The Permanent Disability Evaluation Schedule

BC BUILDING TRADES' POSITION

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Half measures which mitigate but do not remove injustice are, in my judgment, to be avoided. It would be the gravest mistake if questions were to be determined not by a consideration of what is just to the workingman, but of what is the least he can be put off with.

William Ralph Meredith, C.J.O., Commissioner

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Introduction

The BC Building Trades appreciates the opportunity to provide the Workers' Compensation Board with feedback respecting the proposed changes to the Permanent Disability Evaluation Schedule ("PDES"). Given that the PDES is the main methodological tool used by the Board to assess workers' permanent disabilities so as to be able to attach a financial value to them, the Board's proposal to revise this regime is exceedingly important to the Council and its members.

While some of the Board's proposed changes such as incorporating new conditions as well as raising some of the award amounts may improve the existing disability evaluation regime, we think the Board's overall proposal fails to address the key problems with the existing system. Despite the Board's statement about undertaking "a comprehensive review" of the PDES to ensure its effective practice, despite the Core Review recommending a comprehensive review ten years ago, a comprehensive review has yet to be done.

Contrary the Board's assertion, a comprehensive review of the scientific literature reveals that the permanent functional impairment ("PFI") method (aka range of motion ("ROM") method), fails to adequately compensate injured workers for their impairment and loss of earnings. This is critically important because a large segment of the Board's disability assessments are based on the PFI methodology. Given this situation, the Building Trades recommends the following to remedy this situation:

- make impairment on earning capacity the primary method of compensating for permanent disabilities in keeping with section 23(1) and 23(2) of the *Workers Compensation Act*;

- develop an assessment methodology that relies predominantly on a diagnostic based impairment approach similar to the American Medical Association ("AMA") Guide, 6th Edition;
- minimize the use of the PFI/ROM methodology in disability assessments and awards;
- establish internal as well as external mechanisms to ensure medical assessments are performed properly;
- make the necessary policy, procedural, and structural changes to ensure the scientific underpinnings of the new diagnostic assessment approach keeps abreast of medical developments;
- empower third party psychological PFI assessors, not the Psychological Disability Award Committee ("PDAC"), to rate the severity of psychological impairments; and
- implement a schedule of comprehensive reviews every two years.

Issue 1: Current Review of the PDES

The Board has offered two options for consideration with respect to the PDES, namely, the status quo or the adoption of their proposed changes to the PDES. The Board should not limit their options in this fashion. We have already waited far too long for this consultation and endured the draconian changes of 2002 for over a decade. There must be a third option that addresses the fundamental shortcomings of the existing system in a comprehensive manner.

While six Canadian jurisdictions use schedules based on the guidelines developed originally by Dr. Bell, five Canadian jurisdictions have adopted a version of the American Medical Association ("AMA") Guides. In their discussion paper the Board notes that there is ongoing disagreement in the medical literature as to whether the PDES or the AMA Guides' method is the most reliable. The paper goes on to note that it is the consensus of the Disability Awards Medical Advisors ("DAMAs") that the range of motion method used in the PDES is the "gold standard". We disagree with the DAMAs' opinion.

There is no gold standard. If one is to exist, the Board must develop an evaluation regime that addresses the myriad shortcomings of the PDES and employs a diagnostic approach similar to that used in the AMA Guides. The fact that the *Workers Compensation Act* circumscribes the Board to compiling "a rating schedule of percentages of impairment of earning capacity" should not be used as a subterfuge preventing the Board from implementing an AMA-like diagnostic approach if it provides a more effective evaluative method in particular contexts. If legislative amendments are needed to repair the problems with the existing assessment process, those amendments should be sought. And on the topic of legislative language supporting "a rating schedule of percentages of impairment of earning capacity", it should be noted that existing functional disability awards, scheduled and unscheduled, *do not* measure the impairment of earning capacity. That is to say, the Board's *existing policy and practice* of assessing and granting disability awards contravenes the *Act*. This illegitimate policy and practice must stop, and impairment of earning capacity should be made the primary method of compensation in keeping with the statute.

Existing Evaluation Approaches – PDES & AMA

In their discussion paper the Board describes the three different approaches for assessing disability in the PDES and the AMA Guides 6th, 5th, and 4th editions. Those unfamiliar with these methods will gain from a reiteration of that section of the paper.

> Under the PDES used in British Columbia, permanent partial disabilities of the upper extremity, lower extremity, hands and the spine are frequently rated using the range of motion method. Under this method, disability is assessed by comparing a worker's post-injury range of motion to either the range of motion on the worker's uninjured side or scheduled normal range of motion of motion values if there is pathology on the opposite side.
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> In 1993, the AMA Guides edition introduced the DRE method. The DRE method permits the assignment of an impairment rating based primarily on diagnosis, even if maximal medical improvement has not been reached. The AMA Guides 4th edition provided that the range of motion method is to be used when no categories from the DRE method are available, or in close cases to help an evaluator place a patient in the appropriate DRE category. The DRE method continued to be used in the AMA Guides 5th edition.

The AMA Guides 6th edition introduced the DBI method. It is similar to the DRE method insofar as diagnosis is the basis for the rating; however, the rating can be modified to permit information relating to functional status, physical examination findings, and the results of clinical testing to be considered. The rationale for moving away from range of motion assessment is stated in the AMA Guides 6th edition as follows:

> ...Range of motion is no longer used as a basis for defining impairment, since current evidence does not support this as a reliable indicator of specific pathology of permanent functional status. However, range of motion may be used to monitor clinical progress in individuals. The rationale for changes from previous rating methods is to standardize and simplify the rating process, to improve content validity, and to provide a more uniform methodology that promotes greater interrater reliability and agreement.

Problems with the Range of Motion Methodology

Not only is the range of motion ("ROM") assessment method not the gold standard, current medical literature indicates that it is ineffective in measuring a worker's level of impairment. For example, in their research published in *Lumbar Spine Range of Motion as a Measure of Physical and Functional Impairment* (Clinical Rehabilitation, 1999, June 13(3):211-8), Nattrass et al. found that "range of motion measurement methods demonstrated poor validity and do not bear any consistent relationship to the level of physical or functional impairment in subjects with chronic low back pain". Their study was based on a volunteer sample of 34 subjects, 21 females and 13 males, with a mean age of 47.7 years and 40.1 years, respectively. Subjects had chronic low back with or without pain for at least six months duration. Lower back range of motion was measured with a long arm goniometer and dual inclinometer, Waddell Physical Impairment Scale, Waddell Disability Index, and Oswestry Disability Index. The authors ultimately concluded that "there was no evidence for a relationship between low back range of motion and impairment, and thus it would appear illogical to evaluate impairment in chronic low back pain patients using a spinal range of motion model when aiming to measure or compensate disability".

In a study entitled *A Comparison of Lumbar Range of Motion and Functional Ability Scores in Patients with Low Back Pain: Assessment for Range of Motion Validity*, the objective was to quantify the links between lumbar range of motion and scores obtained from functional evaluation tests (Parks, K.A., et al., Spine (Phila Pa 1976) 2003 February 15: 28(4):380-4). Following his review Parks concluded that "the relation between lumbar range of motion measures and functional ability is weak or nonexistent". This study involved 18 workers with chronic low back pain referred to a rehabilitation centre for determination of compensation and fitness for return to work. Using a three-dimensional lumbar motion instrument, the lumbar range of motion was measured. Moreover, standard functional tests were performed for each patient. Comparisons were then made between all the lumbar range of motion values and functional test scores.

In a study performed at the Department of Physical Therapy at Virginia Commonwealth University in the United States, medical researchers unearthed some interesting facts about the effect of age and gender on lumbar sagittal plane range of motion. Using an inclinometer to measure the lumbar range of motion in 1126 healthy male and female volunteers, Sullivan et al. found distinct differences existed between men and women in flexion angle and extension angle, whereas little differences existed between genders for total lumbar sagittal range of motion. Moreover, total sagittal range of motion, flexion angle, and extension angle declined as age increased. Due to the high degree of variability in the measurements, using range of motion to detect impairment was deemed problematic. (*The Influence of Age and Gender on Lumbar Spines Sagittal Plane Range of Motion: A study of 1126 Healthy Subjects*, Sullivan et al., Spine (Phila Pa 1976), 1994 March 15:19(6):682-6.)

Zuberbier et al. undertook research to determine the utility and feasibility of using the AMA Guides range of motion lumbar impairment ratings. The study found that under normal conditions of range of motion measurement, 33% of three consecutive lumbar flexion and 27% of three consecutive lumbar extension measurements failed the lumbar range of motion validity check. Furthermore, from three different experimental sessions (each with more than three consecutive lumbar range of motion measurements taken) only 15 participants (33%) had valid flexion scores and only 24 participants (53%) had valid extension scores across all three sessions. In conclusion the researchers opined that technical complications inherent in the range of motion-based impairment-rating model render the validity checks difficult to perform satisfactorily. As a result they were rarely used. (*Commentary on the American Medical Association Guides' Lumbar Impairment Validity Checks*, Zuberhier OA, et al., Spine (Phila Pa 1976), 2001 December 15:26(24):2735-7.)

But the ultimate death knell to using range of motion to measure impairment has recently emerged from no less than Robert D. Rondinelli, M.D., Ph.D., the Medical Editor for the AMA Guides to the Evaluation of Permanent Impairment, 6th edition. A faculty member for the American Board of Independent Medical Examiners Training Program for the AMA Guides 6th edition, co-director of the American Academy of Physical Medicine and Rehabilitation Disability Certification Program, and a recipient of the prestigious Walter Zeiter Award for his pioneering work in the area of disability assessment, Dr. Rondinelli's medical opinion with respect to disability assessment methodologies cannot be ignored.

Researched in the summer of 2013 and released to the workers' advocate community on POVNET in September 2013, the purpose of Dr. Rondinelli's report entitled *A Critical Review of Spinal Range of Motion as a Method of Assessment Permanent Back Injuries* was to review British Columbia's current and proposed PDES in light of the scientific literature and provide a comprehensive report evaluating its proposed method of assessing permanent back injuries.

Following his exhaustive study of the medical scientific literature (refer to Appendix A for the complete report), Dr. Rondinelli stated his professional opinion on the range of motion method for measuring impairment in no uncertain terms:

> At present, Spinal ROM enjoys historical precedent and traditional acceptance as the conceptual and operational lynch-pin of the BC WCB PFI rating system. It would appear that the major attractions of the ROM-based system for PIR include the objectivity of the measures themselves, and what appears to be their inherent functional base (validity), and their high levels of precision, reliability, and reproducibility. We have now reviewed the relevant body of available scientific literature as summarized above to assess the adequacy of spinal ROM according to these essential qualities of basic measurement theory. Based upon the above analysis one must conclude the following:

Lack of Validity: Spinal ROM has shown to lack validity as an indicator of spinal function for purposes of impairment rating. No clear-cut association between loss of spinal ROM and associated loss of functioning in terms of basic mobility and self-care activities can be shown to exist. The numerous confounder that potentially obscure any such relationship as might exist include, but are not limited to: lack of norms measured in terms of functional ROM as opposed to anatomical ROM (these are not equivalent entities); lack of accountability to the natural effects of aging on spinal ROM; lack of a consistent relationship between pain and ROM for acute and chronic LBP patients, respectively; and lack of predictive associations between loss of spinal ROM and loss of ADLs when such associations have been carefully examined.

Lack of Reliability and Reproducibility: Spinal ROM determined according to commonly accepted procedures and using surface goniometry and inclinometry measurement techniques, has been shown to lack the necessary and desired levels of reliability and reproducibility to reflect clinically significant differences in flexibility of the spine, even in the hands of highly trained raters following standard rating measurement procedures and using healthy, compliant subjects. The magnitude of potential measurement error is sufficient to raise doubts as to the credibility of any examiner's ability to correctly rate the impairment in a normal clinical setting. The potential confounders are numerous including (but not limited to) errors in identification of correct surface landmarks on repeated trials over time; errors in measurement due to choice of examination equipment and technique; errors in measurement due to lack of examiner proficiency; and response bias on the part of claimant or examiner.

Inadequate Feasibility and Ease of Application: Spinal ROM is problematic in terms of feasibility and ease of application. Standard procedures are technically difficult and time-consuming to apply correctly in a clinical setting, and frequently require multiple repetitions to satisfy "validation" methodology. As a result of time and energy constraints, these methodological requirements are typically bypassed and results are, therefore, being obtained incorrectly.

For the above reasons, spinal ROM should be abandoned in favor of other criteria of disablement which have demonstrated better sensitivity to functional loss; play more to the strengths of the physician examiner in terms of their diagnostic skill set; and which are methodologically transparent, efficient and easy to perform. (Underlining added.)

Given the above medical findings respecting the shortcomings of using ROM to measure impairment in general, and the recent exhaustive analysis performed by Dr. Rondinelli in particular, the BC Building Trades cannot support the Board's proposal to retain its PFI assessment methodology for a wide range of workplace injuries.

Looking Backwards

When we look back upon the road the Workers' Compensation System has travelled since the early 1940's and reflect upon the decisions made by the BC Liberal government following the release of the *Winter Report*, it is not surprising that the current disability assessment regime fails to properly compensate workers who have been injured on the job.

Every Royal Commission dating back to the early 1940's has considered WCB's pension system. Neither Justice Sloan in the 1940's and 1950's nor Justice Tysoe in the 1960s thought the permanent functional impairment ("PFI") system, independently and singularly applied, adequately compensated workers. Both recommended a "dual system" whereby workers would be assessed for a PFI as well as an LOE i.e., loss of earnings and, thereupon, would be granted an award in keeping with the assessment method that best compensated their loss. The dual system was ultimately adopted in 1973, and for almost thirty years the Board has assessed for pensions using both methods: PFI and LOE.

Following the victory of the BC Liberals in 2001, the government commissioned Alan Winter to conduct a review of the WCB compensation regime. Published in March 2002, Winter's *Core Services Review of the Workers' Compensation System* ("Winter Report") made myriad recommendations, many of which were reflected in Bill 49 in 2002. Although Winter had recommended many draconian changes already, the BC Liberals' legislative changes went far beyond them. In the context of compensation, while the dual system based its awards on the greater of the disabled worker's reduction of earning capacity and actual loss of earnings, the legislative and policy changes virtually eliminated the availability of pensions based on actual loss of earnings. This, as mentioned above, is contrary to section 23(1) of the Act which expressly states that permanent disability awards must be based on the impairment of earning capacity from the nature and degree of the injury, and section 23(2) which empowers the Board to compile a rating schedule of percentages of impairment of earning capacity for injuries.

The Core Review had not recommended such a change either. On the contrary, Mr. Winter suggested that the dual system be retained, and that Section 23(3) be interpreted to allow an LOE pension award, but only when it was "equitable" to do so. He also recommended the system of assessing permanent functional impairment (i.e., PFI) pensions be revised to reflect the current scientific literature. Thus a PFI would be the default pension, but the LOE pension would be awarded in cases where it was "fair" to do so. To accomplish this task the Core Review recommended the *Workers Compensation Act* not be amended; Winter also cautioned against the removal of the word "equitable" from Section 23 of the Act so as not to limit the Board's discretion to respond fairly to individual cases.

Be that as it may, when Bill 49 was promulgated, Winter's advisory with respect to compensation assessment had been jettisoned, the word and principle of equity was gone, and the "so exceptional" clause was ushered in to eviscerate loss of earning awards. This latter change was bolstered with an amendment that empowered the Board of Directors to make policy which was binding, similar to law, on all decision-makers at the Board and in the appeal system. Combined, these two draconian amendments ensured that workers would rarely meet the "so exceptional" criteria. Indeed, between February 2006 and June 2007 the Board considered 1,992 workers' claims for loss of earnings pensions, and 96%, that is 1,916 claims, failed to meet the LOE policy criteria. Yet out of the 76 claims that did meet the criteria, 68, that is 87%, were granted LOE pensions. Prior to the 2002 legislative changes, approximately 1,000 LOE pensions were awarded annually.

It is critically important to ponder this brief history of the WCB's disability assessment methods because, as Winston Churchill once said, "those who fail to learn from history are doomed to repeat it". Yet repeating the history of the post-2002 legislative changes respecting the use of the PFI assessment method is precisely what the Board is proposing we do. After repeated calls from a number of Royal Commissions in the 1940s, 1950's, and 1960's, the government finally introduced the dual system in 1973. *In essence, the adoption of the dual system was an acknowledgement that a singular PFI assessment methodology failed to compensate workers adequately in many circumstances.* The *Winter Report*, to repeat, recommended that the dual system be retained with changes and that the system for assessing PFI pensions (i.e., the

PDES) be brought up to date. Instead, the government chose to effectively eliminate loss of earnings pensions by bringing in the Section 23(3.1) "so exceptional" clause. And adding insult to injury, it chose not to undertake a comprehensive revision of the PDES.

As argued from the outset, the Board's PDES proposal is not based on a comprehensive evaluation of assessment methodologies and, as a result, it does not capture the myriad shortcomings with the PFI method. In contrast, Dr. Rondinelli and other researchers have undertaken a comprehensive analysis of the ROM method and found it ineffective for measuring impairment, particularly of the spine. Consequently, the BC Building Trades is of the view that we will not move *forward* until we move *past* the ROM/PFI assessment regime.

The Diagnostic Approach

The Building Trades acknowledges that there is no panacea when it comes to measuring a permanent impairment and assigning a quantitative value to it. There are problems with both the ROM method used in the PDES as well as the American Medical Association's diagnosis approach. But it is more potentially fruitful to rectify the shortcomings with the diagnostic method than to retain the current ROM method in the PDES. We are not suggesting the AMA Guides be adopted holus-bolus, but rather that they be employed as a template to develop a "made in BC" diagnostic approach.

Getting from Here to There

As the Board rightly notes in its discussion paper, "the evaluation of permanent physical and psychological disabilities requires consideration of both medical/scientific diagnostic criteria, as well as the experience-based judgment of the professionals who perform the evaluations". Heretofore the Board's review of the PDES has been led by a Senior WCB Disability Awards Medical Advisor (DAMA), a Supervisor in the Disability Awards Department, and members of the Policy and Regulation Division ("PRD"). Moreover, DAMAs with specialties in internal medicine, cardiology, respiratory conditions and ophthalmology have also been consulted. Based on their research and analysis, as well as further consultation with other DAMAs, Disability Award Officers, and various internal stakeholders, myriad issues were reviewed, proposed changes were identified, and the Board's discussion paper was released for stakeholder consultation.

To move forward with our recommended changes, we think the Board must seek external medical advice *outside* of the Board's own internal medical and policy professionals. In keeping with the general thrust of this submission, we take issue with some of the findings of the WCB officials; the lens through which the PDES/AFO review has been viewed is far too narrow and its remedy for its longstanding problems far too limited. The only remedy for this malady is a comprehensive review performed by third party reputable medical experts in the specialty fields at issue.

Critique of the Inter-jurisdictional Comparison

The discussion paper states that "a survey of other workers' compensation jurisdictions in Canada, the United States and Australia reveals that the ratings in the PDES and AFO are generally consistent with the ratings in those jurisdictions". Yet the Board admits that their inter-jurisdictional comparison "does not reflect the methodology behind the ratings". Indeed, they underline that:

> It is important to be aware that the majority of jurisdictions surveyed have their own unique approaches to administering workers' compensation benefits, and use the ratings in their schedules to provide compensation in different ways. For example, ratings may:
>
> - be used to assess different types of disability or impairment;
> - be applied to different amounts (from a worker's actual earnings to a set amount prescribed by statute); and
> - result in awards that are payable over varying time periods.
>
> In addition, jurisdictions vary in their approaches to adding vs. combining ratings, enhancement and devaluation.

The Board also distinguishes among the Canadian jurisdictions, noting that:

> The majority of Canadian jurisdictions provide a lump sum award for the non-economic effects of a permanent impairment (i.e., pain and suffering), and a

> loss of earnings award paid to age 65. In these jurisdictions, non-economic loss awards are calculated with reference to an impairment rating schedule.
>
> British Columbia, and the Northwest Territories and Nunavut use scheduled ratings to calculate permanent disability awards, which are intended to compensate for primarily economic losses. These awards are payable to age 65 regardless of actual loss of earnings, and no separate non-economic loss awards are available.

Given the significant differences in the variety of assessment methodologies throughout Canada, it is effectively impossible to make an inter-jurisdictional comparison. However, while we cannot generate a valid inter-jurisdictional comparison due to the variation in the provincial and territorial assessment methods, it is nonetheless instructive to explore the percentages allocated to similar impairments in the Board's *Comparison of Ratings in Workers' Compensation Jurisdictions (Appendix C)*. It is *instructive* because it illustrates a troubling arbitrariness in the nature of the ratings.

To compare the most "similar conditions", we scrutinized the Board's *Comparison of Ratings in Workers' Compensation Jurisdictions (Appendix C)* in conjunction with the *Inter-jurisdictional Comparison Explanatory Notes (Appendix D)*, and focused solely on those conditions that were not set out in the explanatory notes. We used this method to identify the "most similar" conditions because, according to page 1of the explanatory notes, "if the ratings for a particular condition can be compared in a straightforward manner and no explanation is required, that condition is not included".

Our review revealed that in many cases British Columbia's ratings are *less than* the ratings in other jurisdictions. Admittedly, again, this method of comparative analysis provides a most basic of comparisons, but it is still instructive. Unfortunately, we find there is no rhyme or reason for the different assessment percentages. And if the majority of the other jurisdictions or even a significant number of them provide higher permanent disability awards than British Columbia for a similar condition, we see no reason why our province should be on the lower rungs of the valuations. For example, if an amputation of a thumb's metacarpal is worth 4 percent in British Columbia and a higher percent in eight other jurisdictions, there is no reason for not raising the amount of the disability award, all things being equal. Furthermore, given the effective negation of actual loss of earning assessments resulting from the "so exceptional" test, the PDES ratings should be at the high end, not the low end, of the ratings because in all the other Canadian jurisdictions the assessment schedules are supplemental to an economic loss award that compensates for the impairment of earning capacity on an individual basis.

With reference to the Comparison of Ratings in Workers' Compensation Jurisdictions (Appendix C), the table below shows the differences between British Columbia's assessment percentages (current and proposed) and the basic average percentage for a "similar condition" in the other Canadian provinces and territories.

Item Number	Description of Item	BC Current PDES %	BC Proposed PDES %	Basic Average in Other Jurisdictions %
1	Shoulder Replacement arthroplasty pp.2	6.5	6.5	12
2	Elbow replacement arthroplasty pp.2	5.8	5.8	10
3	Thumb Metacarpal p3	4	4	5
4	Single Finger – Index pp.3	5	5	6
5	Single Finger – Distal Phalanx pp.3	1.6	1.6	2
6	Single Finder – Middle Phalanx pp.3	1.6	1.6	2
7	Single Finger – Proximal phalanx pp.3	0.8	0.8	1
8	Single Finger – Metacarpal pp.3	1	1	2
9	Long Finger – Metacarpal pp.3	1	1	1.5
10	Ring Finger – Distal Phalanx pp.3	1	1	1.2
11	Ring Finger – Middle Phalanx pp.4	1	1	1.2
12	Ring Finger – Proximal Phalanx pp.4	0.5	0.5	0.6
13	Four Fingers pp.4	34	34	38
14	Amputation – All Toes pp.5	5	5	7.5
15	Immobility of Joints – Ankle pp.6	12	12	15

16	Immobility of Joints – Triple Arthrodesis pp.6	7	7	7.5
17	Peripheral Nervous System Conditions – Long Thoracic Nerve pp.9	5	5	8
18	Cervical Spine – Impairment resulting from surgical loss of intervertegral disc pp.11	2 per level	2 per level	5 per level
19	Cervical Spine – Ankylosis (fusion) C1 to D1 including surgical loss of intervertegral disc pp.11	3 per level	3 per level	6 per level
20	Lumbar Spine – Up to 50 compression pp.12	0-2	0-2	2-4
21	Lumbar Spine – Over 50 compression pp.12	2-4	2-4	4
22	Lumbar Spine – Impairment resulting from surgical loss of intervertebral disc D12 to S1 pp.12	2 per level	2 per level	5 per level
23	Lumbar Spine – Ankylosis (fusion) D12 to S1 including surgical loss of intervertebral disc pp.12	4 per level	4 per level	7 per level
24	Visceral Loss/Surgical Conditions – Bilateral	10	10	15

Psychological Disability Award Committee – A Question of Expertise

The Psychological Disability Award Committee ("PDAC") is responsible for reviewing the medical evidence respecting psychological impairments of injured workers, and ultimately assigning a disability award. On every *PDAC Decision LTD Memo* one finds standard boiler plate language which eviscerates the value of recognized benchmark terms such as "mild" and severe" and empowers PDAC to interpret whatever section of the medical report narratives in whatever way they so desire for whatever purpose. The current PDAC boiler plate language reads as follows:

> The Psychological Permanent Disability Evaluation Schedule, approved as published policy, contains benchmark references, distinguished by the terms "mild", "moderate", "marked" and "extreme". These terms are used with reference to the internal structure of the Psychological Disability schedule, and for the sole purpose of determining the associated per cent of disability.

> One of the challenges PDAC faces is reconciling comments and opinions from subject matter experts where terms such as "mild", "moderate", and "severe" are used in the absence of common definitions. It is important to distinguish between the severity of the condition and the severity of the impairment. The Psychological Permanent Disability Evaluation Schedule is based on, but not identical to, the categories outlined in the American Medical Association Guides to the Evaluation of Permanent Impairment. These categories were modified during development of the Board's Psychological Permanent Disability Schedule. In addition, psychological disorders were typically diagnosed based on the Diagnostic and Statistical Manual of Mental Disorders including the Global Assessment of Functioning scale, which also uses the terms, "mild", "moderate", and "severe", but once again, with different definitions. The use of the term "significant impairment", for example, does not relate to a clinical rating scale, but most often is used to mean "clinically meaningful impairment", to distinguish it from normal fluctuations in functioning. <u>For these reasons, the PDAC relies more heavily on the details in the body of the report (the "narrative" referred to in this memo) than on single word descriptors typically used in the summary section of the report</u>. [Underlining added.]

The BC Building Trades is opposed to the ongoing practice of PDAC turning a blind eye to the established benchmark references and using their own interpretation of the narratives set out in the medical reports. We have witnessed the results of this "method" and they are not good; the workers' advocacy community possesses innumerable examples of PDAC's selective narrative analysis and bias that have resulted in inaccurate disability awards for severely mentally impacted workers. It is the third party psychological PFI assessors - those with independence and the necessary expertise - not PDAC, which should rate the severity of the psychological impairment. And they should do so with reference to the established diagnostic approaches such as the AMA Guides.

<u>Issue 2: Process for Ongoing Review</u>

The Building Trades is inclined to support a scheduled review process similar to that used in the Northwest Territories and Nunavut where they are conducted bi-annually on issues raised by claims staff, stakeholders and medical services. Specifically, we support a process of scheduled review in line with Option 2(c) but with the proviso that the "specified intervals" be every two years, not five years. A scheduled review every two years is appropriate because the proper evaluation of permanent impairments and the equitable provision of compensation is a central responsibility of the Board. This responsibility has been undermined because the Board has failed to update the PDES/AFO in a comprehensive fashion since the 1960s. It is for this reason that the Board is now faced with the herculean task of updating this evaluative regime.

Conclusion

This paper sets out the most salient concerns the BC Building Trades has with the Board's proposed changes to the PDES, and proposes a "different route forward" in the interests of working people. If the Board cannot find the requisite resources and resolve to pursue these much-needed changes, they should reintroduce the dual system which at least *attempted* to ameliorate the inequities in the existing system.

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