Assessment of Damages  
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The assessment of damages in the case of severe burns must include (1) acute care medical expenses, (2) rehabilitation needs, (3) psychological counseling for the victim and the family and (4) the vocational handicaps developed as a result of functional limitations. Too early assessment of damages should be avoided as severe contracture deformities may develop, later.

All of the tangible as well as intangible costs associated with burns must be carefully delineated. From the outset it is important to stress that an extensive burn clearly falls into the catastrophic profile. Extensive burn injuries represent a significant cost in acute care medical services and long-term rehabilitation needs. It is also critical that the counseling needs of a patient be considered along with the counseling needs of family members. The family undergoes significant psychological stress, which may range from worry for the patient to worry over financial limitations or guilt feelings over their reaction to the patient's cosmetic deformities. Consideration should be given to a combination of family counseling and education, individual counseling (where necessary) of family members in addition to the individual counseling given to the patient. Family education should focus on training the family members on how to provide for patient needs upon discharge while still reinforcing independence and the development of well behaviors.

Counseling intervention for the child must be provided not only at the time of injury, but also during critical periods of development in the future (i.e., when entering adolescence, age 12 to 14; during later adolescence male-female relationships develop-ages 16 through 18; and during adulthood, ages 21 to 25, as more involved interpersonal relationships become predominant). Even marriage counseling may be needed depending upon the severity of the child's functional limitations, cosmetic deformities and psychological restrictions.

Rehabilitation counseling when appropriately coupled with psychological counseling intervention can help the patient develop a significantly improved sense of self-worth, adequacy, and self-concept. It is critical, particularly in the cosmetically impaired patient that these areas be addressed and the patient be given the opportunity for successful experiences. More specifically, it is not sufficient to deal with these factors of inferiority, self-concept, self-worth and adequacy in the counseling relationship alone. It is critical that the patient have the opportunity to experience success in avocational pursuits, vocational pursuits, academic pursuits, and/or interpersonal relationships so that they can be used in the counseling process to build self-concept and self-worth. It is this combination of individual counseling by the psychologist and/or clinical counselor coupled with the active participation of the client in vocational rehabilitation which has the greatest potential for positive results and the development of adaptive behaviors.
By far the vast majority of burn patients, even those with cosmetic deformities, develop adequate defense mechanisms and are able to function appropriately in society. This is important from a rehabilitation standpoint but it also brings up other considerations for the attorney. Developing adequate defenses and learning to adapt from a psychosocial standpoint does not mean that the individual has necessarily dismissed all of the psychological implications or severe cosmetic impairment. It is still necessary to educate the jury so that they can have an understanding of the process through which the client has passed and also an understanding of the ongoing mechanisms, which are employed, for the patient to maintain the adaptive behaviors developed. Although this may represent a series of intangible damages in the sense that it is not possible for an expert to place a monetary value in these instances, it is still something that the rehabilitation professional must understand if an appropriate evaluation of the client's needs and limitations is to be made.

The reader is referred to *Emotional Care of the Facially Burned and Disfigured* by Norman R. Bemstein, Little Brown and Company, Boston, for a more thorough understanding in the psychosocial implications of the facially disfigured.

It is important to stress that no generalized rules regarding anticipated patient psychological reaction to burns can be established. As with any disability and/or psychological stress there are predisposing factors in the patient's personality make-up, which will at least in part dictate the patient's reaction to injury. Each case must be evaluated on its own merits based on appropriate testing.

A variety of factors must be evaluated when considering functional limitations or vocational handicaps in the burn patient. Taken into consideration must be not only the percentage of body surface involved and the depth of the burns, but also potential complications from smoke inhalation (pulmonary dysfunction), cardiovascular limitations or dysfunction; complications secondary to sepsis, urinary tract and gastrointestinal dysfunction, and severe weight loss. A careful review of all medical information and preferably interviews with physicians who will be involved in the reconstructive surgery in the future should be accomplished. These complications, should be combined with information on age, education, work history and any other relevant factors.

Although it is certainly worthwhile to consider the advice of treating physicians regarding further complications, they cannot always be predicted accurately even after the physician has assumed no further problems would develop. For this reason I caution any parties involved to allow sufficient time to pass before finalizing an assessment from a rehabilitation standpoint as early evaluation of the patient's permanent functional limitations may not always be possible.

Sufficient time must pass for the rehabilitation counselor to be able to assess accurately the impact, not only of the initial burns, but also the subsequent
complications. It is not at all uncommon to have severe contracture deformities develop quite late post-accident. In my own experience severe upper extremity contractures, particularly involving the fingers and hands, have been seen developing many months into the post-burn healing stage. Should a rehabilitation counselor, anxious to move forward with an accurate assessment of future care and service needs, fail to allow sufficient time, the client may find that his actual permanent impairment is much more severe than that outlined in information provided for settlement purposes.

The patient may also require a variety of functional aids both to develop independence and to assist in ambulation. Advances in equipment and/or both medical and rehabilitation treatment procedures may be very important from the standpoint of what is occurring in the field for future care and service needs. At the same time as this educational process should and must take place, it is also essential that the rehabilitation counselor be realistic and accurate. Services or treatment modalities which are unacceptable to a large share of the professional population or which are in such an early stage of research that they cannot be accurately assessed should not be included in a review.

It is also important to recognize that experimental procedures in use at research facilities today may well be employed as standard techniques for treatment where the patient is young and future surgery may not occur until the end of the growth cycle. For this reason the rehabilitation counselor should be as up to date as possible with the research literature so that care can be taken in interviewing treating physicians and discussing potential alternatives for treatment.

Vocational implications must be considered not only in terms of diminution of earning capacity in the individual's ability to maintain work, but also must be considered in relation to the individual's ability to obtain a job. This is particularly true in the instance of the individual who has a cosmetic impairment and the individual who must utilize compressive garments such as the Jobst burn suit for prolonged periods post-treatment. Such suits may be worn for up to two years post-discharge from the hospital and may represent a significant factor in the efforts at placing the burn patient. The longer the individual is out of the labor market post discharge, the more difficult the placement process becomes. Also concomitant psychological factors may result because of the continued reinforcement of feeling of inadequacy, inferiority and limited self-concept.

Although generally, optimism regarding the psychological and rehabilitation potential for the burn patient should be maintained, it must be recognized that as many as ten to twenty percent of burn patients (representing primarily the major burn victims) may demonstrate permanent limitations of a functional or psychological nature sufficient to prevent a return to the labor market. Even for those returning, a diminution in earning capacity coupled with a significant reduction in the ability to enjoy life because of psychological problems may result.
Although certainly representing a small percentage of the burn population, it must be stressed that there are individuals who will require not only long-term counseling, but also permanent care. This may take the form of hospitalization, live-in attendant care (depending upon functional limitations and psychological restrictions) or in the most extreme cases 24 hour a day awake staff.

To view the Glossary of Terms for Burn Injury, click here (please see attached file "LCP 4—Lesson 7- Glossary of Terms for Burn Injury.pdf")

Works Cited: