantum (BOQ) and early agreement on compensation levels are in everyone's best interests, providing fair compensation to claimants in line with the law of tort, enabling responsible parties realise their liabilities in a timely manner and reducing ancillary costs.

CIWG conducted some research in relation to how injuries are graded or assessed internationally concluding that much was to be gained by looking further at European and international systems.

Reducing the costs associated with settling soft-tissue injury claims may have a positive impact on reducing the cost pressures which underpin the price of insurance premiums, particularly as the prevalence of soft-tissue injury claims appears to be so significant.

The Government approved the CIWG Report on the Cost of Motor Insurance in January 2017. The establishment of the PIC was one of the key recommendations in the Report. The then Minister for Jobs, Enterprise and Innovation was given responsibility for establishing the PIC and appointed members from the legal, medical and insurance sectors and relevant government departments and agencies.

1.2 Cost of Insurance Working Group Terms of Reference Summary

The overall objective of the CIWG is to identify and examine the drivers of the cost of insurance and recommend short, medium and longer term measures to address the issue of elevated insurance costs, taking account of the requirement for the need to ensure a financially stable insurance sector. Work is on a phased basis with the first phase having focused on the rising costs of motor insurance and the second phase, since January 2017, focusing on employers and public liability issues. A full "stand-alone" report on this phase of CIWG's work will be finalised by the end of 2017.

A key area identified by the CIWG for reform is the Irish claims environment. Enhanced transparency, along with better data sharing and collection, is required for the identification of trends and appropriate policy responses.

The costs of the claims process had been highlighted by some stakeholders as being a key reason in Ireland for the increase in the cost of insurance premiums. The CIWG examined the overall personal injury claims environment and available cost data. Whilst the CIWG determined that

the legal costs and non-legal costs attributed to overall claim settlement amounts are significant, it was unclear whether trends in costs were a major contributory factor in recent premium increases. Examined in detail also were matters relating to insurance fraud and uninsured driving, reducing collisions and the promotion of road safety.

The CIWG's first Report, published in January 2017, made 33 recommendations across six areas with 71 associated actions providing greater clarity, certainty and transparency in relation to motor insurance costs. The rationale behind the recommendations along with an action plan identifying the responsible bodies and timelines for delivery is set out in the report.

Consumer protection is the central theme running through all the recommendations which are split into three broad categories:

1. Recommendations that are aimed at increasing the transparency in premiums for consumers and allowing them to compare policies and prices effectively and where possible to make the changes to their circumstances that will reduce their premium;
2. Recommendations that are aimed at ensuring effective access to insurance by closer review of the operation of the Declined Cases Agreement, and, ensure certain categories of consumer, e.g. returning emigrants, have an improved experience when seeking to purchase insurance that recognises driver history in other jurisdictions;
3. Recommendations aimed at improving engagement between the consumer and the insurance industry.

In terms of the CIWG's key recommendations:

- The requirement for creation of a National Claims Information Database was identified;
- The BOQ is to be strengthened along with exploring with the judiciary how future reviews of the BOQ might involve their appropriate involvement;
- Several recommendations were made in relation to maximising the PIAB process including that the separate PIAB legislation review currently under way address cases of non-co-operation e.g. non-attendance at medical examinations arranged by PIAB and/or refusal to provide details of claims for special damages;
- Following on from the introduction of the Legal Services Regulation Act 2015 a range of new measures relating to legal costs and legal costs transparency, under Part 10 of that Act, are to come into play in 2018, including the establishment of the new Office of the Legal Costs Adjudicators, to replace the existing Taxing Masters Office;
- In relation to fraud improved data sharing through the development of a database (taking data protection concerns into account) and to identify patterns of suspected fraud were recommended;
- Further co-operation between the insurance industry and An Garda Síochána is important and should be developed;
- To address uninsured driving, a fully functioning insurance database is to be finalised;
- An Garda Síochána to check insurance compliance through technological means such as automatic number plate recognition;
- A review of Section 30 of the Civil Liability and Courts Act 2004 which relates to the Courts Service establishing and maintaining a register of personal injury actions is also proposed.

Following on from previous concerns raised around the uncertainty and cost of the claims process and the method for making awards for personal injuries, the CIWG's first report highlighted the complexities of the personal injury claim framework in Ireland with award levels ultimately set by the judiciary. In this context, the establishment of a Personal Injuries Commission (the PIC) was recommended. This specific recommendation falls under the CIWG objective of improving the personal injury claims environment in Ireland.

The CIWG is currently working on a co-ordinated approach across government, state bodies and industry in terms of the implementation of its recommendations and continues to engage with the Joint Oireachtas Committee on Finance, Public Expenditure and Reform and Taoiseach. The CIWG produced its first Progress Report in May 2017, the second in July 2017 and the most recent in October 2017.

1.3 The PIC Terms of Reference

One of the key recommendations in the CIWG Report was the establishment of the Personal Injuries Commission with four associated action points to be carried out within specific timeframes. The Department of Jobs, Enterprise and Innovation (since re-named as the Department of Business, Enterprise and Innovation) was assigned as the Lead/Owner in respect of each:

- (No. 30) Establish a Personal Injuries Commission (PIC);
- (No. 31) PIC to investigate and make recommendations on processes in other jurisdictions which could enhance the claims process in Ireland;
- (No. 32) PIC to benchmark international PI awards with those in Ireland and report on alternative compensation and resolution models;
- (No. 33) PIC to deliver their third report.

Chapter 1:
Context, PIC Terms of Reference and Approach (continued)

The PIC is chaired by former President of the High Court, Mr. Justice Nicholas Kearns. Membership of the PIC includes relevant medical, legal, insurance and government stakeholders (Part 2 Appendix 1: Membership & Secretariat of the Personal Injuries Commission refers).

The PIC is charged with meeting regularly and having the ability to engage external expertise and invite relevant parties to meetings.

The CIWG report envisaged the PIC researching systems in other jurisdictions for handling personal injury claims, reporting on systems where scales or rating of soft-tissue injuries are used, benchmarking international awards for personal injury cases and analysing and reporting on international compensation levels and compensation mechanisms. It advocated that approaches that clearly link the diagnosis, treatment, prognosis and the award of damages should be examined; the PIC should investigate other models internationally but focus on those applying to common law jurisdictions, and that the PIC may also look at other relevant areas.

The phased work programme of the PIC as outlined in the CIWG report of January 2017 follows:

Phase One (report due by Q4 2017)

In respect of other relevant jurisdictions, particularly in Europe:

- Complete a comprehensive data gathering exercise to assess systems for handling personal injury claims, particularly soft-tissue ('whiplash') claims focusing on causes, frequency/incidence, diagnosis, treatment and appropriate compensation level;
- Report on systems where detailed grading of minor personal injuries is in operation;
- Assess the potential for medical professionals to prepare injury claim reports on a percentage disability basis with 100% being the maximum severity case;
- Assess the potential for a national medical panel of trained and accredited medical specialists for completion of reports with a timely medical assessment of the extent and impact of the injury and include a standardisation of reporting methods by assessing specialists;
- Investigate the potential for the establishment of a panel of medical experts for use in Court.

A summary report should be made to the Minister for Business, Enterprise and Innovation and the Minister of State at the Department of Finance which will:

- Make recommendations as to the possible development of such practices in Ireland;
- Indicate the timeframe for, benefits of, and risk associated with the implementation of the above recommendations.

Phase Two (report due end Q1 2018)

- Establish a high-level benchmarking of international awards for personal injury claims with domestic ones as referred to in the Book of Quantum;
- Analyse and report on international compensation levels and compensation mechanisms;
- Analyse and report on alternative compensation and resolution models internationally, focusing on common law systems while taking account of social welfare, healthcare and related factors associated with each jurisdiction;
- Report on "care not cash" models and variations in place internationally.

A summary report should be made to the Minister for Business, Enterprise and Innovation and the Minister of State at the Department of Finance which will:

- Assess the various systems in place and indicate the feasibility or otherwise for the possible development of such systems in Ireland;
- Indicate the timeframe for, benefits of, and risk associated with the implementation of the above recommendations.

Phase Three (report due end Q2 2018)

The Third report from the Commission with a list of recommendations and timelines should be delivered in Q2 2018.

1.4 Approach taken by the PIC

The PIC was established in early 2017 with the appointment of Mr Justice Nicholas Kearns, former President of the High Court, as chairperson on the 10th of January.

The PIC includes representatives from the medical profession, the legal profession, the insurance sector and government departments and agencies. Members are assisted by alternates however only one member from a relevant body attends meetings. The PIC is supported by a secretariat within the Department of Business, Enterprise and Innovation (previously known as the Department of Jobs, Enterprise and Innovation) (Part 2 Appendix 1: Membership and Secretariat of the Personal Injuries Commission refers).

The business of the PIC is primarily conducted through monthly meetings with the first being held on the 10th of February 2017 where a work plan was agreed (Part 2 Appendix 2: Meetings and Stakeholder Engagement refers). The PIC has engaged external expertise where necessary and invite relevant stakeholders to meetings.

The PIC's primary concern is the assessment of severity of common type injuries. Having looked at other definitions, the PIC has arrived at a functionally efficient definition suitable for the purposes of its work. The PIC has agreed that when reference is made in the Report to 'whiplash' soft-tissue injury claims these are claims where the neck is the predominant injury but other minor injuries may be present.

In carrying out its work the PIC has undertaken a considerable amount of research work with a focus on those other international models applying to common law jurisdictions. Research has also been carried out on countries with different jurisdictional models. Specifically, for this first phase of the work programme, the PIC and Secretariat elected to work with two external medical practitioners; Dr Noel McCaffrey, Sports and Exercise Medicine Specialist and Lecturer in DCU's School of Health and Human Performance and Dr Jean O'Sullivan, Consultant in Emergency Medicine at Tallaght Hospital.

Following detailed consideration, a formal consultation process was agreed upon (Chapter 5, Sections 5.1, 5.1.1 and Part 2 Appendix 5: Consultation Paper refer) with the objective of gathering views from a number of key medical organisations) on five relevant areas of review:

1. Diagnosis;
2. Grading & Scales;
3. Forms;
4. Training & Accreditation;
5. Medical Professional Evidence.

The CIWG report also made recommendations in relation to insurance fraud and these were assigned to the Department of Justice and Equality (DJE) for implementation. It was decided that to facilitate the sharing of knowledge and expertise between PIC members and the Department of Justice and Equality, the PIC would invite Department of Justice and Equality officials to periodically brief PIC members on developments in implementing these recommendations.

PIC is conscious that exaggerated and fraudulent claims contribute significantly in driving up insurance costs. Urgent measures are generally recognised as being required to combat these malpractices. This can be achieved though more rigorous enforcement of existing remedies, through the deployment of new technologies such as telematics, and through greater sharing of information regarding fraudulent claims.

In this regard, the PIC recognises the overlap of its work in examining award levels and the issue of exaggerated and fraudulent claims which is being examined by CIWG, and consequently will work in close liaison with CIWG to ensure effective recommendations address these concerns.

The table which follows illustrates the PIC's agreed work plan for Phase 1 (this report refers) of its 18-month work programme:

Phase 1 - Other Systems Research		
Undertake Research		
Assess different systems for handling PI claims	Jan/Feb 2017	Secretariat
Research dealing with detailed grading of minor injuries	Feb/Mar 2017	Secretariat
Research potential use of objective scales for gradation of PI injuries	Mar/Apr 2017	Secretariat
Examine adoption of consistent approach for diagnosis and evaluation of injuries	Mar/Apr 2017	Secretariat
Evaluate options for use of a medical panel for the courts	Apr/May 2017	Secretariat
Develop initial conclusions and recommendations	May-July 2017	Secretariat
Carry out consultation as appropriate	July-Sept 2017	Secretariat
Liaise with/Update Working Group	June & Sept 2017	Secretariat
Finalise report and publish	Oct-Dec 2017	Secretariat

CHAPTER 2

Settlement Channels, The Courts, PIAB and Personal Injury Costs

2.1 Introduction

Some commentators have suggested that personal injury (PI) claims represent a small but costly element of the overall insurance claims environment. The cost of the PI element of claims is estimated to make up a significant component of the overall cost of claims. This section seeks to provide an overview of the PI system in Ireland and describes the various settlement channels available to claimants. Ireland operates a fault-based (tort) system in relation to PI claims. The PIC will look in more detail at comparative systems in its second report due for completion in Quarter 2 2018.

The underpinning legislative/constitutional framework in Ireland is that the victim of an accident caused by the negligence of others is entitled to be compensated by the party deemed to be liable for that accident. There is a limited period within which claimants can bring a personal injury claim. Compensation comprises general damages which is pecuniary compensation for pain and suffering and special damages which is pecuniary compensation for loss of earnings, treatment costs, etc. Levels of general damages are not defined in legislation but are determined ultimately by the judiciary. Compensation is usually paid as a lump sum however periodic payment orders in respect of catastrophic injury are in use already in a non-statutory form and will shortly be in use in statutory form.

The Book of Quantum (revised in 2016), is a set of guidelines reflecting prevailing levels of compensation for various types of injury and based on what has been paid out in the Courts, by the State Claims Agency, in direct settlements by the insurance sector or awarded by the PIAB.

Medical reports, often provided by both parties, are used in assessing damages. In addition, medical practitioners may give oral opinion on evidence and/or be a witness as to relevant facts in their capacity as expert witnesses. The more common approach to medical reporting is for submission of opinion in the form of narrative style written commentary relevant to diagnostic, prognostic and recovery period information. Typically reports do not incorporate any specific severity scales although occasionally some international scales are referenced. More detail, including, in an Irish context is included in Chapter 3, Section 3.3 – International Scales for Assessment and Rating of Soft-Tissue ('Whiplash') Injuries.

In addition to compensation payable the responsible party is usually held liable for third party or delivery costs arising. Such costs can consist of legal fees (plaintiff and defendant), medical fees, and other fees such as actuarial fees, engineer's fees etc.

Delivery costs vary between settlement channel with PIAB reporting a delivery cost of over 6% and CIWG reporting an overall delivery cost of over 40% on cases settled outside of PIAB.

2.2 Personal Injury Settlement Channels

PI claims can be resolved through the Courts, through PIAB or through direct settlements. All PI claims, with limited exceptions such as medical negligence cases, must in advance of proceedings issuing go to PIAB. PI claims generally arise from motor accidents, workplace accidents (employer liability claims), public place accidents (public liability claims), and medical negligence incidents. This report focuses primarily on motor accident cases and to a lesser extent employer liability and public liability cases. While there is no single source of data relating to overall claims volumes, PIAB reported receiving over 34,000 claims in 2016 (source PIAB Annual Report 2016). Additionally, there are an indeterminate number of cases that are settled directly between parties without ever being referred to PIAB. PIAB estimate that approximately 60% of claims received by them relate to motor cases.

2.2.1 Courts

The right to damages in compensation for personal injury is part of the right to litigate and is also associated with constitutional property rights and the right of access to the courts. Under Article 34 of the Constitution, justice is usually administered in public, in courts established by law by judges appointed in accordance with the Constitution. The District and Circuit Courts deal with PI cases up to a defined financial jurisdiction and have their jurisdiction defined by Statute. The High Court is a court of first instance with full original jurisdiction. Full original jurisdiction and power to determine imply clearly that, whatever limitations may be imposed by law as regards the jurisdiction of the Circuit or District Courts, the determination of compensation levels by the High Court is not regulated by legislation (High Court compensation levels are not regulated by legislation at this time; it will be a matter for the LRC to recommend in due course whether it is feasible to have legislation which caps court awards) and determinations of the Court may only be changed, as appropriate, by a court to which an appeal lies from the High Court (i.e. the Court of Appeal or, in certain instances as provided for in the Constitution, where an appeal from the High Court is heard directly by the Supreme Court).

Chapter 2: Settlement Channels, The Courts, PIAB and Personal Injury Costs (continued)

Although few claims overall are determined by the judiciary, those that are influence levels of compensation throughout the entire PI system. Data from the Courts Services Annual Report 2016 shows that (including medical negligence cases) 390 cases were determined by the High Court, 977 by the Circuit Court and 535 by the District Court.

These cases include cases outside of the scope of PIAB; cases involving medical negligence and Garda Compensation, infant rulings (where an award of PIAB may have been accepted by both parties) and cases where a claim was lodged to PIAB but where an authorisation was issued to the claimant to pursue their claim.

Under the *Civil Liability and Courts Act 2004*, the judiciary are required to have regard to the Book of Quantum in assessing damages. Cases dealt with in court tend to be adversarial with plaintiffs and defendants relying on their own evidence and experts. In respect of medical reports claimants will usually rely on their treating doctor in addition to any specialist reports. There is a practice of agreeing medical reports from medical examiners instructed by respective sides and them being submitted to the Court.

The *Courts and Civil Law (Miscellaneous Provisions) Act 2013* introduced changes to the monetary jurisdiction of the Circuit and District Courts, which had remained unchanged since 1991.

Current jurisdictional limits which came into effect in 2014

Court	1991 Limits	2014 Limits
District	€6,384	€15,000
Circuit	€38,092	€75,000*
*€60,000 for PI cases		

The intention was that the changes would result in a substantial amount of court litigation previously dealt with at Circuit Court level and initiated on or after the 3rd February 2014 being dealt with in the District Court and such litigation which up to then had to come before the High Court being dealt with in the Circuit Court. It was also considered that the changes would ultimately lead to reduced legal costs for those involved in litigation, the intention being that parties do not incur more legal costs than are necessary in circumstances in which they must resort to litigation.

The impact of these changes is currently under review by the Department of Justice and Equality under recommendation 23 of the CIWG Report – review of the impact of the changes to the court jurisdictional limits as they evolve. Consequently, the impact of the changes is not examined in this report.

2.2.2 Personal Injuries Assessment Board (PIAB)

Prior to the establishment of the PIAB in 2004, the usual method for resolving all PI claims was by way of initiating legal proceedings in the courts. A smaller but indeterminate number of cases were settled directly between parties. Approximately 30,000-35,000 cases involved the issuing of proceedings yet less than 10% resulted in a hearing with many settling on the 'steps' of the court. Due to the prevalence of solicitors and barristers in a high percentage of cases along with the use of many, often competing, medical or other third party specialist reports, there was a very high delivery or processing cost on top of compensation payments. Delivery costs were estimated by the Motor Insurance Advisory Board to be at a rate of 46% of the compensation paid and were a significant driver of overall claims costs, in turn contributing significantly to insurance premium costs.

The PIAB was established in 2004 with the aim of removing many cases from unnecessary litigation. Best estimates or forecasts at the time were that up to two-thirds of cases would be removed from unnecessary litigation. However, litigation might be the appropriate forum where liability was in dispute. The PIAB operates an administrative, paper-based process and assesses damages on the same basis as the courts do, i.e. in accordance with the laws of tort. Effectively, this means that the PIAB assesses amounts for General Damages (amounts for pain & suffering), and Special Damages (amounts for financial loss such as wage loss, medical treatment costs or out of pocket expenses). PIAB does not determine or consider liability issues.

An intending applicant must make their claim through the PIAB unless they settle their case directly with the other party. An application consists of the application form itself, a report from the accident victim's treating doctor and a small fee. When the PIAB receives the papers, it passes them to the person against whom the claim is being made, called the respondent, or usually to their insurer. If the respondent consents to the PIAB assessing the case, they pay a fee (currently €600) to the PIAB, who then assess the case. If they don't consent, the PIAB issues an authorisation (Section 14 of the Personal Injuries Assessment Board Act 2003 refers) which permits the claimant to proceed down the litigation route.

In issuing papers to respondents and copying correspondence to insurers where appropriate, PIAB also promotes and facilitates settlements between parties avoiding the necessity for these cases to progress further in the PIAB process or be litigated.

In assessing cases, the PIAB usually requires the claimant to attend an independent medical practitioner for an up-to-date medical examination to include in the medical report where available a final prognosis. Within a legislatively defined time period (usually 9 months), the PIAB's assessors make and issue an award to both parties. If the award is accepted by both parties, an Order to Pay is issued against the respondent who then pays the compensation to the claimant. If either party reject the award, then the PIAB issues an authorisation to the claimant (section 32 of the Personal Injuries Assessment Board Act 2003 refers). Under the legislation either party can reject a PIAB award. Award acceptance is not compulsory as this would deny a person their constitutional right of access to justice which is delivered by the courts.

The introduction of the PIAB facilitated a move away from an adversarial way of resolving PI cases to a non-adversarial way of resolving cases. This has resulted in a scenario whereby a significant number of settlements are made directly between parties (some commentators suggest as high as 60%-70% of all cases) but there is limited publicly available data as to the outcome of these cases. In the absence of full transparency of data for PI claims, it is difficult to have a comprehensive understanding of the entire claims environment. It is noted however that Insurance Ireland are working with the Department of Finance and the Central Bank of Ireland on an information sharing model to address this situation.

PI claimants cannot issue legal proceedings without receiving an authorisation from the PIAB. These Authorisations generally fall into three categories; cases where respondents/insurers have not given their consent to the PIAB to assess the case (approximately 7,000 p/a or 20%), cases where either party reject an assessment made by the PIAB (approximately 5,000 p/a or 15%), or cases that are released under section 17 of the Personal Injuries Assessment Board Act 2003 i.e. cases which are not appropriate for assessment by the PIAB, e.g. wholly psychological cases, cases involving abuse, complex cases with pre-existing injuries, etc. (approximately 9,000 cases p/a or 27%). It is not known what happens to the PIAB authorised cases; whether they go to litigation, whether they are settled or whether the cases do not proceed further.

The PIAB makes awards in about 12,000 cases annually with about 60% (approximately 7,200) of claimants accepting them. The acceptance rate has remained broadly consistent in recent years. These cases are dealt with speedily and at low cost – current delivery cost is approximately 6.5% of the value of the compensation and this is mainly comprised of the fees paid by the claimant and respondent and the costs of the medical reports required to assess the case.

In making its awards, PIAB uses the Book of Quantum so that awards reflect what is likely to be achieved through litigation but at a much lower cost of delivery.

Today, the PIAB's non-adversarial model delivers settlements to claimants without the need for litigation in a significant proportion of cases. Claimants can deal directly with the PIAB or they may, at their own cost, ask a third party, including solicitors, to submit the claim on their behalf. The PIC understands that over 90% of claimants still choose to engage legal representation and predominantly at their own expense. However, in limited circumstances the PIAB allows for legal costs reasonably and necessarily incurred under section 44 of the Personal Injuries Assessment Board Act 2003, for example in cases involving minors, cases involving fatalities and in cases involving identity of respondent issues i.e. in cases where due to the circumstances of the accident it may not be obvious or apparent as to who might be at fault. The total amount of legal fees allowed by the PIAB in assessments is approximately €1.5m per annum.

2.3 Overall Claims Costs in Relation to Personal Injury

Overall claims costs reflect the frequency of claims, average compensation amount, and delivery costs across the three settlement channels; court awards, PIAB awards and direct settlements.

There is limited data available particularly in relation to the frequency and costs of claims settled directly between parties. Some commentators estimate that direct settlements comprise 60%-70% of all cases. Data has been provided to the Department of Finance and to PIAB by Insurance Ireland, but this data does not include comprehensive details of direct settlement awards. Both PIAB and the courts publish data in relation to claims frequency and costs of claims. The CIWG Report estimated that delivery costs in finalised cases settled outside of PIAB were at a rate of over 40% of compensation amounts in the years 2013-2015 inclusive whereas costs of cases settled through PIAB were of the order of 6.5% -7.6% of compensation amounts.

Chapter 2: Settlement Channels, The Courts, PIAB and Personal Injury Costs (continued)

Delivery costs relate to claimant legal fees, insurers' own legal fees and other costs (e.g. engineer reports, medical fees, actuarial reports, etc.). Some difference would be expected given that the PIAB does not settle claims where liability is contested nor does it handle certain categories of complex cases. However, the differential in delivery costs between the settlement channels demonstrates the efficiency to all parties of using the PIAB model where possible and when an early settlement has not been reached.

Outside of the PIAB process, legal costs will typically arise in a number of instances;

- Where insurance companies themselves have legal costs in respect of their handling of claims (including litigation costs where the matter goes to court);
- Where an injured party has legal costs (including plaintiff's litigation costs where the matter goes to court).

Where a plaintiff is successful in his/her case, under the 'costs follow the event' rule, the insurance company will pay their own and the plaintiff's legal costs. Where the insurance company settle a case (i.e. other than in circumstances where an award is recommended by the PIAB and accepted) there will inevitably be a sum paid over to cover the plaintiff's legal costs as part of the settlement.

CHAPTER 3

International Landscape Including 'Whiplash' Injury

Chapter 3: International Landscape Including 'Whiplash' Injury

3.1 European Wide Frequency/Cost of Soft-Tissue ('Whiplash') Claims

In the recent debates on rising insurance costs, many commentators have indicated that Ireland has a very high level of whiplash claims as compared to other jurisdictions and that compensation levels related to whiplash are significantly higher than in other jurisdictions. While the CIWG Report concluded that soft-tissue claims represent a significant component of PI claims it did not quantify the frequency of these claims nor provide a comparison with other jurisdictions.

The PIC has reviewed the available literature and data in an attempt to establish how Ireland compares in terms of soft-tissue/whiplash type claims. Comparing frequency of these claims is problematic in view of the different definitions applied across countries, the lack of data generally available, the nature of the PI system in a particular jurisdiction, the approach taken to whiplash claims e.g. the onus/burden of proof on the claimant in relation to the claim and linking the claim to the event, and the difficulties in diagnosing whiplash injuries.

The PIC has attempted to determine the incidence of such cases in Ireland having regard to the experience of PIAB in handling PI claims. According to PIAB, their best estimate is that approximately 80% of motor personal injury claims currently reported are 'whiplash' related. Motor claims represent nearly 60% of all personal injury claims received by PIAB (the balance is composed of employer liability and public liability claims). Based on this opinion it is reasonable to conclude that soft-tissue injuries (e.g. 'whiplash') account for a large proportion of claims by volume in Ireland. As outlined below the frequency of such claims in Ireland is greater than a lot of other European countries with the exception of the UK.

There is a lack of comparative studies available in relation to the frequency/incidence of personal injury claims in Europe. In a report for the EU Commission's DG Internal Market and Services regarding compensation of victims of cross-border road traffic accidents in the EU 2008, the author quotes that where data is available the number of claims for compensation varies greatly between Member States. The only commonality that can be discerned across Member States is an upward trend in the number of claims made, with the exception of France where a decrease in the number of compensation claims can be seen between 2004 and 2006.

The main source of data available in Europe in relation to whiplash comparisons is the insurance industry, whether from representative bodies such as Insurance Europe, or particular insurers or re-insurers.

The first major cross-border study into minor cervical spine injuries (whiplash related) was conducted in 2004 by the CEA (the Comité Éuropeen des Assurances), a pan-European trade body, now Insurance Europe. The study focused on the numbers and cost of claims in 10 European countries. Cases of multiple injuries were excluded. The study is still cited widely today. The CEA publication reported that bodily injuries represented between 8% in the Netherlands and 18% in Italy of all insurance claims, i.e. including both bodily injuries and property damage. As a percentage of all bodily injuries, minor cervical spine injuries ranged between a rate of 3% in France and 76% in Great Britain. The mean value for all ten countries was 40%. Two of the countries showed very low percentages of minor cervical spine injury in relation to all bodily injuries, i.e., France at 3% and Finland at 8.5%. These two countries were followed by Spain 32%, Switzerland 33%, the Netherlands 40% and Germany 47%. Considerably high percentages of minor cervical spine injuries in relation to all bodily injuries were found in Norway 53%, Italy 66% and 76% in the UK. There was no available data in relation to Belgium.

The AXA Whiplash Report 2013 submitted to the House of Commons Transport Committee claims that in the UK the number of people claiming whiplash over the period 2008-2011 has jumped by 32% to 570,000 a year even though the number of accidents reported has fallen. They quote that 70% of motor insurance personal injury claims are attributed to whiplash injuries at a cost of £2 billion per annum. At the other extreme of the scale the 2004 CEA study estimated whiplash type claims to represent only 3% of all bodily injury claims in France where firm emphasis is placed on objective proof and there are rules regarding qualifications needed to diagnose bodily injury. Akin to Norway, between the 1990's and 2000's Sweden saw a rapid increase in the number of whiplash related injuries. A Whiplash Commission was established and various recommendations put in place such as strict notification requirements. Insurance Sweden's view is that the incidence of whiplash injury is now less than 50% of personal injury compared to 60%-70% in the 1990's. In contrast, Spain has a problem with a growing claims culture. Most recent estimates suggest that 60% of personal injury claims are whiplash related.

The Frontier Report for Aviva (March 2015) estimates that almost 80% of PI claims (UK) are accounted for by 'whiplash' or soft-tissue damages. Since the introduction of measures designed to address whiplash, Norway has seen a downward trend in the frequency of both PI and whiplash over the period 2002-2014. The CEA report of 2004 quotes Spain as having a 'whiplash' incidence of 32% of all personal injury claims with the more recent Frontier report, reporting the national average as 43%.

Norway reports very few problems with whiplash injuries since a Supreme Court ruling in 2010 reiterating a ruling from 1998 concerning the causation between a traffic accident and subsequent soft-tissue injuries and incapacity for work. Norway had reported a rapid rise in the number of whiplash-related injuries in the 1990's. This led to the establishment of a commission to report on diagnostic and assessment criteria with regard to 'whiplash' injuries. Finland reports that there have not been any significant problems with whiplash injuries.

Other studies give an insight into more recent experiences in some countries. Insurance Europe's study on European Motor Insurance Markets (2015) concludes that in France the number of accidents involving personal injury is increasing again (+4% in 2014) after several decades of decrease. Neck complaints are still a matter of concern for German insurers although currently there is no precise data available on this phenomenon. Nonetheless, the associated problems are by far not as serious as they seem to be in other countries. In Germany, the onus of proof is on the claimant that the injury has occurred and was caused by the accident. This objective diagnosis of whiplash increases the burden of proof of injury at the lower end of severity. The claimant must provide convincing evidence of the injury and is also required to prove the link between the accident and the injury.

To conclude, there are considerable variations in the frequency of whiplash claims across Europe as outlined above. Based on available information Ireland's estimated very high 'whiplash' incidence rate of 80% of all motor personal injury claims and the UK's equally high quoted 'whiplash' rate of 76% of all bodily injury claims, appear significantly higher than those in other EU countries such as Germany and France.

A cost comparison is even more difficult where there can be different heads of damages for recoverable non-economic losses. In Italy, Spain and France, compensation for non-economic damage claims is determined with the aid of tables. Likewise, various Nordic countries use tables.

In Germany and the UK, case law precedents or guidelines assist courts and insurers in the assessment and quantification of claims. The PIC is charged with reporting in more detail on international benchmarking of awards in its second report.

According to the 2004 CEA report, Switzerland with an average of €35,000, has the highest cost per claim followed by the Netherlands (€16,500), Norway (€6,050) and Italy (€4,288).

The countries with the lowest average cost per claim are Finland (€1,500), Germany (€2,500), France (€2,625) and Great Britain (€2,878). The average cost for all participating countries is slightly less than €9,000 (Belgium and Spain had no data). There does not seem to be a more up to date analysis of comparable whiplash award levels.

Some level of comparison of the cost of a whiplash claim can be made between levels of damages in Ireland and England/Wales based on the respective versions of the Book of Quantum and the Judicial Studies Board Guidelines. At a cursory level, this indicates that less severe injuries in Ireland tend to attract higher levels of damages but that is less pronounced as the severity of injury increases. The following illustrative table shows a broad comparison of awards for neck and back injuries for Ireland and England/Wales:

Neck Injuries		
Severity or Impact	**Irish Book of Quantum**	**UK Guidelines on General Damages**
Minor	up to €19,400 (£17,168)	up to €7,200 (£6,372)
Moderate	€20,400 to €52,200 (£18,053 - £46,195)	€7,209 to €35,176 (£6,380 - £31,129)
Severe	€76,000 to €139,000 (£67,257 - £123,009)	€59,974 to €119,638 (£53,074 - £105,874)
Back Injuries		
Severity or Impact	**Irish Book of Quantum**	**UK Guidelines on General Damages**
Minor	up to €18,400 (£16,283)	up to €11,435 (£10,119)
Moderate	€21,400 to €55,700 (£18,938 - £49,292)	€11,435 to €35,425 (£10,119 - £31,350)
Severe	€76,000 to €139,000 (£67,257 - £123,009)	€35,425 to €63,703 (£31,350 - £56,374)

Chapter 3: International Landscape Including 'Whiplash' Injury (continued)

Notes

- Irish figures are taken from the 2016 edition of the "General Guidelines as to the Amounts that may be awarded or assessed in Personal Injury Claims". UK figure taken from the 12th edition of the "Guidelines for the Assessment of General Damages in Personal Injury Cases" published in 2013;
- Irish figures are determined through analysis of claims data from 2013 and 2014 from Irish courts, PIAB and insurers. UK figures are set by the UK Judicial College;
- Exchange rate used; £1 = €1.13;
- Comparison is an approximation only as the two books are not exactly equivalent in terms of the categories of injury or the levels of severity;
- For Neck and Back injuries, the highest frequency of severity is in the "Minor" category of injury and therefore most relevant in terms of comparison.

The UK Government in addressing rising cost of motor insurance is proposing to introduce a tariff scheme for soft-tissue injury claims. The tariffs are to be based on how long injuries last (are symptomatic). Additional amounts where a psychological injury is also involved were originally suggested however one global injury figure only is now currently proposed e.g. 0-3 months – £225, 19-24 months – £3,725. A Civil Liability Bill, with a likely publication date of April 2019, is now awaited to carry forward the reforms. What exact tariff levels and what definition of soft-tissue injury will be introduced remains unclear. Implementation work has begun including on pre-action protocols, with the Ministry of Justice having set up a steering group of representatives looking initially at four key areas: IT, Rules, Liability and Support/ Guidance.

3.2 Role of Medical Experts Internationally in Personal Injury Claims

Medical experts play an essential role in the assessment and evaluation of personal injury claims. In most European countries, medical experts are regularly used to evaluate injuries. In some countries, the courts rely on tables compiled by medical experts to determine the level of injury and its permanency. There are differences between EU Member States on the appropriate qualifications and roles of medical experts who in assess personal injury claims.

In some countries, such as Ireland, any doctor can act as a medical expert without specific requirements, while in other countries medical experts must have a specific qualification, or cannot assume such a role while at the same time acting as a claimant's own doctor. Another difference lies in the form and content of the medical expert's contribution. In some countries, they must describe in detail the claimant's injuries, in others they are required to evaluate what degree of disability applies to the claimant. The courts are generally not bound by the experts' reports but usually follow them closely as a guide for determining appropriate compensation.

Although medical experts do not assess the actual monetary value of the victim's claim in any jurisdiction, they do play an essential role in most countries in the process that leads to quantification of compensation for non-economic losses such as pain and suffering. The starting point for most awarding procedures is obtaining medical evidence of a claimant's injuries.

There are 3 general approaches used in the completion of personal injury medical reports:

1. Non-medical scoring – where medical experts give opinion on the extent of the injuries, their effect on the claimant's life and on the future prognosis. They do not give percentages of invalidity relevant for assessing non-economic losses. Courts have discretion in evaluating the extent of the injuries and calculating the amount of damages. Example: Ireland.

2. Non-determinative medical scoring – where medical experts provide opinions that assess the extent of the invalidity in percentage terms. Quantification of damages is not strictly linked to any medical scores or tables. Example: America.

3. Determinative medical scoring – where medical experts rate the victim's physical and where appropriate psychological injuries by reference to medical scoring tables. These scoring tables may be published by medical experts, the legislature, commissions appointed by government or other special boards. Courts quantify damages by assigning monetary values corresponding to the score of the severity. Example: Denmark.

3.3 International Scales for Assessment and Rating of Soft-Tissue ('Whiplash') Injuries

In line with the PIC's draft work programme which has an emphasis on soft-tissue injuries, the use of scales that are used internationally in the assessment of whiplash was examined. The WAD (Whiplash Associated Disorder) scale as developed by the Quebec Task Force (see below) is one such scale which is used throughout the world including in some European countries.

- The Quebec Task Force WAD scale grades injuries into five categories from 0 to 4 and based on severity of symptoms and associated physical signs
- Grade 0 (WAD 0) – where no neck pain, stiffness, or any physical signs are noticed
- Grade 1 (WAD I) – neck complaints of pain, stiffness or tenderness only but no physical signs are noted by the examining physician
- Grade 2 (WAD II) – neck complaints and the examining physician finds decreased range of motion and local tenderness in the neck
- Grade 3 (WAD III) – neck complaints plus neurological signs such as decreased deep tendon reflexes, weaknesses and sensory deficits
- Grade 4 (WAD IV) – neck complaints and fracture or dislocation, or injury to the spinal cord

This scale attempts to provide an objective basis for diagnosing whiplash. It allows medical practitioners to classify patient's injuries according to their level of severity. This helps determine the type and extent of medical care patients will likely need to effectively treat the injuries and resolve accompanying pain and discomfort. The WAD scale is well recognised within international health care and insurance fields and has become the established norm in many parts of the world, albeit in an adapted form in various countries. The PIC has recognised that there are huge advantages in adopting the WAD scale in Ireland as it is internationally used and recognised and has been validated through research.

Some countries use systems of medical scoring or scales linked directly to compensation payments while others use tables as guides for amounts, similar to the Book of Quantum.

There is no universally recognised system of calculating impairment as a percentage although certain guide or systems of medical scoring are frequently used.

In some jurisdictions, medical scoring might be applied to a specific type of injury, or a payment scheme, e.g. occupational injuries and the Department of Social Protection (DSP) scheme for occupational benefit in Ireland.

In the absence of a universal international standard and universally applied system of medical scoring, it is difficult to match a percentage of impairment calculated to a compensation sum. In individual jurisdictions that measure impairment on a percentage basis, the percentage impairment for injuries may vary.

In the UK, The Law Commission discussed the idea of whether to introduce greater reliance on medical 'scores' in their 1998 consultation on Damages for Personal Injury: Non-Pecuniary Loss[1].

The concept of reforming the law by placing greater reliance on medical scores was ultimately rejected. It was suggested that the medical scoring could be used to rationalise different amounts for different injuries, using a scientific basis for comparison.

The Commission expressed no provisional view in advance of the consultation but noted two potentially significant problems with the use of a scoring system; that the rating occurs at the point of injury and that they failed to account for varying patterns of recovery or the subjective cases where severe impacts arise from minor injuries.

With the exception of the British Medical Council who saw some merit in the potential adaptation of existing scales, the overwhelming majority of respondents were opposed to placing greater reliance on scoring. The main opposition was that the majority of consultees felt that scoring systems would be unable to reflect all the subjective factors that should be considered in the assessment of damages.

While this report concentrates on the use of the WAD QTF scale in the context of evaluation of whiplash type injuries, further information regarding the use of international injury severity scales is included in Part 2, Appendix 3: Scales and Grading Systems Internationally. A brief analysis of the use of scales in Ireland follows.

In Ireland, there are a limited number of scales currently in use in PI medical reporting, for example the Hand Injury Severity Score[2] (HISS) and the Green Book (1998) which deals with hearing loss[3]. The HISS describes a classification designed by Campbell and Kay of four grades of increasing severity of hand injury. In relation to hearing loss the Department of Health and Children established an expert group to examine and make recommendations on an appropriate system for the assessment of hearing disability. In 1997, this report known as the "Green Book", was published on 9th April 1998. In its Judgement of December 1999, the Supreme Court agreed in general that the "Green Book" formula was a fair way of assessing hearing impairment.

1 The Law Commission Law Com No 257 DAMAGES FOR PERSONAL INJURY: NON-PECUNIARY LOSS Item 2 of the Sixth Programme of Law Reform: Damages
2 [J. Hand. Surg. [Br.] 21 (3) (1996) 295].
3 Civil Liability (Assessment of Hearing Injury) Act, 1998

Chapter 3: International Landscape Including 'Whiplash' Injury (continued)

The percentage computed in hearing loss cases using the Green Book is the proportion of hearing disability that the individual experiences, rather than the proportion of total body disablement caused by their hearing loss. The Book of Quantum provides guideline amounts for a large range of hand injuries. However, the Book of Quantum does not provide figures for injuries affecting hearing and advises reference to The Report of the Expert Hearing Group/ Green Book for assessing the value of these claims.

The PIC looked at the Disablement Benefit Scheme operated by the DSP where claims are assessed using the level of percentage of whole body disability arising from the injury. Disablement Benefit is a type of benefit paid by the DSP under the Occupational Injuries Scheme. It is based on the applicant's class of PRSI contributions and is paid where an applicant has suffered a loss of physical or mental faculty because of an accident at work, an accident travelling directly to or from work, or a prescribed disease contracted at work.

If an accident or prescribed disease is accepted by the Department as occupational, the applicant is referred for an examination by a medical assessor. Since 2011 payment for occupational accidents are made only where the level of disablement following the injury/disease is assessed at 15% or more. Where the level of disablement is assessed at 15%-19% there is a choice of a taxable pension or a non-taxable gratuity where the assessment is for life. Where the level of disablement is assessed at 20% or more the benefit is paid by a pension called Disablement Pension. The percentage of disability evaluated is linked to monetary amounts specified in legislation. Some commentators have criticised this legislation for being out of step with recent medical developments e.g. in the areas of physiotherapy, occupational treatment and prosthetics.

The basis for administering the DSP's percentage impairment schemes originate from British legislation at the time of the First World War. The DSP have been working towards a standardisation of their medical assessment approach including using the BOQ for the purposes of developing their percentages of disability model and utilising a version of the International Classification of Diseases coding (ICD10).

The DSP's approach to assessment is focussed on consistency, consensus, and credibility. A medical assessment is carried out by the assessors using DSP Protocols in addition to a number of international guidelines. The DSP in their making of an assessment consider all the evidence they receive. They do not currently use a rating scale for soft-tissue neck conditions and no specific objective tests are undertaken by DSP medics in the assessment of injuries or particularly soft-tissue conditions.

3.4 Evaluation of Soft-Tissue ('Whiplash') Claims in Various European Jurisdictions

3.4.1 Ireland

In Ireland, there is a limited period within which claimants can bring a personal injury claim. There is also a constitutional entitlement to access to the courts. Claims can be settled directly in advance of any formal processes. In these instances, respective sides will commission and share medical reports.

All PI claims, with limited exceptions, must go to PIAB and in advance of proceedings issuing. Applications require submission of a medical report, typically completed by the claimant's treating doctor. Where a final prognosis is not included, PIAB will arrange a further up to date medical examination/report with a member of their Independent Medical Panel.

In cases where litigation proceedings are issued, the respective sides will again commission and share medical reports with a view to settlement. In addition to paper based reports, medical professionals may give oral evidence to a Court in their capacity as expert witnesses.

Generally, PI medical reports do not incorporate the use of any specific severity scales although the QTF WAD scale and ICD-10 (International Statistical Classification of Diseases and Related Health Problems – a medical classification list by the World Health Organization) are occasionally referenced. The more common approach to reporting is for submission of opinion in the form of narrative style commentary relevant to diagnostic, prognostic and recovery period information. The medical opinions presented are influential in terms of all settlements or awards made. Extent of disability or whole of body impairment percentage approaches are generally not used, however notable exceptions include specific hand injuries. Claims processing procedural requirements impact on medical report completion and submission timelines.

A doctor wishing to practice medicine in Ireland (to include PI medical reporting), must register with the Medical Council. Doctors can only practice independently as specialists if they have specialist registration.

All doctors are independent notwithstanding they may align to either one of plaintiff or defendant sides e.g. in litigation.

Medical reports, particularly for PI whiplash type injuries, are typically completed by a GP or an Orthopaedic Consultant.

A Book of Quantum has been in use since 2004, with an updated version published in 2016. These general guidelines as to the amounts that may be awarded or assessed in personal injury claims set out the ranges of damages being paid in Ireland in personal injury claims. Previous judgements in relation to quantum can be considered including in any Court appeals procedures.

3.4.2 UK

In the UK, the Ministry of Justice is currently proposing to remove or fix compensation payments for minor Road Traffic Accidents (RTA) soft-tissue injury claims where minor is likely to be defined as an injury of less than six months' duration.

Previously the UK Government announced that it proposed to address the independence of medical experts and their accreditation. The centrepiece of the new system for personal injury medical reports is an internet hub known as MedCo. MedCo facilitates the sourcing of medical reports in soft-tissue injury claims. The system provides a list of relevant experts for every soft-tissue injury claim, using filters to prevent there being any financial link between the expert and the person commissioning the report. The MedCo system went live in April 2015 and since then experts providing a medical report for a soft-tissue injury claim (at a fixed cost) must be registered with MedCo. MedCo is funded and was built by the Association of British Insurers (ABI).

Since April 2016 medical experts providing these reports must be accredited by MedCo (rather than a third-party training provider). MedCo now provides the accreditation training programme. This accreditation is estimated to require 30-35 hours of training[4]. The training covers modules such as professional obligation, clinical examination and legal content. Medical experts wishing to obtain the accreditation must reach mandatory minimum requirements before obtaining the training.

3.4.3 France

The Assessment of bodily injuries in France is based on "The Nomenclature Dintilhac" established by the 2005 Rapport Dintilhac.

The Nomenclature lists all recoverable damages and the methods of valuation. While the nomenclature is not legally binding, it has been referred to by the French Courts and its definitions have been applied. The classification is based on 3 factors:

- Direct victims/indirect victims;
- Temporary losses/permanent losses;
- Economic/non-economic losses.

The medical examiners/experts used in the assessment of bodily injuries must possess specific accreditation. French legislation requires that the doctor must have graduated in legal medical assessment. There are two nationally recognised diplomas, RJDC, (Reparation du Prejudice Corporel), a University diploma in medico – legal assessment or CAPEDOC – (Certificat d'Aptitude à l'Expertise du Dommage Corporel) which is delivered by the French insurers association.

Diagnosis of bodily injury is based on objective proof and no compensation can be awarded without a medical assessment. The compensation is based on the percentage disability, whether this is permanent or temporary, and the age of the claimant.

The medical expert must outline the claimant's losses and provide an opinion on medical sequelae. Non-economic losses can only be quantified following input from the medical expert. A medical report should conclude by providing various points and percentages under the various headings of the nomenclature so they can then be cross-referenced with tables produced by France's regional courts.

The medical expert must wait until the injuries have been 'consolidated' and no longer require treatment, to assess permanent disability. The concept of medical 'consolidation' refers to the date when the injuries stop evolving and are of a permanent nature so that medical treatment is no longer necessary.

4 http://www.medco.org.uk/accreditation/

Chapter 3: International Landscape Including 'Whiplash' Injury (continued)

The headings of non-economic/non-pecuniary loss required to be considered as per the nomenclature are:

Temporary functional deficit This can be broken down into percentages to reflect the reducing level of incapacity as recovery is achieved
Pain and suffering endured Assessed on a scale 0 and 7, with 7 being the most severe pain
Temporary disfigurement Assessed on a scale between 0 and 7
Loss of amenity Assessed on a scale between 0 and 7
Permanent disfigurement Assessed on a scale of 0 to 7, for example scarring, limps etc.
Sexual prejudice (defined as the extent to which the injuries have affected the claimant's sex life) Assessed on a scale between 0 and 7
Permanent functional deficit Assessed on a percentage scale

Permanent functional deficit is calculated when the injuries have achieved 'consolidation' and is assessed as a percentage of permanent incapacity. The type of calculation/scale used is the "calcul au point" or AIPP scale (Atteinte Permanente a l'Integrite Physique et Psychique) which calculates the percentage of incapacity from 1-100 percent. The indicative scale used which advises of percentage rates for various injuries, was published in Le Concours medical and is called the "Barème indicatif d'évaluation des taux d'incapacité en droit commun".

There is also a national convention regarding Personal Injury (IRCA) which allows insurers to settle quickly in cases where the claimant's disablement is measured at less than 5%. In these cases, the insurer of the third-party liability compensates its customer and then seeks recourse of the actual cost of the minimal damages.

3.4.4 Germany

Whiplash is a colloquial term in Germany without a strict definition. The medical term is HWS – Distorsion (Halswirbelsäule-Distorsion), translating as cervical spine distortion injury.

The Comité Européen des Assurances[5] Report in 2004 on Minor Cervical Trauma Injuries[6], referred to previously, put the rate of whiplash at 47% of all personal injury claims in Germany: much less than the figure of 76% in the UK in the same report. Objective diagnosis of whiplash increased the burden of proof of injury at the lower end of severity and compensation is not paid for the most minor injuries.

In Germany, the proof of the injury causality is mandated by law and the onus of proof is on the claimant. The claimant must provide convincing evidence of the injury and prove the link between the accident and the injury. Only when proof of the injury has been established, can the proof that the injury is related to the accident be examined. If the injury was pre-existing, the insurer is only obliged to pay for the additional injury sustained.

In principle, the injured party is responsible for the required medical examination. How this medical examination takes place in an individual case depends on the severity of the injury. The presentation of a medical certificate from a GP or a hospital may suffice in some circumstances, whereas extensive medical assessments may be necessary in others.

The German Courts can appoint their own experts to assist with relevant factual issues rather than relying solely on the expert evidence presented by the parties. Disputed claims require an Independent medical opinion along with the original opinion. The courts also review the opinions of interdisciplinary experts on the causation of the injury.

Compensation for pain and suffering is awarded in Germany on the basis of injury severity, duration of treatment and the age of the claimant. Small injuries such as bruising and scratching do not receive compensation. A claimant is required to prove a certain level of whiplash has been sustained to ensure payment of compensation. Case law precedents assist both the courts and insurers in the assessment and quantification of claims.

There are three levels of severity for whiplash injury; first degree, second degree and third degree with third degree being the most severe. First degree injuries require proof of the injury. There are objective criteria for the assessment of second and third degree injuries.

The medical opinion is required as proof that the injury has occurred and that also the severity can be classified on the 'Abbreviated Injury Scale'.

5 Now Insurance Europe
6 www.svv.ch/sites/default/files/document/file/CEA_HWS-Studie_englisch.pdf

Previously the German Courts considered biomechanical factors. The speed of the impact was examined to see if it was reasonable that a whiplash injury was sustained. This approach however was overturned by the German Courts in 2003.

3.4.5 Sweden

In Sweden, the Whiplash Commission was formed between 2002 and 2005 to look at the rising levels of whiplash claims. Its focus was on the correct diagnosis of whiplash and the need for rehabilitation and treatment. In addition, the Commission made numerous other recommendations including in relation to road safety.

Insurance Sweden's view is that their incidence of whiplash injury is now less than 50% of personal injury claims. This is contrasted with 60%-70% of claims in the 1990's.

Sweden operates a strict liability (no fault) system in that a person who suffers a personal injury as a result of a road traffic accident has a right to compensation for bodily injuries.

If the victim's disability is greater than 10% the file must be submitted to the Road Traffic Injury Commission (Trafikskadenämnd – TSN).[7] This Commission advises the parties on how to compensate for the personal injury and loss of income.

The claims handling process generally comprises two stages; Stage One, which is the medical emergency period or the period until the medical situation of the victim has stabilised, and Stage Two or the 'stabilisation period' when the file is sent to the TSN to determine the degree of disability. Stage One can vary greatly depending on the severity of the injury and the treatment process. Tables released by TSN determine the compensation levels to be paid during this period. The tables use a classification of the severity of the injury and the length of recovery time. Stage Two will not apply to all claimants – when the degree of disability is above 10% the TSN must get involved. The TSN in order to obtain additional medical information has access to doctors who are independent from insurance companies.

Non-pecuniary damage payments include amounts for pain and suffering as recommended by the TSN and on the basis of tables. The amount the claimant is entitled to depends on the seriousness of the injuries and the length of treatment. Payment is often by way of monthly amounts which may reduce over time. There are also compensation payments for disadvantages such as scarring.

The Swedish Whiplash Commission and the Swedish Society of Medicine have produced a comprehensive review on how to diagnose and treat whiplash. They defined whiplash as indirect cervical spine trauma and adapted the use of the QTF classification system. They focus on the 1-3 grades within the 0-4 grades in the WAD scale. Grade 0 was removed as it is the mildest grade of whiplash. The removal of grade 0 stops the least severe of whiplash claims from receiving compensation. Grade 4 is a fracture or dislocation.

When claiming compensation, a claimant's injury symptoms must generally occur within 3-4 days of an accident and be reported promptly. A claim can still be submitted without a medical report in this time period however the claim will be much more difficult to prove.

A characteristic of the Swedish compensation system is that the vast majority of personal injuries claims are settled outside of court. This is attributed to the existence of the TSN (Road Traffic Injury Commission). The TSN provides a recommendation on the level of compensation that should be paid to the claimant. The recommendation is not binding and the claimant can pursue their case through the Courts if they wish however very few cases go through court. All Swedish motor insurers are required to maintain and fund the TSN. In complex cases the claimant may use a lawyer. Legal representation costs are reimbursed based on reasonable time incurred and on the basis of a maximum hourly rate. The amount of remuneration to the legal representative in Sweden is unrelated to the value of the compensation award.

3.4.6 Norway

In Norway compensation resulting from a road traffic accident includes non-economic damages for a medical disability. This aspect is determined using a table of medical disability. The compensation is standardised based on the medical disability and regulated by the state. It is based on a formula developed with the Norwegian Social Welfare Department taking into account the seriousness of the injury and the age of the injured party. Compensation for permanent injury is split into several groups depending on the degree of disability determined. Compensation is not paid for medical disability less than 15%.

The diagnosing process for minor injury claims is carried out by independent doctors. Such doctors are considered 'independent' if they are not the claimant's own GP or, for example, if they work in a public hospital. There is no independent panel of doctors however unlike in other Scandinavian countries.

7 https://www.trafikskadenamnden.se/Information-in-English/

Chapter 3: International Landscape Including 'Whiplash' Injury (continued)

Norway reported a rapid rise in whiplash-related injuries in the 1990's. This led the Norwegian Ministry of Health and Social Affairs to commission a report on diagnostic and assessment criteria with regard to whiplash injures which was submitted in 2000. The report referenced the QTF WAD classification lower grades which do not include objective findings. They concluded that symptoms ought to appear at the time of the accident.

Since the introduction of measures designed to address whiplash claims Norway has seen, over the last ten years, a downward trend in the frequency of personal injury claims and 'whiplash'. In 2010 the Norwegian Supreme Court (reference: HR-2010-2166-A, case no. 2010/970) also referred to as the 'Ask Judgement', ruled that the assessment of causation by 'whiplash' injuries should be evaluated in light of a number of criteria that establish causation between car accidents and 'whiplash'.

These criteria included the necessity that evidence of symptoms following an accident must appear within 72 hours. Health problems evident after the accident must not be a continuation of health problems that the patient had before the accident. In the assessment of evidence greatest weight must be given to the evidence close in time to when the accident occurred. In the months after the judgment, several judgments have been pronounced within this area in courts of lower instance (for example 10-103369TVIOTIR/02, LF-2009-121377, LF-2010-156465, 10-127904TVI-BBYR/03 and LH-2010-79241). Following the 'Ask Judgment', the criteria for obtaining compensation for 'whiplash' injuries has become more restrictive.

CHAPTER 4

Diagnosis, Treatment and Accreditation/ Standardised Reporting

Chapter 4: Diagnosis, Treatment and Accreditation/Standardised Reporting

4.1 International Approaches to 'Whiplash' Diagnosis and Treatment

International approaches to the assessment of WAD (Whiplash Associated Disorder) have been explored by research groups. The international initiative of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and its Associated Disorders (BJD)[8] published the results of its work in 2008. The BJD review concluded that there is no gold standard diagnostic test for detection.

There are variances internationally in the use of specific tests however there are many similarities in the approach used to assess WAD injury and widespread reference also of the QTF scale.

Countries which use modified scales such as Germany and Sweden have derived these from this scale. There is widespread reference within nationally published clinical guidelines to the importance of using validated and internationally accepted scales in the assessment of injuries.

The common approach from jurisdictions includes:

- History taking;
- Widespread application of the Canadian C Spine rule in deciding the appropriateness of X-Rays;
- Observation of posture;
- Palpation testing;
- Cervical range of motion tests.

MRIs (Magnetic Resonance Imaging) and CTs (Computed Tomography) are usually recommended at the more serious end of the WAD spectrum. Australian, French and UK guidelines refer to the use of the Neck Disability Index (NDI) and the Visual Analogue Scale (VAS) for pain assessment. These tests are referenced in Part 2, Appendix 6: Final PIC Medical Report Template (including Neck Disability Index and Visual Analogue Scale).

Other specific tests are used in certain jurisdictions including tests which are generally only recommended when more severe symptoms e.g. neurological, are indicated. There are no universally recommended tests.

The International Association of Legal Medicine (IALM) published a consensus document: The Padova Charter on the Methods of Ascertainment and Criteria of Evaluation of Personal Injury and Damage under Civil-Tort Law - 2016[9]. This is an international consensus document focusing on the very initial phase of the compensation procedure (i.e. the ascertainment of the injury/damage). It was aimed at achieving harmonisation in the assessment of damages, including medico legal reporting and the examination process.

The IALM highlighted that despite international divergence in tort law systems and compensation procedures, the starting point for any awarding procedure was a clinical and medico legal assessment.

Summary Table

References to 'whiplash' assessment approaches in guidelines:

	QTF/ Modified QTF Scale	History Taking	Canadian C Spine Rule	Observation of Posture	Palpation Tests	Cervical Range of Motion	NDI	VAS
South Australia	X	X	X	X		X	X	X
New South Wales	X	X	X				X	X
UK		X				X	X	X
Canada	X	X				X	X	X
USA		X		X	X	X		
Sweden	X	X				X		X
France				X	X	X	X	X
Germany		X		X	X	X		
Ireland		X		X	X	X		

8 http://bjdonline.org/

9 Int J Legal Med DOI 10.1007/s00414-015-1244-9

QTF/Modified QTF Scale – The Quebec Task Force WAD scale grades injuries into five categories from 0 to 4, based on severity of symptoms and associated physical signs. Sweden and Germany grade injuries in a similar way but with less categories.

History Taking – This would normally include information such as the Patient's date of birth and details, details of the accident and the circumstances of how it occurred, the time since the accident, the claimant's current and previous symptoms and details of any previous accidents and injuries, particularly to the neck.

Canadian C Spine Rule – The Canadian C-Spine Rule is a decision-making tool used to determine when radiography should be used in patients following trauma.

Observation of Posture – Observing the claimant's movements, e.g. sitting down, getting up etc., and in particular head posture and positioning.

Palpation Tests – Touching the claimant with hands to ascertain areas of tenderness on the claimant's body.

Cervical Range of Motion – Assessing if there is any restriction in the claimant's ability to move their neck, i.e. move their chin to their chest or look over their shoulder. A cervical range of motion exam will ascertain if the claimant's flexion, extension, lateral flexion and rotation are within normal limits.

NDI – Neck Disability Index is a self-assessment questionnaire tool used where the claimant advises how their neck pain has affected their ability to manage everyday tasks.

VAS – The Visual Analogue Scale (VAS) is a popular tool for the measurement of pain on a linear basis.

The PIC recommends the adoption of a standardised approach to examination and reporting of soft-tissue injuries going forward. This approach should be along the lines of South Australia Clinical guidelines for best practice management of acute and chronic whiplash – Government of South Australia and the Motor Accident Commission 2008 which is abbreviated and outlined below.

1. History Taking
2. Physical Examination
2.1. Observation of Posture
2.2. Assessment of cervical range of motion
2.2.1. Flexion, extension, rotation and lateral flexion
2.3. Neurological testing of sensation
2.3.1. Reflexes and muscle strength (when patient complains of pins and needles)
2.4. Assessment of associated injuries and co-morbidities
2.5. Use Canadian C-Spine rule to ascertain whether x-ray required
3. More Specialised Physical Examination
3.1. Assessment of joint position error (cervical proprioception)
3.2. Assessment of cervical flexor muscle control
3.3. An assessment of widespread sensory hypersensitivity
4. MRI/CT and other diagnostics such as EMG etc. to be used in cases of WAD III WAD IV and WAD V
5. At the initial visit practitioners should: classify the WAD grade using the Quebec Task Force Classification
6. Assess pain using the Visual Analogue Scale (VAS)
7. Assess disability using the Neck Disability Index (NDI).

Chapter 4: Diagnosis, Treatment and Accreditation/ Standardised Reporting (continued)

The PIC is of the view that a consistent and clear approach in the assessment of soft-tissue injuries to include the use of the WAD scales following international best practice is recommended. This is explored in further detail in later stages of this report.

4.2 Objective Tests/MRI in Soft-Tissue ('Whiplash') Assessment

MRI uses a powerful magnetic field, radio waves and a computer to produce detailed pictures of joints, soft-tissues, bones and all other internal body structures.

Whiplash describes the manner in which the head is moved suddenly to produce a sprain in the neck and typically occurs after rear-end automobile collisions. It is one of the most common mechanisms of injury to the cervical spine. It appears however that an MRI scan will not in all cases objectively and definitively demonstrate the presence of a soft-tissue injury to the neck. It is also considered that in many cases changes appearing on an MRI scan may be related to factors external to an accident, for example age related or degenerative changes. The Government of South Australia Clinical Guidelines for best practice management of acute and chronic whiplash-associated disorders (November 2008) determined that there is no role for specialised imaging techniques, including MRIs, in WAD grade I and II injuries and might be used in selected WAD Grade III patients on the advice of a medical or surgical specialist.

An MRI may be useful to a doctor treating the claimant however in an entirely PI medical reporting and legal context an MRI could not be used as irrefutable evidence of an injury occurring due to an accident. It is also noted that use of MRI has a limited role in the clinical management of less severe whiplash injuries and the majority of whiplash injuries are at the lower levels of severity. An MRI differs to an X-ray in that an X-ray can usually provide definitive evidence of the presence or the absence of a fracture. Carrying out these examinations on a routine basis would add additional costs to claims.

There have been suggestions that an MRI scan of the cervical spine could be used on a routine basis as a method of reassuring patients, i.e. to demonstrate *the lack* of a substantial injury and to eliminate the perception that many claimants may have that their undergoing of an MRI is an automatic indication of the severity of the injury.

Another suggestion for employing regular MRIs in a PI medical reporting context was an example where pain is persistent and severe but the examination findings do not fit with this scenario. Using an MRI scan could be helpful in *ruling out* a cause for the ongoing symptoms that could plausibly be attributed to the accident, and may give medical practitioners greater confidence and support when stating that the injuries are not significant.

In a recent journal article[10] dealing with low velocity whiplash claims and referring to MRI scans it was pointed out that:

'Radiological findings are not necessarily associated with symptoms or pain and cannot be used to establish causation in a case where there has been a whiplash injury. In clinical practice, there can be severe neck pain with normal radiographs and MRI scans and, conversely, grossly abnormal radiographs and scans with no neck pain at all.'

'Disc degeneration is very common in the general population and may be present without causing any symptoms.'

'Controlled studies of symptomatic and asymptomatic patients have shown no difference in the rate of disc degeneration on MRI and abnormalities on MRI are not generally seen after 'whiplash'.'

'Studies on patients with whiplash injuries have demonstrated a similar incidence of MRI abnormalities to that in the general population.'

'Studies of cervical spines in individuals who have no complaints referable to the neck and no history of injury have demonstrated various different abnormalities such as flattening of the normal cervical lordosis (curvature) and disc degeneration without symptoms or evidence of injury in asymptomatic individuals.'

The Bone and Joint Decade 2000-2010 Task Force on Neck Pain and its Associated Disorders (BJD) also concluded that:

'The assessment for fracture in the emergency room and the diagnosis of neck pain with radiculopathy are of value but there is little evidence that diagnostic procedures for neck pain without severe trauma or radicular symptoms have validity and utility.'

and,

'The finding of degenerative changes on imaging has not been shown to be associated with neck pain'.

It is therefore difficult to advocate the routine use of MRI's in view of the lack of prognostic value and the high cost of the procedure. In addition, the indiscriminate use of MRI's could potentially confuse matters by the identification of abnormalities which have little clinical significance.

10 Low Velocity Whiplash Injury, Nikhil Shah and Stuart Matthews, Bone & Joint360, volume 3, issue 4, August 2014

While there could be some benefits to the routine use of MRI's, the benefits appear to be insufficient to merit the recommendation of their widespread use due to the lack of prognostic value and the cost associated with their completion. Ultimately the decision to perform additional tests (e.g. MRI's) should be at the discretion of the examining medical professional.

Increased patient and general stakeholder education regarding MRI's could also be considered. It may be helpful to emphasise that undergoing an MRI scan does not necessarily correspond with the suspicion of or the existence of any serious injury and the fact that many abnormalities or degenerative changes shown in scans are frequently age related or pre-existing and have not been caused or affected by the subject accident.

4.3 International Accreditation of Medical Professionals and Standardised Reporting

There are differences between various EU Member States and internationally on the qualifications required of medical professionals in assessing personal injury claims.

A number of jurisdictions require medical professionals who complete reports on whiplash injuries to have specific skills and training. Some jurisdictions have developed specific training courses and only medical professionals with the related accreditation and qualification can provide reports for use in the settlement of claims.

In South Australia, a claimant is required to produce an independent medical assessment conducted by a medical practitioner who has been accredited by the Motor Accident Injury Commission. French legislation requires that a doctor completing a medical report, must have graduated in legal medical assessment and possess one of two available nationally recognised diplomas. In the UK, medical professionals providing reports for MedCo must receive specific accreditation.

4.3.1 UK MedCo

MedCo is a non-profit making organisation and operates as part of a new system introduced in the UK. The aim is to facilitate the sourcing of Medical Reports in soft-tissue injury claims brought under the Ministry of Justice's new Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents.

The UK Government announced that it proposed to address the independence of medical experts and their accreditation. The centrepiece of the new system for medical reports would be an internet hub known as MedCo, to be funded and built by the Association of British Insurers (ABI), which would provide a list of relevant experts for every soft-tissue injury claim, using filters to prevent there being any financial link between the expert and the person commissioning the report.

Medical experts wishing to obtain MedCo accreditation must reach mandatory minimum requirements before obtaining MedCo's accreditation training. MedCo accreditation is estimated to require 30-35 hours of training. The training covers modules such as professional obligations, clinical examination and legal content and is delivered online. (www.medco.org.co.uk).

4.3.2 France

In France, medical experts used in the assessment of bodily injuries must possess specific accreditation. French legislation requires that the doctor must have graduated in legal medical assessment. There are two nationally recognised diplomas, RJDC, (Reparation du Prejudice Corporel), a University diploma in medico – legal assessment or CAPEDOC – (Certificat d'Aptitude à l'Expertise du Dommage Corporel – Certificate in medical studies: legal redress for physical injury) which is delivered by the French insurers association.

Diagnosis of bodily injury in France is based on objective proof and no compensation is awarded in the French Courts without the report of a medical expert. The personal injury convention (IRCA) allows insurers who have signed up to it to settle minor personal injury claims directly. It is the victim's responsibility to provide evidence of his/her loss by obtaining a medical report from a physician and submitting this to the insurer. However, the insurer may subsequently procure an additional expert opinion.

The compensation is based on the percentage disability, whether this is permanent or temporary, and the age of the victim. The medical expert must outline the claimant's losses and provide an opinion on medical sequelae. Non-economic losses can only be quantified following input from the medical expert. A medical report should conclude by providing various points and percentages under the various headings of the nomenclature so they can then be cross-referenced with tables produced by France's regional courts. The medical expert must wait until the injuries have been 'consolidated' and no longer require treatment, to assess permanent disability. As previously outlined, the concept of medical 'consolidation' refers to the date when the injuries stop evolving and are of a permanent nature.

Chapter 4: Diagnosis, Treatment and Accreditation/ Standardised Reporting (continued)

Permanent functional deficit is calculated when the injuries have achieved 'consolidation' and is assessed as a percentage of permanent incapacity. The type of scale used is the 'calcul au point' or AIPP scale (Atteinte Permanente a l'Integrite Physique et Psychique) which calculates the percentage of incapacity from 1-100 percentage. The indicative scale used which advises of percentage rate for various injuries, was published in Le Concours medical and is called the "Barème indicatif d'évaluation des taux d'incapacité en droit commun".

4.3.3 South Australia

In South Australia, a claimant is required to produce an ISV Medical Assessment Report. This an independent medical assessment conducted by a medical practitioner who has been accredited by the Motor Accident Injury Assessment Scheme.

To be considered for accreditation under the Scheme, the Minister for Finance in South Australia has determined an applicant must be:

- A registered Medical Practitioner (Specialist or General);
- Accredited as a Permanent Impairment Assessor, with "Return To Work" programme;
- Satisfactorily complete the training modules prescribed by the Accreditation Panel;
- Satisfy any other conditions prescribed by the Motor Accident Injury Assessment Scheme.

4.4 Irish Context and the PIAB Model

A doctor wishing to practice medicine in Ireland (which includes PI medical reporting), must register with the Medical Council. Doctors can only practice independently as specialists if they have specialist registration. However, there is no specific accreditation required or benchmark standard for a doctor wishing to complete a medical report for use in a personal injury claim.

To be included on PIAB's independent medical panel, medical practitioners must hold a primary qualification recognised by the Medical Council of Ireland and be a fully registered practitioner on the General Medical Register with the Council.

Doctors wishing to provide reports in their capacity as a specialist must provide evidence of their additional qualification in accordance with their specialisation. Where the speciality is included on the Register of Medical Specialities recognised by the Medical Council of Ireland, the doctors can provide proof of either. Independent medical reports for PIAB in cases of whiplash injuries are usually completed by GPs or Orthopaedic Consultants.

4.5 Expert Panel

One of the tasks set out for the PIC in the CIWG report was to investigate the potential for the establishment of a panel of medical experts for use in court.

Under this arrangement, the parties in personal injury proceedings would be restricted to using experts from a panel designated by the courts. Potentially, where the parties could not agree on an expert (s) from such a panel, the court would choose the expert for both parties.

Earlier sections of this report set out the role of medical practitioners in terms of existing practices in the Irish personal injuries environment. Reference is also made to the role of medical practitioners in other European countries which effectively fall into 3 categories:

- The medical experts give opinion on the extent of the injuries and their effect on the claimant's lifestyle and on the future prognosis of the injury. The courts evaluate and calculate damages;
- The medical experts provide opinions that assess the extent of the invalidity in percentage terms;
- The medical experts rate the victim's physical and psychological injuries by reference to published medical scoring tables. The courts quantify damages by assigning monetary values corresponding to the severity score.

The courts are generally not bound by the experts' reports but usually follow them closely in providing a guide for appropriate compensation.

As already referred to medical experts play an essential role in the assessment and evaluation of personal injury claims throughout Europe. In some countries, such as Ireland, any doctor can act as a 'medical expert' without further requirements, while in other countries medical experts must have a specific qualification (e.g. France, where a doctor completing a medical report, must have graduated in legal medical assessment and possess one of two available nationally recognised diplomas) and usually cannot assume such a role while at the same time as acting as a claimant's own doctor (e.g. Norway).

In the UK, medical professionals providing reports for MedCo must receive specific accreditation. All MedCo reports have a fixed report fee of £180. In Ireland, previous attempts to agree fixed fees for medicolegal reports were considered to be contrary to competition legislation. Under the MedCo system a list of relevant experts for every soft-tissue injury is provided using selection filters to prevent there being any financial link between the experts and the person commissioning the report and to ensure the independence of the medical

experts. Notwithstanding the MedCo model/approach, difficulties remain in the UK with regard to the deployment of medical experts providing reports.

The German Courts can appoint their own experts to assist with relevant factual issues rather than relying solely on the expert evidence presented by the parties. Disputed claims require an independent medical opinion along with the original opinion. In Ireland, medical expert evidence is procured by both plaintiffs and respondents and both are presented to the court.

In Norway, the diagnosing process for minor injury claims is carried out by independent doctors. Such doctors are considered 'independent' if they are not the claimant's own GP or, for example, if they work at a public hospital. However, there is no independent panel created specifically for this issue, unlike in other Scandinavian countries.

Current practice in Ireland in cases that go to court is that separate reports are usually submitted from medical practitioners representing both parties. Additionally, the practitioners can be called upon to give evidence in court. Their role in this regard is primarily as an 'expert' but also on occasion as a witness to relevant medical fact.

The use of multiple medical experts by opposing parties is leading to unnecessary costs and such costs are being passed on to the losing litigant, translating in turn into increased insurance premiums. Data from Insurance Ireland provided to the CIWG demonstrated that outside the Personal Injuries Assessment Board (PIAB) process costs related to claimant legal fees, insurers' own legal fees and other costs (e.g. engineer reports, medical fees, actuarial reports, etc. – referred to in the aggregate as 'delivery costs') result in a differential of 40% when compared to the cost of settling claims within the PIAB process. Independent medical experts are also utilised in the PIAB process however total delivery costs are stable at around 6.5%.

In considering the merits for the establishment of an independent medical panel consideration needs to be given to:

- The rights of the parties including the rights of claimants to put their own case forward, including constitutional rights;
- The potential real cost savings of any such arrangement – the use of a panel of medical experts by the Court might remove the need for multiple medical reports from both parties;
- The potential improvements, if any, in the quality of medical reports and whether they can assist the Court;
- The independence/integrity/impartiality of the medical reports;
- The logistics of developing and operating such a panel in view of the volume of cases going to Court and ensuring cost containment, quality, coverage and capacity.

The Department of Justice and Equality and the Department of Jobs, Enterprise and Innovation sought legal advice from the Office of the Attorney General on the establishment of an independent panel of medical witnesses for personal injury cases, where the medical witness is limited to a witness from a panel.

The legal advice is to the effect that Ireland has an adversarial system of litigation in which rights to fair procedures and access to the courts are constitutionally protected. Litigants have a right to present their case as they see fit. They also have a right to test and probe evidence presented by the other side if necessary, by cross examining witnesses and tendering their own evidence. It is the constitutional duty of the Judge to decide upon conflicts as to fact and on the basis of evidence tendered.

The PIC's view is that prohibiting parties from presenting evidence through their chosen witnesses and mandating the use of a single witness from an independent panel would likely interfere with parties' rights to fair procedures and access to the courts and would thus give rise to constitutional issues. It could also impinge on the court's jurisdiction to make fair and independent determinations on the basis of all relevant admissible evidence.

It may be possible to make available an independent medical panel to be used by the court at its discretion, but this would be supplementary to the witnesses the parties chose to produce and the Judge chose to admit.

Accordingly, it would appear that unless the claimant waives their rights, they will continue to seek reports from their treating doctor and a cost will be incurred accordingly. Similarly, the respondent/insurer is likely to refer to their medical experts. Intuitively using a 3rd layer of an independent medical panel, even on a voluntary basis, may only add to costs.

Chapter 4: Diagnosis, Treatment and Accreditation/ Standardised Reporting (continued)

The PIC also identified a number of practical issues in terms of how to define an expert witness, who would determine whether a particular witness was suitable to be on the panel, who would establish, maintain and operate the panel. Although PIAB currently operates an Independent Medical Panel, as it has no role in the litigation process it would not be an appropriate body to manage a panel for the Courts. The only likely body for this role may be the Courts Service and the establishment of such a panel would be a considerable administrative burden. Other issues of concern that could arise relate to access to the panel, coverage, capacity, financial and quality issues.

Separately Insurance Ireland sought Senior Counsel's opinion on the matter and shared the opinion with the PIC. While the advice offered a different perspective, it acknowledged that effectively a claimant's own doctor cannot be excluded from the process. The view of PIC was that the perspective proposed was unworkable in practice in a personal injury context, and risked adding another layer of costs which would run contrary to what the PIC was seeking to achieve.

With regard to attempting to improve the quality of medical reports, the PIC considers that while using a panel may improve reporting, earlier sections in this report recommend standardised reporting and the promotion as best practice of appropriate training for all practitioners who are involved in medico-legal reporting or are acting as a witness/expert. This may overcome issues whether perceived or otherwise in terms of independence and integrity of medical reports.

The Ministry of Justice in the UK's Whiplash Reform Programme also emphasised the importance of establishing a standardised medical assessment approach, in addition to extensive training for medical professionals, to create consistency and enable accurate diagnoses to be made in personal injury cases (particularly soft-tissue cases).

In summary, the PIC does not recommend the establishment of an independent panel of medical experts for use by the courts. The PIC prefers an approach in this area combining a template for assessing soft-tissue ('whiplash') injuries along with best practice guidelines. The PIC believes its recommendations in relation to standardisation of reporting and accreditation of appropriate medics as a best practice model, will, if implemented successfully, significantly improve the existing environment.

The PIC has noted the recommendations of the Law Reform Commission in relation to expert witnesses in its recent (2016) major report on Reform of the Law of Evidence. In particular, the Commission notes the recommendations to the effect that it be set out clearly in statute that the duty of an expert witness lies to the court and not to the party who has hired them and would see progress on many of these key recommendations as central to improving the effectiveness of expert witnesses in terms of their value in assisting the courts.

CHAPTER 5

Consultation and Recommendations

Chapter 5: Consultation and Recommendations

5.1 Consultation Process

The PIC having considered how to deliver on the first phase of its work heard suggestions from medical specialists of how greater standardisation in the diagnosis of soft-tissue injuries would be of benefit and how this might be achieved.

Following detailed consideration, the PIC concluded that a formal consultation process should commence to gather views from a number of key medical organisations.

The Secretariat complemented this analysis with desk based research of how standardisation in assessing soft-tissue injuries is achieved in other jurisdictions.

Information on this work including findings and conclusions was outlined in a Consultation paper 'Standardising the approach to the evaluation of soft-tissue personal injury claims – a consultation concerning 'Whiplash' injuries in Ireland' (Part 2 Appendix 2: Consultation Paper refers) which issued on the 16th of May 2017.

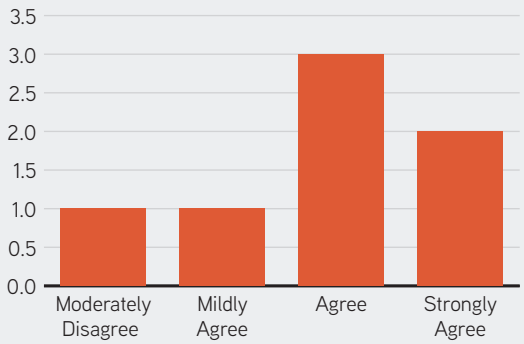
Ten key medical organisations were requested to review all the content of the consultation paper and respond by completing in full and returning information in the form as set out in a questionnaire section of the paper. The form of questioning, where appropriate, allowed for the scaling of responses by incorporating in the questionnaire the use of Likert scales. Fifteen questions were asked under five key headings; diagnosis, grading & scales, forms, training & accreditation and medical professional evidence, 15 questions in total were asked. Rationale information for answers provided was also requested.

The PIC received a good level of response to the consultation. Two organisations declined for stated reasons to respond. Two separate responses from one organisation were received and were treated individually for the purposes of the review. One organisation submitted a letter late in the process which was a summary reflecting individual organisation member views but not organisational policy.

Summary of Consultation Responses

1. All parties responding agreed, to varying degrees, with the statement that the adoption by medical professionals of a standardised approach to the examination of soft-tissue ('whiplash') injuries will bring more consistency to medical reporting and diagnosis. The key stated rationale supporting the view was that a standardised approach to the examination of soft-tissue ('whiplash') injuries is in line with current medical advice and international best practice.

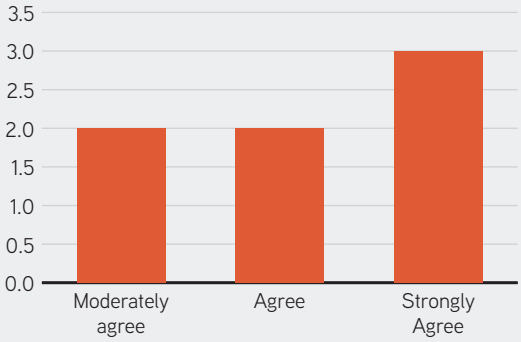
2. The majority of respondents agreed, to varying degrees with the standardised approach as proposed by the PIC and outlined in parts 1-5 of the consultation document. The key stated rationale supporting the view was that the proposed approach is current/evidence based, captures both subjective and objective information and can also facilitate repeat evaluation which assists in tracking recovery.



3. Respondents were split evenly in terms of their required yes/no response to the question: are there any additional frequently used tests that should be considered by the PIC? Some additional tests identified by those Respondents who answered yes were considered by the PIC.

4. More respondents agreed than disagreed with the proposed inclusion of self-testing measures to reflect a claimant's own perception of their pain levels and to benchmark same in the context of any improvements ascertainable in later examinations. For those who disagreed, it was felt that where a compensable injury is involved self-testing is not quantifiable/reliable and might encourage catastrophising. Positive feedback on this proposal included the approach being international best practice and used for many other disorders, that self-testing affords an injured party to express the personal effect of an injury and that repeated self-scoring may effectively demonstrate symptom abatement.

5. All respondents agreed, to varying degrees with the use of the Quebec Task Force (QTF) classification as the preferred model for the grading of Whiplash Associated Disorder injuries. The key stated reasons supporting this view were that the QTF classification is validated, concise, commonly used, accepted internationally and evidence/examiner based.

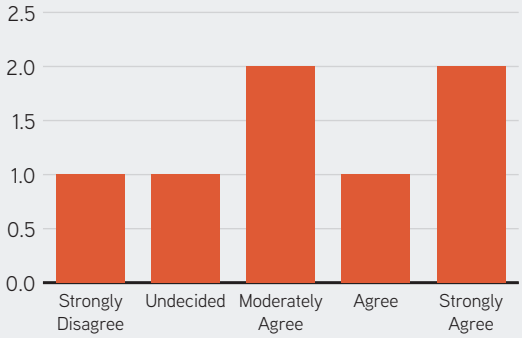


6. The majority of respondents were of the view that no other alternative grading models to QTF should be considered.

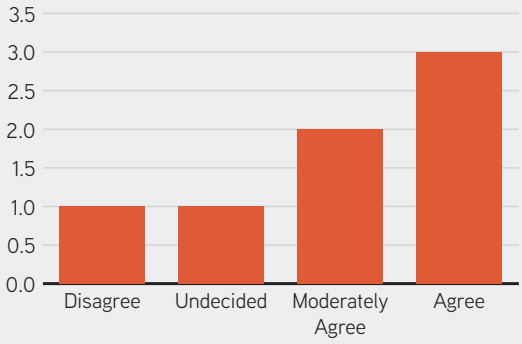
7. The majority of respondents answered no to the yes/no response question; are there any alternative or additional scales that you would consider appropriate for the evaluation of soft-tissue ('whiplash') and/or non-soft-tissue ('whiplash') injury? Additional scales which were suggested were the Impact of Event Scale and unspecified scales for injuries with symptoms with/without underlying degenerative disease and with/without radiographic evidence of acute injury.

8. The stated majority view was that claimants instead of medical experts should complete self-measure tests. The rationale provided included the observation that completing self-measure tests provides insight of a claimant's own symptom experience which is verifiable by the medical professional through observation.

9. The significant majority of respondents agreed to varying degrees that compulsory formal training, accreditation and qualification would improve consistency and quality of soft-tissue medical reports. A notable observation was that persisting WAD conditions can have complex biopsychosocial (relating to the intricate, variable interaction of biological and psychosocial and social factors) implications that require an experienced (trained/accredited and qualified) assessor.

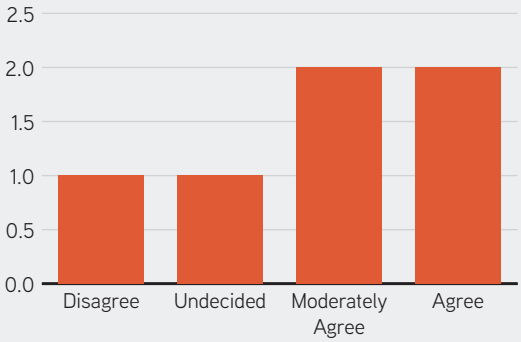


10. The substantial majority of respondents agreed to varying degrees that a CPD based programme is the appropriate level of expertise required for medical experts completing relevant reports. The key stated rationale for this view was that most clinical process benefits from periodic educational review and that the approach would lead to achievement of the related requirement for standardised assessments in this area. It was also suggested that the approach might remove financial incentive for providing/getting reports.



Chapter 5: Consultation and Recommendations (continued)

11. The substantial majority of respondents agreed that a proposed training course for medical experts on soft-tissue injury medical reporting should be delivered. Stated reasons included that the approach is reflective of best practice management, would facilitate reduced variation/promote quality in the assessment of WAD and would afford an opportunity for knowledge development.



12. The majority of respondents felt that individual medical bodies, as opposed to independent training providers, should deliver a training course on soft-tissue injury medical reporting.

13. Examples regarding delivery and content for inclusion suggested by respondents included:
    - Anatomy;
    - Psychology;
    - Sociology;
    - Therapeutics;
    - Specialised physical examination skills;
    - Radiology;
    - Evaluation of sick role behaviour;
    - Report completion skills/outcome measures;
    - Current literature on prognostic indicators;
    - Context information e.g. costs to the state and the importance of encouraging injured parties back to work;
    - Definitions;
    - Pathophysiology;
    - Grades and classifications;
    - Evidence;
    - Guidelines;
    - Acute and chronic injury management;
    - The biopsychosocial model, pain and history taking.

    Delivery models for the training suggested included:
    - A modular approach;
    - E-learning options;
    - Workshops to include demonstration;
    - Objective evaluation e.g. certification;
    - 2-3 year re-validation;
    - Report sample review to compliment on-going accreditation.

14. Comments provided on the level of expertise that should be required of medical experts in general included:
    - Demonstrated ability to evaluate cases consistently and objectively and with reference to a common reporting template;
    - Training in the management of spinal injuries;
    - Experience regarding early and ongoing care of soft-tissue injuries;
    - Registration as a medical practitioner;
    - Competency in the assessment of X-rays/MRI scans;
    - Inclusion in the IMC's register of Medical Specialists for a speciality where the training programme encompasses formal training in the assessment and management of patients with traumatic injuries;
    - Experience in the management of acute and chronic WAD;
    - Extensive experience in the assessment and management of WAD and the biopsychosocial consequences of WAD, expertise in psychological evaluation;
    - Trained regarding mechanism of injury in respect of causation of injury;
    - Higher speciality training in emergency medicine via FRCEM (Fellowship of the Royal College of Emergency Medicine);
    - Evidence of clinical specialisation within musculoskeletal physiotherapy e.g. relevant master's degree;
    - Specialist membership of ISCP (Irish Society of Chartered Physiotherapists/relevant clinical interest group and clinicians should have specific specialist qualification such as in orthopaedics, neurosurgery, emergency medicine, neurology, sports medicine, rheumatology or general surgery (desirable)).

15. The substantial majority of respondents agreed that in certain circumstances medical experts with an on-going relationship with a claimant can be seen as being independent and free from conflict when providing an expert opinion. This is dependent on the existence of safeguards and the adherence to obligations particularly with regard to the best practice approach and guidelines which are being advocated by the PIC and acknowledging also the medical expert's duty to the Courts.

In relation to the use of a standardised form, amending feedback was provided by two Respondents on the proposed template, which is a variant of one used by the PIAB. Improvement suggestions made in arriving at the final version medical template (Part 2, Appendix 6: Final PIC Medical Report Template (including Neck Disability Index and Visual Analogue Scale refers) were predominantly stylistic or for ease of reference/ interpretation.

5.1.1 Consultation Response Summary

The PIC received varying levels of feedback on the questions asked and on additional matters also. Some minor clarifications require follow-up. All the submissions received were analysed, presented to and considered in detail by the PIC. The consultation responses can be considered broadly supportive of the recommendations which are the basis for the final recommendations and action points arrived at by the PIC. The PIC is appreciative of the engagement from Respondents. All consultation responses received written acknowledgement and thanks on behalf of the PIC.

5.2 Conclusions

Following on from the extensive desk based research and completion of the consultation process the conclusions the PIC has reached are focused on the following key areas:

- The recommendation of a standardised approach for the completion of medico-legal reports on whiplash injury;
- The use of the QTF WAD scale in reporting;
- Training and accreditation for all doctors completing medico-legal reports;
- A modified medical report template based on the PIAB medical report template;
- The use of the NDI and VAS to measure a claimant's assessment of their own pain.

The PIC has concluded that the adoption by medical professionals of a standardised approach to the examination of soft-tissue ('whiplash') injuries and use of a standardised reporting template will bring more consistency to medical reporting and diagnosis. Feedback received from the consultation process is broadly supportive of the introduction of a standardised approach. The PIC recommends the adoption of a standardised approach to examination and reporting of soft-tissue injuries going forward. This standardised approach should be along the lines of South Australia Clinical guidelines for best practice management of acute and chronic whiplash.

WAD grading, the NDI and VAS are recommended for inclusion in all soft-tissue ('whiplash') examinations and reports going forward. In furtherance of this aim the WAD grading and NDI and VAS scales should be incorporated into all soft-tissue ('whiplash') medical report templates. An approach to include an element of self-testing (by an injured party) should be used notwithstanding limitations and qualifications applying to such a practice.

The possibility of additional tests and tools for the examination and evaluation of soft-tissue ('whiplash') injuries was discussed at the PIC and incorporated into the consultation process. No persuasive evidence however was provided to adopt, on a routine basis, additional tests such as for example MRIs. Consequently, it has been agreed that the use of any additional tests and tools should be left to the discretion of the examining specialist.

Training and accreditation in PI medical ('whiplash') reporting is agreed as being best practice for those wishing to complete relevant reports and should be delivered to improve the consistency and quality of reporting. The PIC has agreed that such training and accreditation should and could be introduced initially as part of a medical practitioner's continuous professional development (CPD) training programmes and overseen by an appropriate professional/regulatory body. Comments on the possible training curriculum provided by respondents to the PICs consultation process will be provided by PIC to training bodies to assist in the roll-out of the training programme. The focus of the training programmes developed should be on the quality and standard of the training. The Irish Medical Council (IMC) or an alternative appropriate medical regulatory body should undertake a role in the awarding of CPD points.

Chapter 5: Consultation and Recommendations (continued)

On the issue of the independence of practitioners, responses from Respondents to the question in the PIC consultation process were split. The PIC agreed that the mandatory use of doctors who have not treated a claimant could not be suggested due to several issues including constitutional rights and coverage difficulties.

The use of an Independent medical panel in court proceedings is not being recommended by the Commission at this point in time for the reasons outlined in Section 4.5 – Expert Panel of this report. The reasons for this recommendation are the legal advice indicating that the approach would impinge on the constitutional rights of claimants and PIC's view that the proposal was unworkable in practice in a personal injury context.

It is anticipated that the recommendations relating to a standardised approach to reporting and appropriate training and accreditation of those writing PI medical reports will greatly enhance the personal injury claims environment.

The suggested template attached in the Appendix is intended for use at all stages of the process; at settlement stage by insurers, during PIAB process and during litigation. It was agreed that the proposed PIC template should include a section with a declaration or acknowledgement for signing, advising that the expert should be independent and under no duty to any party paying the fee of the expert. It was additionally suggested that the template could be referred to in court rules to ensure maximum uptake and referred to in any pre-action protocols developed.

The view of the PIC is that the use of unnecessary or surplus expert reports should be minimised. However legal advice suggests that it will not be possible to mandate the use of a single expert or panel. It may be possible in the future to have a statutorily codified duty of an expert witness similar to that outlined in The Law Reform Commission's Report on Consolidation and Reform of Aspects of the Law of Evidence[11]. There are also recent Rules of the Superior Courts[12] which do not currently apply to personal injury actions, however it is desirable that the rules contained therein regarding expert evidence and the use of a single joint expert could apply to personal injury claims in the future. Obtaining more consistency and standardisation in the reports, as recommended by the PIC should reduce the need for multiple reports.

It is anticipated that the recommendations relating to a standardised approach to reporting and appropriate training and accreditation of those writing personal injury medical reports will greatly enhance the personal injury claims environment.

5.3 Initial Recommendations and Action Points

The following table details the initial key recommendations arrived at by the PIC. To facilitate implementation, associated and required action point information is included. A suggested timeframe for the implementation of these recommendations is also included although the achievement or otherwise of these time frames will become clearer as implementation commences. The rationale for the benefits to be realised from implementing these recommendations has been set out already to a significant extent in the substantive content of this report.

11 http://www.lawreform.ie/_fileupload/Evidence%20Report%20Completed%20Revised%2018%20Jan.pdf

12 S.I. No. 255 of 2016 – Rules of the Superior Courts (Chancery and Non-Jury actions and other designated proceedings: Pre-trial procedures) 2016. These rules were due to come into operation on the 1st October 2016 affecting proceedings subject to case management under Part II of Order 63C.

S.I. No. 254 of 2016 – Rules of the Superior Courts (Conduct of Trials) 2016 – Due to come into operation on the 1st day of October 2016.

Recommendation	**A Standardised Approach to examination of and reporting on soft-tissue injuries should be adopted.**
Suggested timeframe for implementation	**To allow for the changeover in examination and reporting procedures it is suggested that a timeframe of mid-2018 is appropriate.**
Action Points	1. The Quebec Task Force (QTF) Whiplash Associated Disorder (WAD) grading should be used going forward by all medical professionals reporting on relevant injuries.
	2. The Neck Disability Index (NDI) and Visual Analogue Scale (VAS) should be included going forward as part of personal injury medical reporting examinations.
	3. Additional tests should be at the discretion of the examining medical professional.
	4. The template form included in the Appendix should be used by examining medical professionals in all relevant cases. 4(a) Insurers should ensure that all cases commissioned by them from medical examiners going forward are completed in line with the template form. 4(b) PIAB should redesign their Form B going forward to reflect the recommended standardised template. 4(c) Court Rules changes should be considered which would require reports to be produced using the standardised format. 4(d) The use of standardised medical reports should be included in any pre-action protocol developed for personal injury claims.
	5. Relevant medical professional bodies to publish, as soon as possible, guidelines in respect of training for use by medical professionals.
Recommendation	**Training and Accreditation of medical professionals who complete personal injury medical reports should be promoted. This should become 'Best Practice' and training should be introduced at the CPD level.**
Suggested timeframe for implementation	**By end 2018**
Action Points	1. All those involved in commissioning reports should ensure the use of accredited medical professionals for completion of their personal injury medical reports, when the relevant training and accreditation programmes are in place.
	2. Members of the PIAB panel completing personal injury medical reports should in respect of completion of relevant injury medical reports, when the relevant training and accreditation programmes are in place, be accredited accordingly.
	3. The Accreditation requirement should be included in any pre-action protocol developed for personal injury claims.
	4. The quality of the training should be monitored from implementation in the same manner applicable to existing CPD programmes.
	5. The CPD training could be delivered by individual medical professional bodies to their members or by independent training providers to medical professional bodies and medical practitioners.

Chapter 5: Consultation and Recommendations (continued)

Recommendation	**Link future publications of the Book of Quantum to the newly standardised examination and reporting injury categories i.e. 'whiplash' soft-tissue injuries/QTF WAD scales. The Cost of Insurance Working Group report of January 2017 recommends that the next review of the Book of Quantum should take account of the output of the work of the PIC. This recommendation highlights the output of the initial PIC report in terms of its potential impact on this next review.**
Suggested timeframe for implementation	**2019 when the next Book of Quantum is due for publication.**
Action Points	1. PIAB to consider in the context of the next Book of Quantum.
Recommendation	**Relevant injury data should be collated and published by appropriate bodies.**
Suggested timeframe for implementation	**By end 2018**
Action Points	1. PIAB to produce information going forward relating to the incidence of 'whiplash' soft-tissue injuries.
	2. Other relevant bodies to publish data relating to the incidence of 'whiplash' soft-tissue injuries. There may be merit that such data available from insurers forms part of the National Claims Information Database which is being developed by the Central Bank of Ireland and which needs consideration by the relevant parties involved.
Suggested timeframe for implementation	**By end 2018**

The recommendations and action points represent significant enhancement to the overall personal injury claims process in Ireland. The associated implementation work requires stringent monitoring to mitigate the risk that they might not be fully or correctly implemented. Such monitoring should include reported information in respect of both the progress and impact relevant to the implementation of the recommendations. The risk of not implementing these recommendations is that Ireland will not be in line with best practice with those countries who have taken steps to improve the operation of their respective personal injury systems.

5.4 Next Phase for the PIC

Under the terms of reference for the PIC, the work is divided into three phases with distinct reporting timelines. This Report details the work carried out in Phase One. The terms of reference for Phase Two are:

- Establish a high-level benchmarking of international awards for personal injury claims with domestic equivalents as referred to in the Book of Quantum;
- Analyse and report on international compensation levels and compensation mechanisms;
- Analyse and report on alternative compensation and resolution models internationally, focusing on common law systems while taking account of social welfare, healthcare and related factors associated with each jurisdiction;
- Report on 'care not cash' models and variations in place internationally.

Throughout the debate on the cost of insurance many stakeholders have referred to the experience in other jurisdictions and that compensation levels in Ireland appear to be higher than elsewhere. It has been queried whether soft-tissue/whiplash injury claims are as prevalent in other jurisdictions and whether it is possible to introduce alternative compensation systems, for example a 'care not cash' system. Phase Two will examine these issues. This work is under way and various stakeholders have been contacted in relation to acquiring relevant data and to facilitate an understanding of comparative systems in other jurisdictions.

The PIC will produce a summary report by end March 2018 to the Minister for Business, Enterprise and Innovation and the Minister of State for Financial Services which will:

- Assess the various systems in place and indicate the feasibility or otherwise for the possible development of such systems in Ireland;
- Indicate the timeframe for, benefits of, and risk associated with the implementation of the above recommendations.

PART 2: APPENDICES

Appendix 1: Membership and Secretariat of the Personal Injuries Commission

Appendix 2: Meetings and Stakeholder Engagement

Appendix 3: Scales and Grading Systems Internationally

Appendix 4: References

Appendix 5: Consultation Paper

Appendix 6: Final PIC Medical Report Template (including Neck Disability Index and Visual Analogue Scale)

Appendix 1: Membership and Secretariat of the Personal Injuries Commission

Members	Alternate Member	Organisation
Mr Justice Nicholas Kearns Chair		
Kathryn McGuill Replaced by Jonathan Small from the 08/09/2017	Jonathan Small	Competition and Consumer Protection Commission
Colm Forde Replaced by Eadaoin Collins 18/09/2017	Breda Power	Department of Business, Enterprise and Innovation
Conan McKenna	Tracy O'Keeffe	Department of Justice and Equality
Aidan Hanratty	Kerry McConnell	Insurance Ireland
Professor Michael Stephens		Irish Hospital Consultations Association
Conor O'Brien	Helen Moran	Personal Injuries Assessment Board
Siobhan Hayes	Simon Watchorn	State Claims Agency
Sara Moorhead	Finbarr Fox	The Bar of Ireland
Stuart Gilhooly	Frances Twomey	The Law Society of Ireland
Secretariat		
Derval Monahan Secretary		Department of Business, Enterprise and Innovation
Eoghan Coyne		
Etain Finn		Personal Injuries Assessment Board
Stephen Watkins		

Appendix 2: Meetings and Stakeholder Engagement

Meetings

The business of the Commission is primarily conducted through monthly meetings. PIC has the ability to engage external expertise and through its work invited relevant parties to contribute, make presentations and attend some meetings.

Stakeholder Engagement

Association of British Insurers (ABI)
Department of Health
Department of Justice and Equality
Department of Social Protection
Enterprise Rent a Car
Health Information and Quality Authority
Health Service Executive
Insurance Ireland
Irish Association of Emergency Medicine
Irish College of General Practitioners
Irish Hospital Consultants Association
Irish Medical Organisation
MedCo UK
Ministry of Justice UK
Motor Insurance Bureau of Ireland (MIBI)
Mr Garry Fenelon
Royal College of Physicians of Ireland
Royal College of Surgeons in Ireland

Appendix 3: Scales & Grading Systems Internationally

USA

America is a federal state and due to its immense size and diversity the American personal injuries litigation system cannot be easily summarised. For any particular tort, states differ on the causes of action, types and scope of remedies, statutes of limitations, and the levels of damages etc. For example, a few jurisdictions allow actions for psychological injury even in the absence of physical injury to the plaintiff, but most do not. It is for these reasons the PIC deemed it inappropriate to explore personal injury system aspects of this jurisdiction in depth for comparative purposes. Examples from best practice in medical examination approaches from this jurisdiction have been explored in the report.

The AMA Guides,[13] published by the American Medical Association, provide percentage measures of whole body impairment, sometimes referred to as WPI and are used both in the USA and internationally. There is no direct link with compensation payments between the percentages and compensation amounts.

They are widely used in workers' compensation automobile casualty and personal injury cases to quantify permanent losses associated with injury or illness. The use of the AMA Guides in workers' compensation varies by State.

These Guides are sometimes also referred to in jurisdictions outside the state in calculating injuries as a percentage of whole body impairment including Canada, the Netherlands, Australia, New Zealand, Hong Kong, Colombia and South Africa.

Within the Guides *Impairment Evaluation* refers to the "acquisition, recording, and reporting of medical evidence, using a standard method such as described in the Guides to determine permanent impairment associated with a physical or mental condition."

The result is an *Impairment Rating* which is a "consensus-derived percentage estimate of loss of activity, which reflects severity of impairment for a given health condition, and the degree of associated limitations in terms of Activities of Daily Living (ADLs)." (*Guides*, Sixth Edition, Glossary).

There are qualifications available in the use of the Guides. ABIME (American Board of Independent Medical Examiners) certification is available for those wishing to obtain accreditation in the use of the AMA Guides however it is not a compulsory qualification for the completion of medico legal reports in the US.

13 AMA Guides® to the Evaluation of Permanent Impairment, Sixth Edition

France

In France, in all cases, the mechanism of valuation is based on a medical scale. The tables are prepared by Courts in individual jurisdictions but have a similar structure in all jurisdictions.

The assessment of bodily injuries in France is based on "The Nomenclature Dintilhac" established by the 2005 Rapport Dintilhac. The Nomenclature lists all recoverable damages and the methods of valuation. There are several heads of prejudice as previously outlined. The medical assessment defines the level of each head of non-pecuniary loss, and for each head of prejudice, there is an amount defined by out of Court or by Court decision.

While the nomenclature is not legally binding, it has been referred to by the French Courts and its definitions have been applied.

Permanent functional deficit is calculated when the injuries have achieved "consolidation".

The concept of medical "consolidation" refers to the date when the injuries stop evolving and are of a permanent nature so that a medical treatment is no longer necessary except to prevent an aggravation. Permanent functional deficit is assessed as a percentage of permanent incapacity. The type of calculation/scale used is the "calcul au point" or AIPP scale (Atteinte Permanente a l'Integrite Physique et Psychique) which calculates the percentage of incapacity from 1%-100%.

The indicative scale used which advises of percentage rates for various injuries, was published in Le Concours medical and is called the "Barème indicatif d'évaluation des taux d'incapacité en droit commun".

Spain

The new Spanish regulation, known as the Baremo, for the assessment of damages in personal injury claims came into force 1 January 2016.

In principle, this system is only compulsory for the assessment of damages arising out of road traffic accidents, but it is standard practice to use this assessment method in other personal injury matters as well. It is based on a compulsory fixed tariff method for the assessment of non-pecuniary losses.

Sweden

Compensation for non-pecuniary loss in Sweden, with a few exceptions, is determined according to standardised tables produced by the Road Traffic Injuries Commission and by Insurance Sweden. The tables are not specific to whiplash and are updated on an annual basis.

The Swedish Supreme Court has approved this model of calculating compensation. The headings for non-pecuniary loss include; pain and suffering, disadvantage, incapacity and specific inconvenience. The incapacity head of compensation is based on a Swedish determined degree of disability of 1% to 99%.

Italy

In Italy, permanent invalidity is calculated using tables established by the Court of Milan which are updated annually. The Italian Corte de Cazzione has ruled that Milan tables are a guideline.

The judge has the possibility to personalize the quantification increasing amounts provided by the Court of Milan's tables by up to 20%. Calculations are made on the basis of former court decisions.

Germany

A compensation chart (Schmerzensgeldtabelle) is used as a point of orientation, allowing judges to reflect on similar cases over the years. The chart lists several cases, spanning a wide range of injuries, and includes also the compensation that was required according to the verdict. It is not a catalogue that lists an exact sum for every injury, but rather a series of examples against which a case at hand can be compared. All damages that can be remunerated are assigned pursuant to the German Civil Code. While the French system individually quantifies several heads of damage, the German system encompasses the various heads as a combined total.

Calculation is based on national law in combination with evidence, whereby the claimant will be asked to provide medical certificates or supporting documentation in respect of special damages claims.

Denmark

Compensation for loss due to personal injury is governed by the Danish Liability for Damages Act, (EAL) 2005 which determines the items for which the claimant may claim indemnification, for instance compensation for loss of earnings, for pain and suffering, permanent injury or compensation for loss of earning capacity. Each year the amounts of damages for personal injuries are carefully adjusted by statutory law to keep in tune with the index of prices and wages. There is a scale related to permanent injury that is established by the AES. The scale operates with a grade of percentages, based on the injury.

Australia

The MAA (Motor Accident Authority) guidelines in New South Wales are used to assess a person's degree of permanent impairment following a motor vehicle accident. Damages for non-economic loss can only be awarded where the permanent impairment of the injured person is greater than 10%. The guidelines published by the MAA use the American Medical Association Guides to the Evaluation of Permanent Impairment, Fourth Edition as their basis. However, they have made significant changes to ensure they suit Australian clinical practice and legislation.

In the Northern Territory, payments are made subject to a minimum threshold of 5% whole person impairment. The only lump sum payments made under the scheme are for permanent impairment. Assessments for whole person impairment are made by an independent medical practitioner in the appropriate field, using the American Medical Association (AMA) Guide 6th edition.

In South Australia injuries are measured against an Injury Scale Value ("ISV Scale") and assigned a numerical value. The ISV Scale contains a list of all recognised injuries and the range in value which can be assigned. An ISV Medical Assessment is to be undertaken when the injury has stabilised. The ISV Table is used to determine an Injury Scale Value. It is a measure of injury severity that assigns a value between 0 and 100 for an injury based on available medical evidence. It also considers the impact of the injury on the individual. A person's injury must exceed prescribed thresholds in order for that person to be eligible for compensation. The value assigned to an injury is linked to a prescribed amount of compensation. In circumstances where a person has sustained multiple injuries the dominant injury (the injury with the highest value on the ISV Scale) must exceed the threshold in order to receive compensation. To obtain compensation for non-pecuniary or non-economic loss (Pain and Suffering) the claimant must be assessed to have an ISV of more than 10.

In Queensland, for general damages to be awarded by a court a person's injury must be assessed against the Injury Scale Values outlined in the Civil Liability Regulation 2014.

The ISVs range from 0 (not severe enough to warrant any general damages) to 100 (gravest conceivable injury). In determining the appropriate ISV for a psychiatric injury, the Psychiatric Injury Rating Scale (PIRS) must be used. The Guides to the Evaluation of Permanent Impairment published by the American Medical Association are used in assessing physical impairments.

The State of Victoria operates a 'No Fault Scheme' for compensation for those injured in a Motor Vehicle Accident known as the Traffic Accident Commission (TAC). Entitlements include compensation for loss of earnings and medical and rehabilitation expenses and if

Appendix 3: Scales & Grading Systems Internationally (continued)

negligence is established that the accident was 100% not the claimant's fault they may have an entitlement to pursue a Common-Law Claim. To pursue a Common-Law Claim in Victoria the claimant must exceed the threshold of 10% Whole Person Impairment for a lump sum payout[14].

Western Australia operates a Compulsory Third Party (CTP) Insurance scheme. Under the CTP scheme, motor vehicle personal injury compensation is available for people that can establish a driver of a licensed motor vehicle was at fault in the accident. Costs covered include: treatment, care and support (including medical treatment and rehabilitation), pain and suffering, past and future economic loss and claims management expenses. Claimants must initially make a claim with the Insurance Commission[15]. The Insurance Commission pay reasonable and necessary expenses up to the maximum amounts set out in the Australian Medical Association recommended rates for medical services, medical treatment and diagnostic imaging on an ongoing basis until the claim is settled. In order for compensation to be paid, the injuries need to be assessed at a certain level of severity as caps and thresholds apply. General damages are based on a percentage of the maximum threshold. Since July 2017, all claims for non-pecuniary loss must exceed a minimum threshold of $21,000 and the maximum amount payable is $412,000. A Threshold Schedule is used to assess the amount payable.

In Tasmania, the Motor Accidents Insurance Board (MAIB) [16]has been established to administer the funding and payment of Tasmania's Compulsory Third Party (CTP) motor accident insurance scheme. The scheme provides medical and income benefits on a no-fault basis to people injured as a result of a motor accident.

Claims can be settled directly with the MAIB; or a common-law action for damages can be taken, and either settled during the proceedings or, if not settled, decided by a judicial officer. The MAIB pays the claim and legal costs on behalf of the defendant. 10% of a lump sum settlement must be paid to the Health Insurance Commission.

The compulsory third party insurance scheme in the ACT is administered by The Australian Capital Territory Compulsory Third-Party Insurance Regulator, known as the CTP Regulator[17]. Unlike other Australian territories it operates a court based model of resolving claims. Claimants are provided with access to treatment and rehabilitation payments for up to 6 months after an accident to ensure treatment is obtained as soon as possible following an accident and to guarantee a better health outcome. After a claimant's injury stabilises, a severity assessment can be made and compensation determined.

UK

In the UK, the Judicial College publish Guidelines for the Assessment of General Damages (formerly the Judicial Studies Board Guidelines) which set out financial brackets for common types of injury and are regarded as the starting point for assessing damages. The Guidelines for general damages are a distillation of previous and current award levels and intended as a guide rather than a fixed tariff system. The Guidelines are designed to provide a clear and logical framework for the assessment of general damages while leaving the discretion of the assessor unfettered, as every case must depend to a degree on its own facts. All judges involved in hearing personal injury cases in England and Wales automatically receive a copy of the book. The Guidelines are reviewed on a two-yearly basis and are intended to reflect awards actually made by the courts rather than a judgement of where the awards ought to be[18]. The guideline amounts are typically formatted in Severe, Moderate and Minor categories with three separate award amounts contained within each of these categories.

Northern Ireland

In March 1992, the first edition of the Guidelines for the Assessment of General Damages was published by the Judicial College in England.

It was considered necessary to produce a separate edition of Guidelines for Northern Ireland as the level of damages in Northern Ireland is significantly higher than in England and Wales. The Judicial Studies Board of Northern Ireland – JSBNI[19] followed the headings adopted in the original guidelines with some minor variations to produce the Guidelines for the Assessment of General Damages in Personal Injury Cases in Northern Ireland.

14 https://www.tac.vic.gov.au/
15 https://www.icwa.wa.gov.au/
16 http://www.maib.tas.gov.au/
17 https://apps.treasury.act.gov.au/compulsorytpi

18 Foreword to the Thirteenth Edition of the Judicial College's Guidelines for the Assessment of General Damages in Personal Injury Cases. The Judicial College Guidelines (formerly JSB Guidelines)/The Judicial College Guidelines/ Foreword to the Thirteenth Edition of the Judicial College's Guidelines for the Assessment of General Damages in Personal Injury Cases
19 http://www.jsbni.com

Appendix 4: References

Law reform consultation expert evidence

Law reform report on consolidation and reform of aspects of the law of evidence

Law Society July 2016 expert evidence

European Motor Insurance Markets Report November 2015

Emergency department treatments and physiotherapy for acute whiplash: a pragmatic, two-step, randomised controlled trial

RCEM Guidelines

EU Commission's DG Internal Market and Services regarding compensation of victims of cross-border road traffic accidents in the EU 2008

The first major cross-border study into minor cervical spine injuries (whiplash related) was conducted by the CEA (the Comité Éuropeen des Assurances), a pan-european trade body, now Insurance Europe, in 2004. Insurance Europe's study on European Motor Insurance Markets (2015) concludes that in France the number of accidents involving personal injury is increasing again (+4% in 2014) after several decades of decrease.

The AXA Whiplash Report 2013

The Frontier Report for Aviva March 2015

The 2005 Report of the Swedish Whiplash Commission

The Swedish Society of Medicine and The Whiplash Commission Medical Task Force 2006: The modified Swedish classification of whiplash injuries differs from the QTF classification in that WAD grade 0 (no symptoms and normal physical findings) and WAD grade IV (fracture, dislocation or ligament rupture) are not part of the classification.

10-103369TVIOTIR/02, LF-2009-121377, LF-2010-156465, 10-127904TVI-BBYR/03 and LH-2010-79241) – Norwegian judgements

"The Nomenclature Dintilhac" established by the 2005 Rapport Dintilhac.

http://www.whiplashkommissionen.se/www.whiplashkommissionen.se/english/english.html

https://www.trafikskadenamnden.se/Information-in-English/

The Comité Européen des Assurances Report in 2004 on Minor Cervical Trauma Injuries-www.svv.ch/sites/default/files/document/file/CEA_HWS-Studie_englisch.pdf

http://www.medco.org.uk/accreditation/

The Law Commission Law Com No 257 DAMAGES FOR PERSONAL INJURY: NON-PECUNIARY LOSS Item 2 of the Sixth Programme of Law Reform: Damages

AMA Guides® to the Evaluation of Permanent Impairment, Sixth Edition

https://www.tac.vic.gov.au/

https://www.icwa.wa.gov.au/

http://www.maib.tas.gov.au/

https://apps.treasury.act.gov.au/compulsorytpi

Foreword to the Thirteenth Edition of the Judicial College's Guidelines for the Assessment of General Damages in Personal Injury Cases. The Judicial College Guidelines (formerly JSB Guidelines)/The Judicial College Guidelines/Foreword to the Thirteenth Edition of the Judicial College's Guidelines for the Assessment of General Damages in Personal Injury Cases

http://www.jsbni.com

http://bjdonline.org/

Int J Legal Med DOI 10.1007/s00414-015-1244-9

International Statistical Classification of Diseases and Related Health Problems (ICD-10th revision) (WHO)

http://www.lawreform.ie/_fileupload/Evidence%20Report%20Completed%20Revised%2018%20Jan.pdf

S.I. No. 255 of 2016 – Rules of the Superior Courts (Chancery and Non-Jury actions and other designated proceedings: Pre-trial procedures) 2016. These rules were due to come into operation on the 1st day of October 2016 affecting proceedings subject to case management under Part II of Order 63C.

S.I. No. 254 of 2016 – Rules of the Superior Courts (Conduct of Trials) 2016 – Due to come into operation on the 1st day of October 2016.

Road Traffic Injury Commission (TSN) Sweden

Neck Diability Index (NDI)

Visual Analogue Scale (VAS)

Appendix 5: Consultation Paper

Standardising the approach to the evaluation of soft-tissue personal injury claims

A consultation concerning 'whiplash' injuries in Ireland.

(To assist completion, a soft copy of this consultation document is available by E-mailing an appropriate request to Secretarypic@djei.ie).

May 2017

CONTENTS

Introduction
Background
Procedure
Part 1 – Diagnosis
Part 2 – Grading & Scales
Part 3 – Forms
Part 4 – Training and Accreditation
Part 5 – Medical Professional Evidence
Questionnaire
Next Steps
Annex

Introduction

1. In line with the terms of reference as set out by the Cost of Insurance Working Group (CIWG), the Personal Injuries Commission (PIC) has been examining soft-tissue ('whiplash') injury. Areas reviewed include:
    i. International experience;
    ii. Diagnosis and treatment;
    iii. Approaches to diagnosis;
    iv. Standardised medical reporting;
    v. Use of objective tests;
    vi. Severity scales;
    vii. Medical professional skills, training and accreditation.

Following detailed consideration PIC has concluded that a formal consultation process should commence to gather views from a number of key medical organisations.

Background

2. The Minister for Finance, Mr Michael Noonan T.D., began a review of insurance policy in early 2016. As part of that review the CIWG was established in July 2016 chaired by the Minister of State at the Department of Finance, Mr Eoghan Murphy T.D. The objective of the CIWG was to identify and examine the drivers of the cost of insurance and recommend short, medium and longer term measures to address the issue of increasing insurance costs taking into account the requirement for a financially stable insurance sector.

3. The CIWG published a report on 10 January, 2017 which noted that between January 2011 and January 2017, motor insurance premiums increased by 51% (far in excess of both EU trends and general inflation trends in the wider economy). One of the report's conclusions was that personal injury claims are a major determinant in the price of motor insurance premiums. Consequently, any major shift in the value or volume of personal injury claims can have an impact on insurance premium prices.

4. Compensation settlements can be arrived at directly between an insurer and a claimant, through the Personal Injuries Assessment Board (PIAB) process, or through litigation. To facilitate greater consistency in awards, PIAB publish a Book of Quantum which provides detailed information of prevailing compensation levels paid through all settlement channels. However, throughout the CIWG's deliberations stakeholders voiced their concerns regarding a perceived lack of consistency in personal injury claim awards.

5. A lack of consistency in award levels can reduce the incentive to settle claims early. Settling personal injury claims quickly has the potential to reduce ancillary costs. Consistency in award levels can be positively influenced by consistency in medical reporting and grading of injuries by all stakeholders who settle personal injury claims.

6. Soft-tissue ('whiplash') injuries have been identified by all stakeholders as accounting for up to 80% of all motor liability personal injury claims made in Ireland. Consequently, if the costs associated with settling soft-tissue injuries could be reduced, this could have a positive impact on reducing the cost pressures which underpin the price of motor insurance premiums.

7. The CIWG proposed the establishment of the PIC, under the remit of the Department of Jobs, Enterprise and Innovation (DJEI). All the CIWG's recommendations have been proposed with a view to reducing the cost of motor insurance premiums. The PIC is chaired by former President of the High Court, Mr Justice Nicholas Kearns. Members of PIC represent relevant stakeholders from Government Departments and agencies, as well as the medical, legal and insurance sectors. The PIC Secretariat is provided by the Department of Jobs, Enterprise and Innovation. The first monthly meeting of the Commission took place in February 2017.

8. The terms of reference for the first phase of the PIC's work are:

   In respect of other jurisdictions particularly in Europe:

   i. Complete a comprehensive data gathering exercise to assess systems for handling personal injury claims, particularly soft-tissue ('whiplash') claims, focusing on causes, frequency/incidence, diagnosis, treatment and appropriate compensation levels;

   ii. Report on systems where detailed grading of minor personal injuries is in operation;

   iii. Assess the potential for medical professionals to prepare injury claim reports on a percentage disability basis with 100% being the maximum severity case;

   iv. Assess the potential for a national medical panel of trained and accredited medical specialists for completion of reports with a timely medical assessment of the extent and impact of the injury and include a standardisation of reporting methods by assessing specialists;

   v. Investigate the potential for the establishment of a panel of medical experts for use in Court.

9. To date the PIC has considered how to deliver on some of the terms of reference related to the first phase of its work. PIC has heard suggestions from a number of medical specialists of how greater standardisation in the diagnosis of soft-tissue injuries would be of benefit and how this might be achieved. The Secretariat has complemented this analysis with information of how standardisation in assessing soft-tissue injuries is achieved in other jurisdictions.

Procedure

10. Information on PIC's work to date including findings and conclusions is outlined in Parts 1-5 of the consultation document. Respondents are requested to review all content and respond by completing in full and returning information in the form as set out in the questionnaire section. Responses, preferably by electronic mail, should be submitted no later than 5 pm, 30/06/2017. A soft copy of the consultation document for ease of completion is available on request by E-mailing Secretarypic@djei.ie.

11. Any queries, information over and above that requested in the consultation document or complaints can also be sent to the same E-mail address.

12. Contact details are as follows:

    PIC Secretariat
    Department of Jobs, Enterprise and Innovation
    Earlsfort Centre
    Lower Hatch Street
    Dublin D2 D02 PW01

    Email: Secretarypic@djei.ie

    Telephone:
    Eoghan Coyne 01 6312548, 086 8295247
    Etain Finn 01 6312542

13. Copies of this consultation paper are being sent to:

    i. Irish Medical Organisation,

    ii. Irish College of General Practitioners,

    iii. Irish Hospital Consultants Association,

    iv. Irish Association of Emergency Medicine,

    v. Royal College of Surgeons in Ireland,

    vi. Royal College of Physicians of Ireland,

    vii. Department of Health,

    viii. Health Service Executive,

    ix. Health Information and Quality Authority,

    x. Department of Social Protection.

14. The PIC may decide to publish submissions received on the DJEI website in due course. A decision on any such placement may occur without prior consultation with respondents to this consultation process. If a respondent does not wish any material contained in its submission to be published in this way because it is considered commercially sensitive or confidential, then this should be clearly indicated (with reasons) in the submission.

Appendix 5: Consultation Paper (continued)

15. Please note that all submissions received will be subject to the Freedom of Information Act 2014. Consequently, when submitting material, parties should specify any information which they consider should not be released, and identify the grounds under the Act which support the non-release of the information.

Part 1 – Diagnosis

16. From PIC's research into practices in other jurisdictions a standardised approach to soft-tissue ('whiplash') diagnosis is commonly utilised. While it is acknowledged that there are no definitive objective tests for 'whiplash', particularly those of a minor or moderate nature, the PIC suggests that medical professionals following a standardised approach will introduce more consistent analysis of claimant's injuries.

17. A suggested standardised approach to the physical examination of claimants and modelled on the approach adopted in South Australia would include, in addition to history taking and observation of the claimant, the following steps:

    i. Assessment of cervical range of motion;

    ii. Palpation of claimant for tenderness;

    iii. Checking for neurological signs;

    iv. Assessment of whether there are any associated injuries or co-morbidities present;

    v. Confirmation of whether any diagnostic tests were carried out and report of results where relevant; and

    vi. Assessment of the claimant's psychological state and general medical condition.

Annex B refers.

18. The Neck Disability Index (NDI) (Annex E refers) and Visual Analogue Scales e.g. for pain assessment, should be completed (Part 2 Scales & Grading below refers).

19. PIC have concluded that medical reports for soft-tissue ('whiplash') injury claims should provide detailed grading which is broadly aligned to guidelines in use in South Australia (Annex refers). This model builds on previous work by the Quebec Task Force (QTF).

20. The (QTF) on Clinical Classification of Whiplash Associated Disorder (WAD) was established to classify and recommend treatment for whiplash-associated disorders. After years spent gathering data from multiple sources, the task force issued their report in 1995 (published in the Clinical Journal, Spine).

21. Associated guidelines should also identify the approach and steps that should be undertaken by medical professionals in informing their grading decisions. The aim of the guidelines will be to ensure greater consistency in evaluation and reporting.

Part 2 – Grading & Scales

22. There are a variety of scales used to measure or classify soft-tissue ('whiplash') and wider injury types. Whole body percentage disability basis scale variations, linked to compensation levels are used in Norway and France, for example. Some scales are used selectively including in the Irish jurisdiction examples being in respect of hand injury evaluation and those used by the Department of Social Protection.

23. A Visual Analogue Scale (VAS) is a psychometric response scale which can be used in questionnaires. It is a measurement instrument or scale for subjective characteristics or attitudes that cannot be directly measured. When responding to a VAS item, respondents specify their level of agreement to a statement by indicating a position along a continuous line between two end-points.

24. In 1995 the QTF developed a classification system that was designed to improve the management of WAD. This system provides a guide to the signs and symptoms of whiplash, indicative of the seriousness of the injury sustained. The QTF method of classifying injuries is internationally recognised, validated and referred to in research.

    Countries with different scales for WAD diagnosis such as Germany and Sweden have based them on a modified version of the QTF classification.

25. The clinical classification provided by the QTF is:

    Grade 0: no neck pain, stiffness, or any physical signs are noticed.

    Grade 1: neck complaints of pain, stiffness or tenderness only but no physical signs are noted by the examining physician.

    Grade 2: neck complaints and the examining physician finds decreased range of motion and point tenderness in the neck.

Grade 3: neck complaints plus neurological signs such as decreased deep tendon reflexes, weakness and sensory deficits.

Grade 4: neck complaints and fracture or dislocation, or injury to the spinal cord.

26. While many medical professionals currently refer to the QTF classification in their reports, it is proposed that all medical professionals completing medical reports will use these classification methods to grade a claimant's soft-tissue injury in their reports.

27. The PIC proposes that the NDI be completed as part of any examination of soft-tissue ('whiplash') injury claims.

Part 3 – Forms

28. The PIC proposes a standardised and consistent medical report evaluation template (Annex C refers – sample template based on the Personal Injuries Assessment Board's medical Form B template) for soft-tissue ('whiplash') injury claims, to be completed by medical professionals and for use by all parties involved in settling soft-tissue ('whiplash') claims. The template will specifically address any soft-tissue ('whiplash') injury aspects of a claim and reflects the standardised approach outlined in Part 2. It includes provision for information on WAD grading and both NDI and VAS information.

29. The completed NDI form template would be annexed to the completed standardised medical reporting template for soft-tissue ('whiplash') injuries. This specific report structure would be used in all cases where claimant's present with soft-tissue ('whiplash') injury.

Part 4 – Training & Accreditation

30. Research indicates that there are differences between EU Member States on the qualifications required of medical professionals in assessing personal injury claims. A number of jurisdictions require medical professionals who complete reports on soft–tissue ('whiplash') injuries to have specific skills and training. Some jurisdictions have developed specific training courses and only medical professionals with the related accreditation and qualification can provide reports for use in the settlement of claims.

31. French legislation requires that a doctor in some instances acting as a medical professional must have graduated in legal medical assessment and possess one of two available nationally recognised diplomas.

32. In 2015 in the UK, MedCo was launched to facilitate the sourcing of medical reports in soft-tissue injury claims under the Ministry of Justice' new Pre-Action Protocol for Low Value Personal Injury Claims in Road Traffic Accidents. Medical professionals providing reports for MedCo must receive specific accreditation. MedCo's training, which covers modules such as professional obligations, clinical examination and legal content, is delivered online and estimated to take 30-35 hours (www.medco.org.co.uk).

33. In order to maintain a level of consistency in the standard of reporting and following on from the specific examples in France and the UK, it is suggested that a compulsory formal qualification has merits for medical professionals wishing to complete personal injury case medical reports. It is suggested that this qualification could be relatively easily delivered in the form of a CPD accredited programme.

Part 5 – Medical Professional Evidence

34. The PIC's terms of reference in relation to investigating "the potential for the establishment of a panel of medical experts for use in Court" refer.

35. The CIWG report commented that "Other jurisdictions have established specific qualifications for medical professionals in this area of expertise to facilitate more detailed grading of injuries. It is noted that some jurisdictions use a national panel of trained and accredited medical advisors".

36. In December 2016, The Law Reform Commission published the Report: Consolidation and reform of aspects of the law of evidence. This recommended:

"the draft Evidence Bill should provide that an "expert" is a person who appears to the court to possess the appropriate qualifications, skills or experience about the matter to which the person's evidence relates (whether the evidence is of fact or of opinion), and who may be called upon by the court to give independent and unbiased testimony on a matter outside the knowledge and experience of the court, and that the terms "expert evidence" and "expertise" should be interpreted accordingly."

Appendix 5: Consultation Paper (continued)

Questionnaire

1. **The adoption by medical professionals of a standardised approach to the examination of soft-tissue ('whiplash') injuries will bring more consistency to medical reporting and diagnosis.**

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree

Please explain your reasoning.

2. **To what extent do you agree or disagree with the proposed standardised approach outlined (parts 1-5 of this consultation refer)?**

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree

Please explain your reasoning.

3. **Are there any additional frequently used tests that should be considered by the PIC?** ☐ **Yes** ☐ **No**

Please explain your reasoning.

4. **To what extent do you agree or disagree with the inclusion of self-testing measures to reflect a claimant's own perception of their pain levels and to benchmark same in the context of any improvements ascertainable in later examinations?**

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree

Please explain your reasoning.

(Part 2 – Grading & Scales)

5. To what extent do you agree or disagree with the use of the QTF classification as the preferred model for the grading of WAD injuries?

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree

Please explain your reasoning.

6. Are there any alternative grading models that you would consider appropriate for the grading of WAD injuries?

☐ **Yes** ☐ **No**

Please explain your reasoning.

7. Are there any alternative or additional scales that you would consider appropriate for the evaluation of soft-tissue ('whiplash') and/or non-soft-tissue ('whiplash') injury?

☐ **Yes** ☐ **No**

Please explain your reasoning.

(Part 3 – Forms)

8. Who do you suggest should complete self-testing measure records?

☐ **Claimants** or ☐ **Medical experts**

Please explain your reasoning.

Appendix 5: Consultation Paper (continued)

(Part 4 – Training & Accreditation)

9. To what extent do you agree or disagree that compulsory formal training, accreditation and qualification for those medical professionals reporting on soft-tissue ('whiplash') injury will improve the consistency and quality of reports?

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree

Please explain your reasoning.

10. To what extent do you agree or disagree that a continuous professional development based accreditation/ qualification is the appropriate level of expertise required for medical experts completing medical reports on soft-tissue ('whiplash') injuries?

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree

Please explain your reasoning.

11. To what extent do you agree or disagree that a training course for medical experts on soft-tissue injury medical reporting should be delivered?

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree

Please explain your reasoning.

12. Who should deliver a training course for medical experts on soft-tissue injury medical?

☐ **Individual medical bodies to their own respective members**

☐ **Independent Training Provider/s**

Please explain your reasoning.

13. Please provide comments on the content for inclusion and delivery of proposed training for medical experts as regards soft-tissue ('whiplash') injury medical reporting.

(Part 5 – Expert Evidence)

14. Please provide comments on the level of expertise that should be required of medical experts in general.

15. To what extent do you agree or disagree that a medical expert with an on-going relationship with a claimant is independent and free from conflict when providing an expert opinion?

Strongly Disagree	Disagree	Moderately Disagree	Mildly Disagree	Undecided	Mildly Agree	Moderately Agree	Agree	Strongly Agree

Please explain your reasoning.

Appendix 6: Final PIC Medical Report Template/ Neck Disability Index

Medical Reporting Template
for Soft-Tissue ('Whiplash') Injury

Claimant Name			
Address			
Gender		Marital Status	
Date of Birth			
Occupation			
Currently at Work	☐ Yes ☐ No		
Height		Weight	
R/L Hand Dominant			
Date of Accident		Examination Date	
Time elapsed since date of accident (accident date to examination date)	Years Months		

Brief details of the accident/incident

Injuries Sustained (including diagnostic information)

Details (include history of condition immediately after accident and in subsequent few days)
Summary Diagnostic Information

Date first Treatment Sought			
From whom			
Was patient hospitalised?			
If yes, where?			
Duration of inpatient stay?		Length of absence from Work	
Number of GP visits		Number of Physiotherapy sessions	
Number of Specialist/s visits			
Identity of Specialists, if known			

Treatment/Investigations to date

Medications/dosage/changes in e.g. last six months

Appendix 6: Final PIC Medical Report Template/ Neck Disability Index (continued)

Please Complete Where Injury is Neck Pain or Whiplash Associated Disorder

Assessment of cervical range of motion	☐ Normal	☐ Abnormal
Palpation for consistent tenderness	☐ Present	☐ Absent
Neurological Signs	☐ Present	☐ Absent

Treatment/Investigations to date

The claimant should compete the attached NDI Questionnaire – Neck Disability Index

NDI Score = %

Following Assessment claimant should be classified to the Quebec Task Force (QTF) Classification of Grades

Indicate the WAD Grade

☐ WAD 0 ☐ WADI ☐ WAD II ☐ WAD III ☐ WAD IV

If the claimant's WAD Grade has changed during the course of their recovery, please comment on same:

Relevant Medical History (including previous and subsequent accidents)

☐ Nil relevant

☐ Aggravation of pre-existing condition?

If yes, give nature of pre-existing condition

Give details of previous accident history, if any

Was pre-existing condition active/symptomatic before the accident?

Lifestyle Effects

Occupational

Recreational

Domestic/Personal

Appendix 6: Final PIC Medical Report Template/ Neck Disability Index (continued)

Present Complaints

Clinical Findings on Examination

Clinical Description of effects of Claimant's Illness/Accident/Disablement

	Normal	Mild	Moderate	Severe	Profound
Mental Health	☐	☐	☐	☐	☐
Learning/Intelligence	☐	☐	☐	☐	☐
Consciousness/Seizure	☐	☐	☐	☐	☐
Balance/Co-ordination	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Manual Dexterity	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐
Bending/Lifting/Stooping	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing Stairs	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

Anticipated treatment required into the future

Opinion/Comment/Latest Prognosis

Indicate the degree to which you feel the claimant's symptoms/disability have been caused by the accident/event which is the subject of this claim? Tick one box
Based on my assessment the accident/event accounts for
☐ 1. none of the symptoms/disability
☐ 2. a small proportion (≤ 25%) of the symptoms/disability
☐ 3. a moderate proportion (50%) of the symptoms/disability
☐ 4. most (≥ 75%) of the symptoms/disability
☐ 5. all of the symptoms/disability

Are further investigations required?	☐ Yes ☐ No

Have all reasonable steps been taken to alleviate remaining symptoms/disability? ☐ Yes ☐ No If no, please elaborate

Is a full recovery expected?	☐ Yes ☐ No
Estimated time period to full recovery	
Are late complications expected?	☐ Yes ☐ No
Are further Specialist reports recommended?	☐ Yes ☐ No

General Comments and Observations

Completed by

Name	
Address	
Qualifications	

Declaration

The completing expert undertakes that he/she is independent and under no duty to any party paying their fee for this report.

Signature	
Completion Date	

Appendix 6: Final PIC Medical Report Template/ Neck Disability Index (continued)

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and **mark in each section only the one box that applies to you**. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1: Pain Intensity

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Reading

- ☐ I can read as much as I want to with no pain in my neck
- ☐ I can read as much as I want to with slight pain in my neck
- ☐ I can read as much as I want with moderate pain in my neck
- ☐ I can't read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all

Section 5: Headaches

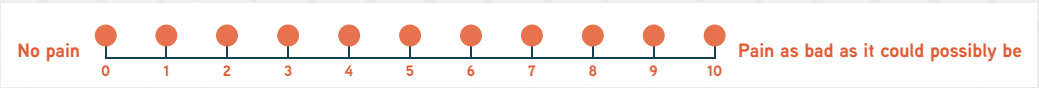
- ☐ I have no headaches at all
- ☐ I have slight headaches, which come infrequently
- ☐ I have moderate headaches, which come infrequently
- ☐ I have moderate headaches, which come frequently
- ☐ I have severe headaches, which come frequently
- ☐ I have headaches almost all the time

Section 6: Concentration

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

Visual Analogue Scale (VAS) for pain

The VAS for pain consists of a 10cm line with two end-points representing 'no pain' and 'pain as bad as it could possibly be'. Patients with WAD are asked to rate their pain by placing a mark on the line corresponding to their current level of pain. The distance along the line from the 'no pain' marker is then measured with a ruler giving a pain score out of 10.



Personal Injuries Commission

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