FAIR AND EQUITABLE COMPENSATION OF NON-PATRIMONIAL DAMAGES SUFFERED IN MOTOR VEHICLE ACCIDENTS – PSYCHOLOGICAL TRAUMA

Introduction

Historically, claims for compensation for non-patrimonial losses have been based on medical evidence confirming pain and suffering, and the reasonableness of the claim in that regard (nexus between the accident and symptoms). Indeed, the prescribed procedures, including documentation to be completed in support of claims against the RAF, are explicit with regard to the "medical" information required.

The unintended consequence of this is that there is not formal acknowledgement of the fact that victims of motor vehicle accidents may not only suffer physical injuries with psychological concomitants, but may also suffer psychological "injuries" in the absence of physical injuries. Consequently, victims of motor vehicle accidents who have suffered psychological injury without physical injury have been compelled to somaticize in order to claim physical injuries which would then facilitate the process of claim. This clearly places the burden on those healthcare practitioners who are encumbered with consultation because of the unintended consequences of the articulation of legislation. In other words, victims of motor vehicle accidents had to claim physical symptoms in order to access compensation, even when those physical symptoms were offered as an analogue for psychological injury; for example, the victim claiming lower back pain or persisting post-concussion syndrome, when those claims were clearly disproportionate with any injuries that may have been suffered in the accident under consideration.

Progressive practice has recognised that pain and suffering comprises both physical and psychological components, and the complex interaction between these. As a consequence, that interaction has been at least implicitly acknowledged and considered in the awarding of non-patrimonial damages.

However, the preponderance of evidence required in support of such claim has come from the medical experts. The courts appeared generally to have been guided by that evidence, and in doing so has accepted a pragmatic and broad definition of "medical" expertise to include not only that of medical practitioners, but also ancillary (paramedical) healthcare professionals and clinical psychologists, who are not ancillary healthcare professionals but healthcare professionals of first instance.

However, with the advent of the RAF Amendment Act 19 of 2005, which came into operation on 01 August 2008, the Courts have been conservative in definition of the

term "*medical practitioner*". Such interpretation has resulted in increased burden on "those who are registered with the Health Professions Council of South Africa as medical practitioners" and who now, pragmatically, are required to act as gatekeepers for the expert opinion of not only ancillary healthcare professionals, but also for clinical psychologists.

The paradoxical effect of this is that rather than reducing costs of expertise in the case of victims of motor vehicle accidents who have suffered psychological injury without physical injury, costs are increased because the victim has to access medical opinion as well as clinical psychological opinion.

A proposed solution; the parallel pathway

The existing process for identifying, validating and quantifying non-patrimonial losses suffered by victims of motor vehicle accidents and who have suffered physical injury as well as psychological injury is in the process of revision. The proposed revision has process integrity, and is supported by the appropriate systems.

However, that process is inappropriate for victims of motor vehicle accidents who have suffered psychological injury without physical concomitants. To illustrate (graphically), a young mother is the driver of a motor vehicle that is involved in a collision. She does not suffer physical injury, apart from possibly some muscle stiffness because of the force of impact. However, her child who is a restrained passenger in the motor vehicle suffers critical injuries in that accident. The mother not only witnesses her severely injured child, but is powerless to intervene and save that child's life. She has to stand by and watch as her child dies. She is profoundly traumatised and consults with a clinical psychologist in order to address the critical incident stress and, potentially, post-traumatic stress disorder. She undergoes appropriate psychotherapy, and clinical evaluation is that she does not require management by medical professionals. Notwithstanding appropriate psychotherapy, she remains symptomatic.

Current legislation and conservative interpretation of that legislation requires that in order to submit a claim she would have to consult with a medical practitioner who would then complete and submit the required documentation to the RAF. That medical practitioner would probably recommend clinical psychological opinion, which would then be submitted to the RAF. Current legislation does not allow for a clinical psychologist to submit founding documentation in support of claims against the RAF.

While revision of, or amendment to, current legislation would align intent and process, provision must be made for founding clinical psychological opinion in support of claims

against the RAF and where the victim has not suffered physical injury to be submitted to that institution.

Proposed process

1. Motor vehicle accident:

    1.1. With no physical or psychological injury: No claim - process stops
    1.2. With physical injury and possibly psychological "injury": continue in prescribed medical process
    1.3. Without physical injury, but with psychological "injury": enter into parallel claim process for non-pecuniary damages

2. Clinical psychological claim process:

    2.1. Consult with clinical psychologist
    2.2. Clinical psychologist completes and submits "Initial Clinical Psychological Report", including making recommendations for further management
    2.3. Clinical psychologist completes and submits "Progress Clinical Psychological Report"
    2.4. Clinical psychologist completes and submits "Outcome Clinical Psychological Report"
    2.5. This process does not require that the same clinical psychologist examines, treats or reports on the initial, progress and outcome status of the victim of the road accident
    2.6. this process also assumes appropriate professional management of the victim of the road accident

Information required in the Initial Clinical Psychological Report

1. Appropriate demographic detail

    1.1. Name(s)
    1.2. Surname
    1.3. Date of birth
    1.4. Identity number

2. Date of consultation

3. Accident detail

    3.1. Date
    3.2. Time

4. Particulars of the accident

    4.1. Whether victim was driver or passenger
    4.2. Number of occupants in the vehicle
    4.3. Relationship of occupants to victim
    4.4. Nature and severity of injuries sustained by occupants of the vehicle
    4.5. Nature and severity of injuries sustained by other victims of the accident

5. Description of psychological sequelae of the accident

    5.1. At the accident scene
    5.2. within the 1st 72 hours
    5.3. progression of sequelae
    5.4. accessing appropriate counselling/intervention

6. Clinical psychological assessment of the victim

7. Referral as indicated

8. Identifying detail of the clinical psychologist

    8.1. Signature
    8.2. Full names
    8.3. Professional registration number
    8.4. Practice registration number

Information required in the Progress Clinical Psychological Report

1. Appropriate demographic detail

    1.1. Name(s)
    1.2. Surname
    1.3. Date of birth
    1.4. Identity number

2. Date of consultation

    2.1. If possible, the number in the sequence of progress evaluations

3. Accident detail

    3.1. Date
    3.2. Time

4. Particulars of the accident

    4.1. Whether victim was driver or passenger
    4.2. Number of occupants in the vehicle
    4.3. Relationship of occupants to victim
    4.4. Nature and severity of injuries sustained by occupants of the vehicle
    4.5. Nature and severity of injuries sustained by other victims of the accident

5. Description of psychological sequelae of the accident

    5.1. At the accident scene
    5.2. within the 1st 72 hours
    5.3. progression of sequelae - how have the nature and severity of sequelae changed since the last report was completed? (Resolution/recovery, improvement, deterioration, new symptoms)
    5.4. impact of appropriate counselling/intervention, if accessed

6. Clinical psychological assessment of the victim

7. Referral as indicated

8. Identifying detail of the clinical psychologist

    8.1. Signature
    8.2. Full names
    8.3. Professional registration number
    8.4. Practice registration number

Information required in the Outcome Clinical Psychological Report

1. Appropriate demographic detail

    1.1. Name(s)
    1.2. Surname
    1.3. Date of birth
    1.4. Identity number

2. Date of consultation

    2.1. Identify whether initial and progress reports have been perused
    2.2. if these have, specify which reports have been perused

3. Accident detail

    3.1. Date
    3.2. Time

4. Particulars of the accident

    4.1. Whether victim was driver or passenger
    4.2. Number of occupants in the vehicle
    4.3. Relationship of occupants to victim
    4.4. Nature and severity of injuries sustained by occupants of the vehicle
    4.5. Nature and severity of injuries sustained by other victims of the accident

5. Description of psychological sequelae of the accident

    5.1. At the accident scene
    5.2. within the 1st 72 hours
    5.3. progression of sequelae - how has the nature and severity of sequelae changed since the last report was completed? (Resolution/recovery, improvement, deterioration, new symptoms)
    5.4. impact of appropriate counselling/intervention, is accessed

6. Clinical psychological assessment of the victim

7. Residual sequelae manifest at the outcome assessment:

   7.1. Description of persisting sequelae

   7.2. Severity of “permanent” sequelae* on the victim’s ability to maintain appropriate:

      7.2.1. Domestic, academic or employment autonomy
      7.2.2. relationships with family, friends, acquaintances and contacts

   7.3. Need for further therapy/counselling

   7.4. Future vulnerability

8. Identifying detail of the clinical psychologist

   8.1. Signature
   8.2. Full names
   8.3. Professional registration number
   8.4. Practice registration number

* these “permanent” sequelae would then form the basis of calculation of quantum