Monthly General Meeting - Second Saturday of each Month

The
Returned and Services League of Australia

TERRIGAL WAMBERAL RSL SUB BRANCH

Address all Correspondence to Honorary Secretary

President: Peter White
Hon. Secretary: David Ferry
Hon. Treasurer: Simon Averell

64 Dover Road WAMBERAL NSW 2260
Phone: (02) 4384 2661
Email: rsl@breakerscc.com

15 April 2018

Compensation and Rehabilitation for Veterans
Productivity Commission
GPO Box 1428
Canberra City ACT 2604

Veterans Compensation and Rehabilitation inquiry

1. My name is William Forsbey and I am an Advocate Level 4 with the Terrigal Wamberal RSL Sub Branch and I would like to make a submission (Attachments 'A' and 'B') to the subject inquiry.

2. My submission addresses the terms of reference in relation to DVA's handling of claims by veterans, particularly in regards to DVA use of Departmental Medical Advisors (DMA) and/or Contracted Medical Advisors (CMA).

3. If there is any further information required regarding my submission, please contact me as indicated below.

Regards,

William Alan Forsbey
Advocate Level 4
Terrigal Wamberal RSL Sub Branch

Attachments 'A' and 'B'

List of DMA Issues

The following paragraphs outline some of the issues involving the Department's increasing reliance on Departmental Medical Advisors (DMA).

1. Veteran 1 Tinnitus Assessment

A DMA determined that veteran's tinnitus was "*Tinnitus every day, but tolerable for much of the time*" despite veteran stating his tinnitus was "*Very severe tinnitus, present every day, causing distraction, loss of concentration and extreme discomfort, and regularly interfering with sleep*". DMA did not have any medical or other documents to support his change to the veteran's statement. Furthermore, the severity of tinnitus can ONLY be determined by the veteran. There is no medical procedure that can determine the severity of tinnitus.

2. Veteran 2 Clinical Onset and Back Assessment

Despite medical reports from the veteran's treating doctor's that included an orthopaedic specialist, the DMAs refused to accept these reports regarding onset of osteoarthritis. Furthermore, a Contracted Medical Officer has altered the medical impairment assessment provided by an orthopaedic specialist. The orthopaedic specialist completed an Upper Limb Conditions Medical Impairment Assessment on 7 June 2016. In paragraph 7, "Describe his overall ability to use his upper limbs", "Right Upper Limb", the orthopaedic specialist selected the following description "uses right limb inefficiently in all circumstances". In the Combined Impairment Report dated 4 July 2016 prepared by Contracted Medical Officer, it has been altered this to read "Can use limb reasonably well in most circumstances, but frequent difficulties are manifested by:

- minor loss of digital dexterity causing handwriting changes, or difficulty in manipulation of small or fine objects, and
- minor loss of grip strength causing difficulty in gripping moderately heavy to heavy objects".

This is a complete contradiction to the signed assessment provided by the orthopaedic specialist.

This alteration meant the veteran was assessed at 60% Degree of Incapacity instead of 90% Degree of Capacity. The initial application was lodged on 7 January 2015. It was finally settled on 16 August 2016.

3. Veteran 3 Back Assessment

The veteran's treating doctor provided a Medical Impairment Assessment – Cervical Spine Condition dated 13 November 2015. In this report the doctor clearly stated that the Cervical Spondylosis effected the use of his Right Upper Limb stating "*Can use limb reasonably well in a few circumstances only*". The DMA who provided the Combined Impairment Report dated 16 June 2016 completely ignored this statement by the treating doctor and did not assess the effect of the Cervical Spondylosis on the Upper Limbs. It is worth noting that the DMA used GARP 5 despite the fact that GARP 5 was replaced by GARP 2016 as of 1 April 2016. GARP 2016 clearly states at Chapter 3, Impairment of Spine and Limbs, Part 3.3 Spine, page 82, The assessment

of other effects of spinal conditions, that "If a spinal condition causes an effect on limb function, then that effect on limb function is also to be assessed under Parts 3.1 or 3.2". This was not done to the detriment of the veteran.

4. Veteran 4 Diagnosis

The delegate requested a X-ray report and forwarded the X-ray report and associated medical evidence to a Departmental Medical Advisor. The DMA made the following statement "Morton's Neuroma is unconfirmed on imaging (X-ray left Foot, dated 16 February 2016)". A simple search of the Internet at websites such as the Mayo Clinic and the American Orthopaedic Foot & Ankle Society state that X-rays are used to rule out other causes and that a thorough physical examination is required for diagnosis of Morton's Neuroma. Other imaging such as Ultrasound and MRI are may be useful. The DMA should have recommended a thorough physical examination by a podiatrist or orthopaedic specialist. Instead, the DMA made the following statement "*Based on Repatriation Medical Authority (RMA) opinion Metatarsalgia is not a disease or injury and as the aetiology of the Metatarsalgia is unconfirmed, there is no diagnosable condition*". The DMA completely ignored the provisional diagnosis made by the veteran's treating doctor which was "Morton's Neuroma". This opinion was also supported by

The RMA revoked the SoPs for Metatarsalgia, namely 39 and 40 of 1996, in March 2011. However, they did not revoke the SoPs for Morton's metatarsalgia, 92 and 93 of 2010. In SoP 93 of 2010, Section 3, Kind of injury, disease or death, (b) it states "*For the purposes of this Statement of Principles, "Morton's metatarsalgia" (also known as Morton's neuroma) means….*". Secondly, the DMA's statement that "*as the aetiology of the Metatarsalgia is unconfirmed, there is no diagnosable condition*" makes no sense. Given that "aetiology" (in medicine) means "the cause of a disease", it is incorrect to state that because I may not know the cause of disease, therefore there is no condition. A Podiatrist's report dated 18 March 2016 it is confirmed that veteran suffers from Planar Fasicitis and neuroma secondary to the Planar Fasicitis. The podiatrist also confirmed that a X-ray is not a suitable form of imaging for a soft tissue condition.

The initial claim was submitted on 22 July 2015. The claim was rejected on 26 February 2016, based on the DMA's comments, and is now the subject of a VRB appeal.

5. Veteran 5 Diagnosis Memory Impairment

A medical opinion dated 9 July 2015 was provided by DMA stating "*Psychiatrist in his report dated February 2015 diagnoses Chronic Major Depression. Memory problems can be a symptom of major depression. Psychiatrist report does not mention any cognitive impairment.*" The psychiatrist in his report dated February 2015 clearly stated "*In summary, in my opinion as a result of his exposure to the above mentioned toxins veteran suffers from severe chronic Major Depression. In addition as a result of this exposure he suffers from memory impairment*". Further, the psychiatrist had made numerous references in his report to veteran's cognitive impairment at paragraph 3, paragraph 4, sub-paragraph 4, paragraph 10 and the last paragraph. This is a gross misrepresentation of the psychiatrist diagnosis.

6. Veteran 6 Assessment

I have attached a document (Attachment 'B') that outlines the issues in the assessment of veteran's Back conditions. Once again it involves DMAs ignoring or altering the diagnosis provided by treating doctor or specialist.

As it can be seen from the above there are serious issues involved in the Department's almost total and unwavering reliance on the opinion of DMAs. In all of the cases above the Australian Health Practitioner Regulation Agency indicates that the DMAs referred to are registered as General Practitioners with no other specialist qualifications. However, these DMAs are overriding the diagnosis provided by veterans' treating doctors and specialists and in some cases shown are altering or ignoring medical assessments provided by these doctors and specialists. Furthermore, these DMAs are making these changes without having physically examined the veterans.

The Medical Board of Australia has a code of conduct for doctors entitled "Good medical practice: a code of conduct for doctors in Australia". It is my belief that the Department's DMAs are in breach of this code of conduct. The areas of concern are:

a. **Chapter 8, Professional Behaviour, 8.7 Medico-legal, insurance and other assessments**. In sub paragraph 8.7.1 there is a statement *"……and ensuring that you have the person's consent*". I do not believe that the Authorization Consent that accompanies claims stating "*I authorise the Department of Veterans' Affairs to obtain medical/psychological, clinical, employment or other information about me from Service Health Centres, medical practitioners, hospitals, clinics, insurance companies, Australian Government Departments or Agencies, or other organisations in relation to this claim or its review*" could be seen as the veteran giving consent to a particular doctor to perform a medical assessment or diagnosis. This is especially so given that sub paragraph 8.7.2 states "*Explaining to the person your area of medical practice, your role, and the purpose, nature and extent of the assessment to be conducted*". I have rarely, if ever, seen a DMA report that states that the DMA has advised the veteran of their area of medical practice or that they have sort consent from the veteran. The veterans are not even provided with the name of the DMA making the diagnosis.

b. **Chapter 8, Professional Behaviour, 8.8 Medical reports, certificates and giving evidence.** In Sub paragraph 8.8.1 it states "*Being honest and not misleading when writing reports and certificates*". At sub paragraph 8.8.2 it states further "*Taking reasonable steps to verify the content before you sign a report or certificate, and not omitting relevant information deliberately*". Finally, at sub paragraph 8.8.4 it states "*Making clear the limits of your knowledge and not giving opinion beyond those limits when providing evidence*".

c. **8.11 Conflicts of interest**. The fact that DMAs are contracted by the Department of Veterans' Affairs could been seen as a conflict of interest and not in the best interest of the veteran.

d. **<u>8.12 Financial and commercial dealings</u>**. Sub paragraph 5 is of interest stating "*Being transparent in financial and commercial matters relating to your work, including in your dealings with employers, insurers and other organisations or individuals*".

<u>List of DVA Delegate Issues</u>

7. Veteran 7 Depression and Panic Disorder Decision

In their Reasons for Decision, page 2, "*Evidence considered*" the delegate has included a "*Veteran's Review Board Decision dated 22 July 2015*". I am not sure which case that particular VRB Decision referred to but it is not the case regarding veteran's Social Anxiety Disorder appeal. The published VRB decision in veteran's case is dated 21 December 2015.

In their Reasons for Decision, page 2, "*Rejection of Liability: Depression Panic Disorder*", paragraph 3, the delegate states "*The date of onset for your conditions have not been determined by psychiatrist*". This is incorrect. In the Injury and Disease Detail Sheets for Depression and Panic Disorder (These documents are mentioned in "*Evidence Considered*") the psychiatrist has clearly stated the onset date on page 2 of each form.

In their Reasons for Decision, page 4, paragraph 5 the delegate states "*In their decision, the VRB accepts your aggravation of social anxiety as an aggravation of signs or symptoms under section 30 of the Military Rehabilitation and Compensation Act (MRCA). The VRB also states that diagnosed condition of social anxiety disorders was onset prior to you commencing within the ADF service. However they acknowledge that aggravation of this condition was due to formal investigations at RAAF Base Tindal in 206/2007*". Once again, this is incorrect. In the published VRB decision dated 21 December 2015, Determination and Reasons, paragraph 24 states "*In her report of 14 October 2015 the psychiatrist stated that the underlying pathology of his social anxiety was subsequently aggravated during his time at Tindal in 2006/2007 where there was a significant worsening of pathology*". Furthermore, at paragraph 33 the Board states "*The Board sets aside the determination under review and substitutes its determination that liability is accepted for social anxiety disorder under section 23(1) of the MRCA*". Section 23 (1) of the MRCA states:

> "*The Commission must accept liability for an injury sustained, or a disease contracted, by a person if:*
> *(a) the person's injury or disease is a service injury or disease under* ***<u>section 27</u>****; and*
> *(b) the Commission is not prevented from accepting liability for the injury or disease by Part 4; and*
> *(c) a claim for acceptance of liability for the injury or disease has been made under section 319*".

The above clearly indicates either incompetence or a lack of appropriate training.

8. Veteran 6 Original Lumbar Decision

In the Decision Letter the delegate stated that the determination was made using Statement of Principles, Instrument Number 63 of 2014 (Balance of Probabilities). The delegate set out the factors known to contribute to the condition as:

- Carrying or lifting loads while bearing weight,
- Lumbar intervertebral disc prolapse,
- Trauma to the lumbar spine, and
- Flying aircraft as specified.

The first three factors are in SoP 63 of 2014. However, there is no factor "Flying aircraft as specified" in the SoP 63 of 2014. However, there is a factor 6(l) that states "flying in a powered aircraft as operational aircrew, for a cumulative total of at least 2 000 hours within the 25 years before the clinical onset of lumbar spondylosis". Operational aircrew now includes all other operational aircrew in addition to pilots and co-pilots, but still excludes persons who were passengers only. [redacted] was operational aircrew on C130H Hercules aircraft.

The SoP 63 of 2014 was amended on 2 July 2014 when factor 6(l) was revised from "*Flying aircraft as specified*" to read "*flying in a powered aircraft as operational aircrew…….*". As a result of this error the veteran was forced to lodge an appeal against the decision to reject his claim. Once again the above clearly indicates either incompetence or a lack of appropriate training.

I have highlighted two cases above regarding issues with delegates competence and/or training. I have had quite a few cases were delegates have quoted incorrect or old SoPs and also assessed Factors which are not in the current SoPs.

Impairment Assessment
Lumbar Spondylosis

1. The Guide to Assessment of Rate of Pension (GARP) 2016 outlines the procedures for assessing the impairment of various body systems. In the case of the above conditions Chapter 3 – Impairment of Spine and Limbs, Part 3.3 Spine, is applicable.

2. The Combined Impairment Assessment Report dated 30 June 2016 was completed by DMA [redacted]. DMA [redacted] indicated that a Medical Impairment Assessment by Doctor [redacted] dated 25/06/2015 was used in this report. A Workability Report dated 10 June 2015 by Doctor [redacted] was not provided to DMA [redacted]

3. It is worth noting that Doctor [redacted] has contradicted himself in is Medical Impairment Assessment dated 25/06/2015. On page 3, A. SUMMARY AND ASSESSMENT, sub paragraph 3.1, Range of movement, he stated that Flexion 50 degrees, extension 5 degrees, rotation and lateral left and right 20 degrees. In Chapter 3 of GARP, Table 3.5.1, AVERAGE RANGES OF JOINT MOVEMENTS, shows that the Thoraco-Lumbar Flexion is 90 degrees and extension is 30 degrees. This would equate to a loss of movement of about half of normal range of movement. This is supported by Doctor [redacted] in his Workability Report dated 10/06/2015 and by Professor [redacted] in the attached report dated 25/08/2016. There is an unsigned Thoraco-Lumbar Spine Condition Medical Impairment form included with Doctor [redacted]'s report where at paragraph 6, "*Is there restriction of range of thoracolumbar spinal movement?*". The box "*minor loss*" is ticked. DMA [redacted] has ignored the assessment in the signed section of Doctor [redacted]'s report and did not assess LOSS OF MUSCULOSKELETAL FUNCTION: SPINAL MOVEMENT as per Table 3.3.1.

4. At page 2 of the Interim Combined assessment report Spine and Limbs – Lower Limbs/Sciatica, DMA [redacted] has failed to assess the Loss of Function from Table 3.3.2. In his assessment report dated 25/06/2015, Doctor [redacted] indicated On page 3, A. SUMMARY AND ASSESSMENT, sub paragraph 3.2 Pain – Including resting joint pain that rest pain is minimal. Pain when sitting is up to 7/10. This supported by Doctor [redacted] on page 4 of his Workability Report.

5. At page 2 of the Interim Combined assessment report Spine and Limbs – Lower Limbs/Sciatica, LOSS OF MUSCULOSKELETAL FUNCTION AFFECTING LOWER LIMBS, DMA [redacted] indicated "*walks in a manner normal for age on a variety of different surfaces*". In an unsigned Lower Limb Spine Condition Medical Impairment form included with Doctor [redacted]'s report at paragraph 4, "*Does he require the support of one or both hands to rise from the sitting position?*". The box "Yes" is ticked with the qualification "*He requires the support of one hand*". Reference to Table 3.3.2 indicates an impairment rating of 20 points.

6. The correct assessment of the Thoraco-lumbar spine for veteran should be as follows:

Table 3.3.1	Loss of about half of normal range of movement	20 points
	Aged Adjusted Score	18 points

Loss of Musculoskeletal Function (Based on Use of Spine)

Table 3.3.2 Thoraco-lumbar spine condition generally causes pain or undue fatigue within half an hour, and so requires frequent changes of posture.

10 points

Adjusted Score 9 points

Take highest of 3.3.1 and 3.3.2 18 points

Loss of Musculoskeletal Function Affecting the Lower Limbs

Table 3.2.2 is unable to rise from the sitting position without the assistance of one hand. (No age adjustment)

20 points

Resting Joint Pain

Table 3.4.1 Pain in any joint, or combination of joints, that is often present at rest but which is mild. (No age adjustment)

2 points

7. Based on the above the correct Combined Impairment for veteran is as follows:

Hearing and Tinnitus	5 points
Spine and Limbs – Thoraco-Lumbar Spine	18 points
Lower Limbs	20 points
Spine and Limbs-Resting Joint	2 points
Emotional and Behavioural	48 points

Total Impairment (rounded): 70 points