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THE VETERANS' ADMINISTRATION DISABILITY RATING SCHEDULE: HISTORICAL DEVELOPMENT AND MEDICAL APPRAISAL

A REPORT

ON

VETERANS' BENEFITS IN THE UNITED STATES

BY

THE PRESIDENT'S COMMISSION ON VETERANS' PENSIONS

STAFF REPORT NUMBER VIII

PART B

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INTRODUCTION

This monograph, prepared by staff of the President's Commission on Veterans' Pensions, is the second of three parts of the report on service-connected disability benefits and related programs. Volume VIII, part A, presents a general analysis of these benefits; part C, the results of statistical surveys.

This volume on the Veterans' Administration Disability Rating Schedule analyzes the background, philosophy, scope, and structure of the schedule, and is written in two sections: Section I—The evolution and development of the schedule; section II—Medical appraisal of the present Veterans' Administration Schedule for Rating Disabilities. (It should be noted that inasmuch as the rating schedule is used in determining disability in non-service-connected pension cases and certain presumptions affect eligibility for such pensions, the discussion in the present volume has significance for the pension as well as the compensation programs.)

For surveying and examining the extensive material two sources, considered to be the standard works in the field of veterans' compensation and pensions in the United States, were utilized as starting points. The first is the work of Dean William H. Glasson.[1] The second is the work of Prof. William P. Dillingham.[2] Another source of ready reference material used was, Laws Relating to Veterans, by Elmer A. Lewis.[3] Other source materials included: Executive orders; reports of the Commissioner of Pensions; Veterans' Administration reports, regulations, policy determinations, manuals, etc.; Committee hearings of the House of Representatives and Senate, reports, documents, etc.; congressional debates; journals of Congress; journals of the Continental Congress; United States Statutes at Large, public laws, Congressional Globe; American State papers, claims; and many other similar items.

The focus of section I of this monograph is on the statement: "The percentage ratings [in the schedule] represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations."

Wherever in the text references are made to acts of Congress and the source reference is not quoted, the law may be found under that date in the United States Statutes at Large. Wherever public laws are quoted, they may be found in Laws Relating to Veterans.[4]

Section II of the monograph presents the results of a survey by the President's Commission in which replies by 155 medical specialists to an extensive questionnaire on the rating schedule, presumptions, and statutory awards are analyzed.

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[1] William H. Glasson, Federal Military Pensions in the United States (New York, 1918).
[2] William P. Dillingham, Federal Aid to Veterans, 1917 to 1941 (Tallahassee, 1952).
[3] Elmer A. Lewis, Laws Relating to Veterans, 2 volumes (Government Printing Office: Washington 1951).
[4] Ibid.

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THE VETERANS' ADMINISTRATION DISABILITY RATING SCHEDULE: HISTORICAL DEVELOPMENT AND MEDICAL APPRAISAL

SECTION I

A STUDY OF THE BACKGROUND, SCOPE, AND STRUCTURE OF THE VETERANS' ADMINISTRATION SCHEDULE FOR RATING DISABILITIES, AND RELATED STATUTORY AWARDS AND PRESUMPTIONS

Chapter I. Evolution and Development of Rates and Rating for Service-Connected Disabilities Prior to 1917

PRE-AMERICAN COLONIAL PERIOD

In 1592–93 the British Parliament passed the first relief act for veterans returning from England's wars, retroactive to the 25th day of March 1588. Those veterans who risked their lives or lost their limbs or "disabled their bodies" in the defense and service of England were rewarded by a scheduled rate payable quarterly in amounts adjudicated by the justices in Quarters Sessions at rates not to exceed 10 pounds a year for a private, nor 20 pounds to a lieutenant.[1] Lesser rates could be adjudicated by the justices in Quarters Sessions. The monetary benefits were chargeable to the place from which the veteran was pressed, or if not pressed, to the place of residence, or both.

The British Parliament continued and amended the Statute of 1592–93, and by 1601 a new relief act for veterans was passed. This new act increased the rates for service-connected disabilities, as well as the contribution of the parishes.

AMERICAN COLONIAL PERIOD

1624 Colonial Virginia

The General Assembly of Colonial Virginia in 1624 passed a law for the benefit of those veterans who "shall fall upon their adjoyning Salvages", who "shall be hurte upon service to be carried at publique charge; in case any be lamed to be maintained by the country according to his person and quality." [2] In 1644 the Virginia Assembly enacted a law providing benefits for service-connected disabilities of veterans fighting the Indians who "were hurte and maymed and disabled from providing for their necessary maintenance and substance." The unscheduled rates for these maimed and disabled veterans with service-connected disabilities were provided for by the countries of the veterans' residence at rates as determined locally.

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[1] William H. Glasson, Federal Military Pensions in the United States (New York, 1918), p. 10.
[2] Henings, *Statutes at Large*, I, 121–129.

In 1676 a Virginia Act for veterans fighting the Indians, who were disabled with service-connected disabilities were paid an unscheduled rate and a "pension dureing their lives, and during the time of such disabilities." [3]

1636 Colonial Plymouth Colony

As early as 1636 the Pilgrims enacted in their court that a disabled "souldier" was granted an award at unspecified rates, but that "hee shalbee majntained competently by the Collonie during his life." [4]

1676 Colonial Massachusetts Bay Colony

The General Court of the Massachusetts Bay Colony appointed in 1676 a standing committee to consider the petitions of soldiers, with service-connected disabilities, for relief, and to report to the court what "they judged meet to be done."

In 1679 the general court ordered some wounded soldiers to apply to this committee for relief.[5] Rates were not scheduled but were adjudicated in accordance with the merits of the case.

After the union of Massachusetts Bay and Plymouth by the charter of 1691, an act of November 23, 1693, was passed for unscheduled rates for service-connected disabilities.[6] This law continued to disabled soldiers and seamen the yearly rates allowed by the former government, and provided for the granting of relief out of the public treasury to such as might thereafter "incur a service-connected disability."

1661–1678 Colonial Maryland

Veterans of the Indian Wars in Colonial Maryland were awarded benefits for service-connected disabilities by an enactment of the Assembly, and confirmed in April 1862, "that every person that shall adventure as a Souldier in any warre in the defence of the Country and shall therin happen to be maymed or receive hurt, shall according to his place and Quallity receive mayntenance from the Country according to his disabillity for mayntayning him selfe." [7]

The Maryland militia law of November, 1678, contained comprehensive disability benefit provisions. It promised the disabled veteran who should be so injured while defending the province as to be rendered incapable of getting a livelihood, a yearly rate out of the public levy of the province. This rate was to be proportioned to, and for the time of, the disability.[8] This is the first historical rating of partial disabilities, in America, for a temporary or a permanent disability.

1691 Colonial New York

A law passed on May 6, 1691 did not provide for any specified rates for service-connected disabilities.[9]

1718 Colonial Rhode Island

Every veteran with a service-connected disability unable to maintain himself and family, including parents, was awarded an annual

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[3] *Ibid.*, II, 331, 347, 440.
[4] Plymouth Colony Records, XI, Laws, 106.
[5] Records of Colony of Massachusetts Bay, V, 80, 227.
[6] Acts and Resolves of Province of Massachusetts Bay, I, 135.
[7] Archives of Maryland, Proceedings of Assembly, 1637–38 to 1664, p. 436.
[8] Ibid., 1678–1683, p. 58.
[9] Glasson, op. cit., p. 16.

rate from the General Treasury as the General Treasury deemed sufficient.[10]

These examples of legislation for service-connected disabilities in the colonies show that the rates were not specifically fixed; that eligibility requirements specified the disabled veteran must be incapable of "mayntayning himselfe." Being "maymed" or receiving a "hurte" in itself did not qualify the veteran. The Colony of Maryland initiated the first system of rating in proportion to and duration of the disability. The colonies were familiar with awards for service-connected disabilities, so that the Continental Congress, later, was able to incorporate the best features of all into their resolutions for rates and awards to disabled veterans of the American Revolution.

AMERICAN REVOLUTION PERIOD

1776

The colonists became experienced in awards for service-connected disabilities to veterans of the French and Indian wars. By the time of the Battle of Lexington and Concord, April 19, 1775, individual States had made provisions for the relief of disabled veterans with service-connected disabilities. The States did not rely entirely upon the Continental Congress to provide for the relief of disabled soldiers. Some, like Virginia and Pennsylvania, independently made liberal provision for the disabled veteran and for the widows and orphans of the slain.

Soon after the Battle of Lexington and Concord, the Continental Congress gave temporary aid to petitioning disabled veterans. On June 26, 1776, on a petition, William Whiting, a soldier who was wounded in the Continental Army at Quebec, was paid $20 out of the Public Treasury to enable him to return to his family at Norfolk, Conn. William Whiting may be said to be the first disabled veteran paid a benefit for a service-connected disability, from the Treasury of the United States.[11]

June 20, 1776

Even before the Declaration of Independence, a committee of five had been appointed "to consider what provision ought to be made for such as are wounded or disabled in the land or sea service, and report a plan for that purpose." [12] On the committee were representatives of Massachusetts, Virginia, Georgia, Rhode Island, and New York. Four of the five members of the committee were from colonies whose legislation for service-connected disabled veterans was stated above.

The first national pension law in the United States, August 26, 1776

The plan submitted by the committee of five was adopted by the Continental Congress, August 26, 1776, and became the first national law of benefits to disabled veterans for service-connected disabilities.[13] This act established a scheduled rate of half pay for life or during disability to every officer, soldier, or sailor losing a limb in any engagement or being so disabled in the service of the United States as to render him incapable of earning a livelihood. A proportionate nonscheduled benefit was allowed to the veteran, "though not totally disabled from getting a livelihood, such monthly sums towards his subsistence" as was judged adequate by the assembly or other repre-

[10] Ibid, p. 16.
[11] W. C. Ford, Journals of the Continental Congress, V, 484.
[12] Journals of the Continental Congress, V, 469.
[13] Ibid., 702–705.

sentative body of the State of residence but not to exceed half pay. The several assemblies were requested to make up a list of totally and partially disabled with the amount of the award in each case. This list was to be forwarded to Congress.

The inauguration of awarding benefits to veterans for service-connected disabilities was the birth from British and colonial precedent and experience.

The framers of the resolution were undoubtedly familiar with such legislation in their colonies. The scant resources and power of the Continental Congress made it necessary to entrust the execution of the plan to the States. The Continental veterans benefit program was just as effective as the individual States chose to administer in the absence of uniform regulations.

The same resolution contained a proviso that all such disabled officers and soldiers who were entitled to the benefits contained therein, and found to be capable of doing guard or garrison duty were to be formed in a corps of invalids. Disabled officers, marines and seamen of the Navy entitled to the provisions of the resolution and found capable of doing any duty on board the Navy, or any department thereof, "shall be employed."

September 25, 1778

On September 25, 1778, Congress extended the relief provided by the resolution of August 26, 1776 to those who had been disabled before that date and since the commencement of hostilities.[14]

April 23, 1782

Nine months before a general peace was signed (January 20, 1783), an act of the Congress of the Confederation on April 23, 1782, provided that all sick or wounded soldiers, unfit for duty either in the field or in garrison and applying for a discharge in preference to being placed or continued in the corps of invalids, were entitled to be discharged and were to receive an allowance of $5 per month for life in lieu of all pay and emoluments, and irrespective of rank and degree of disability. It was recommended to the several States to pay such pensions annually and to draw upon the superintendent of finance for the money advanced.[15]

June 7, 1785

After the Army was disbanded on November 3, 1783, the Congress of the Confederation again considered the matter of veterans' benefits. On June 7, 1785, resolutions were passed, recommending uniform procedures in the processing of disabled veterans.[16] The resolutions also specified that commissioned officers, disabled in the service of the United States, so as to be wholly incapable of military duty, or of obtaining a livelihood, were allowed an annual scheduled rate equal to half of their pay, and to those who shall not have been disabled in so great a degree, were allowed a proportionate yearly rate corresponding with the degree of their disability, compared with that of an officer wholly disabled. Disabled enlisted men disabled in the service of the United States so as to be wholly incapable of military or garrison duty, or of obtaining a livelihood by labor, were allowed a scheduled

[14] Journals of the Continental Congress, XII, 953.

[15] The Secretary of War recommended a disability discharge with half pay per month, but this was struck out by Congress, and $5 per month was substituted. Journals of the Continental Congress, XXII 209–210.

[16] Journals of Congress (Washington, 1823), IV, 534–535, and Journals of the Continental Congress XXVIII, 435.

rate of $5 per month. Those with partial disabilities were awarded an unscheduled rate corresponding with the degree of their disability, compared with that of an enlisted man wholly disabled.

Each State was required to submit annually a list of disabled veterans showing the rate awarded, age, service, and disability of each to the Office of the Secretary of War for review of service records and transmittal to Congress for final action.

June 11, 1788

The final resolutions of the Congress of the Confederation, on the subject of veterans' disability benefits, were passed on June 11, 1788.[17] They contained a provision:

> That no person shall be entitled to a pension as an invalid who has not, or shall not before the expiration of six months from this time, make application therefore, and produce the requisite certificates and evidence to entitle him thereto.

September 29, 1789

After the ratification of the Constitution in 1788, the United States Congress in 1789 provided that payments to disabled veterans granted and paid by the States should be extended for a year and paid by the United States.[18] In July of 1790, and again in March of 1791, Congress granted further extensions to the disabled veterans of the American Revolution.

During the war and under the confederation, the States were entrusted with the administration of the laws for the relief of service-connected disabled veterans. Some of them failed to act.[19] There was not a complete transfer of disabled veterans lists from State to National rolls. Some individual States continued to pay regular amounts to persons who had been paid benefits for various causes under State laws and without authority of Congress. The administration of the disabled veterans' benefits were taken over from the States and placed under the supervision of the Secretary of War. However, Congress for a long time reserved to itself direct control over the final allowance of claims.[20]

The new Federal Congress was beset with petitions from disabled veterans of the Revolution for original awards for service-connected disabilities or increase. Since the time limit under the general law of the Confederation had expired, relief could be obtained only through the enactment of a new general law or through special legislation for individual cases.

March 23, 1792

Congress passed an act for disabled veterans of the War of the Revolution with service-connected disabilities on March 23, 1792.[21] In this act Congress unified and put into operation the first national adjudication system for service-connected disabilities for veterans of the Revolution. The method of administration placed the adjudication of service-connected disabilities and the rating for total and partial disabilities in the United States circuit court system. The judges, upon receipt of the claims, as required in the law, were required to "forthwith proceed to examine into the nature of the wound,

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[17] Journals of Congress, IV, 821, and Journals of the Continental Congress, XXXIV, 209.
[18] 1 Statutes at Large, 95.
[19] Journals of Congress (1823 edition), IV, 873. The lists may be found in Papers of the Continental Congress, No. 27, p. 367.
[20] Glasson, op. cit., p. 54.
[21] 1 Statutes at Large, 243.

or other case of disability of such applicant, and having ascertained the degree thereof," to certify the same, and transmit their opinion in the case to the Secretary of War, including what proportion of the monthly pay of such applicant was equivalent to the degree of disability ascertained "in manner aforesaid."

In essence, the act constituted a bureau in the circuit court system for the examination, rating, and allowance of claims for service-connected disabilities, with decisions subject to review and revision by the Secretary of War and Congress. Federal judges of the circuit court considered the act as an infringement of their judicial duties as granted under the Constitution and denied the power of Congress to impose such duties on the judiciary. The judges of the Circuit Court of New York asserted:

> * * * that the judiciary was a distinct and coordinate branch of the Government and that neither the legislative nor the executive branch could constitutionally assign to the judicial any duties but such as were properly judicial and to be performed in a judicial manner. They thought that the duties prescribed by the act in question were not of that description, since the decisions of the court were made subject to suspension by the Secretary of War and to revision by the legislature. Under the Constitution neither an executive officer nor even the legislature was authorized to sit as a court of errors on the judicial acts or opinions of the circuit courts. The judges of the New York circuit were, however, willing to regard themselves as commissioners, designated by official instead of personal descriptions, and therefore at liberty either to accept or decline the office. As the objects of the law were benevolent, they agreed to pass upon claims as commissioners in the same room in which the court was held, adjourning court for that purpose for short periods during the session.[22] * * *

February 28, 1793

On February 28, 1793, Congress repealed the objectionable sections of the act of 1792.[23] New regulations were established. The act of 1793 imposed no duty of making a decision on the judge. Claimants for disability compensation were to appear before the judge of the district, in which the veteran resided, or before three persons specially authorized by the judge. Evidence was taken upon oath or affirmation of the veteran. The evidence had to prove decisive disability to have been the effect of known wounds, received while in the actual line of his duty, in service of the United States during the Revolutionary War.

Every claimant was required to have a physical examination by two physicians or surgeons authorized by the judge. The physicians reported to the judge in writing, their opinion, upon oath or affirmation, of the nature of the disability, and in what degree it prevents the claimant from obtaining his livelihood by labor. The degree was entered as entitled to a full pension, or a half, or so forth.

The claimant required lay evidence of 3 freeholders, of the veteran's place of residence for 2 years immediately after he left the service. These witnesses testified to the existence of his disability during that period; and of their own knowledge, the mode of life, employment, labor or means of support.

The judge of the district was required to transmit a list of such claims, with the evidence, to the Secretary of the Department of War. The Secretary of War, after ascertaining the validity of the claim from service records, forwarded the list of claimants with necessary remarks to Congress for final adjudication. Congress granted all

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[22] Glasson, op. cit., pp. 56–57.
[23] 1 Statutes at Large, 324.

claims included in the Secretary's report whom he found to clearly have established their claims.[24] The act was in effect for 2 years, when it was allowed to expire.

March 3, 1803

Congress reenacted benefits to disabled veterans of the Revolution who qualified under the act of March 3, 1803.[25] Rates remained the same as under the act of 1793. A full rate to commissioned officer was considered to be the one-half of his monthly pay, and the proportions less than a full rate were like proportions of half pay. A full rate to a noncommissioned officer, private, or seaman was $5 per month, and the proportions less than a full rate were like proportions of $5 per month. The rate for a commissioned officer was limited and not to exceed a higher rate than the half pay of a lieutenant-colonel. The administrative processing of the claim remained the same as under the act of 1793.

The claimant had to prove decisive disability to have been the effect of known wounds received while in the actual line of duty, in the service of the United States during the Revolutionary War.

Unlike the 1793 act, the claimant was examined by some "respectable" physician who reported in writing his opinion, upon oath or affirmation, of the nature of the disability, and in what degree it prevented the claimant from obtaining his livelihood.

Every claimant had to produce evidence of his having continued in the service of the United States, to the conclusion of the war in 1783, or having been left out of the service in consequence of his disability, or in consequence of "some derangement of the army", and of the mode of life or employment he had followed since, and of the original existence and continuance of his disability.

The most important change in procedure granted the Secretary of War the power of final action on the claims.

RATES AND RATINGS SUBSEQUENT TO AMERICAN REVOLUTION

April 10, 1806

The act of April 10, 1806, on behalf of disabled veterans of the Revolution formed the basis for all subsequent laws for the relief of service-incurred disabled veterans, including those of the Regular Army.[26] The rates were a "full disability," for a total disability. For partial disability, proportions less than a "full pension" of the corresponding proportions of the half pay. The rate for a commissioned officer was limited to and not to exceed the rate of half pay of his rank or grade, for total disability, and in no case was the pay to exceed half-pay of a lieutenant colonel. The rate for total disability for noncommissioned officers, musicians, soldiers, marines, or seamen, was a full pension of $5; and the proportions, less than a full disability pension, were like proportions of $5 a month.[27]

In substantiating a claim a disabled veteran was required by the regulations to: have all evidence taken under oath or affirmation,

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[24] American State Papers, Claims, 85–128, contains a list of such claims. See table 2, p. 71 ff., for a list of some names with adjudicated rates.

[25] 2 Statutes at Large, 242.

[26] 2 Statutes at Large, 376.

[27] This rate was changed, so far as officers below the grade of captain and privates were concerned, by the act of April 24, 1816. The full pension rate for a first lieutenant was $17; a second lieutenant, $15; a third lieutenant, $14; noncommissioned officer and lower $8 per month; and for disabilities of a degree less than the highest, a sum proportionately less. 3 Statutes at Large, 296.

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before the judge of the district of the veteran's residence, or some person commissioned by the judge; decisive disability, the effect of a known wound or wounds received while in actual service and line of duty; the nature of such disability, and in what degree it prevented the claimant unable to procure a subsistence by manual labor, proved by the affidavit of some reputable physician, either from his own knowledge and acquaintance with the claimant, the physician or surgeon in his affidavit, particularly describing the wound or wounds "from whence the disability appears to be derived." For an increase in pension the affidavits of two physicians were required. Final action on the claim was reserved by Congress.

FINALITY OF ACTION

March 3, 1819

Congress finally abandoned the attempt to participate in the detailed administration of the general laws for disability benefits. The fourth section of an act of March 3, 1819, gave the Secretary of War power to place persons entitled to invalid pensions under the act of April 10, 1806, and under the fourth section of the act of April 25, 1808.[28]

At the same time another change in the method of administering the pension laws was a provision for the biennial examination of invalid pensioners by two surgeons or physicians. This examination had in view the removal from the roll of those invalids who had recovered from their disabilities. In cases where the pensions were originally granted for total disability in consequence of causes which could not in whole or in part be removed, the examination was not required. An exception was also made in favor of invalid pensioners of the Revolution who had availed themselves of the act of March 18, 1818.[29] The act, however, was repealed July 14, 1832.[30]

March 2, 1833

Under the laws then existing the Secretary of War was the only responsible officer in the administration of the pension acts. Congress established a branch in the War Department, under the name of the Pension Office, with an officer at its head to be known as the Commissioner of Pensions.[31] This responsible officer was to administer the laws under the general direction of the Secretary of War.

GENERAL LAW, ACT OF JULY 14, 1862

Veterans' benefits for service-connected disabilities were provided for in the act of July 14, 1862, known as the General Law.[32] This law made the rates for service-connected disabilities specific for residuals of wounds and diseases, instead of contingent upon residuals of "known wounds", as most service-connected disabilities were under previous laws. It was entirely a new law, wiping the statute books clean of all previous laws, so far as they might have any application to service-connected disabilities arising subsequent to March 4, 1861. All service-connected disabilities originating after this date, in all branches and grades of the military and naval service of the United

[28] Statutes at Large, 526.
[29] 3 Statutes at Large, 514.
[30] 4 Statutes at Large, 599.
[31] 4 Statutes at Large, 622.
[32] 12 Statutes at Large, 566–569.

States, were adjudicated under the provisions of this act. This law was designed to be a permanent statute, applying to all wars in which the United States became involved, subsequent to March 4, 1861, and to the regular military and naval peace establishment; instead of being special and limited like most of the laws for service-connected disabilities heretofore passed. The temporary character of most of the provisions of similar laws theretofore enacted and the consequent demand for new legislation, whenever there was occasion to call out any portion of the military forces of the country, had introduced doubt and confusion in those concerned in their administration. This act was designed to put an end to all of this, so far as cases might arise subsequent to March 4, 1861.

The act provided for commissioned and noncommissioned officers, enlisted personnel, volunteers, and militia of the Army, and commissioned and noncommissioned officers and petty officers and grades lower, or other persons in the Navy or Marine Corps. Those who made proper proof and conformed to the regulations in pursuance of the law, were placed upon a list of invalid pensions of the United States for disability by reason of any wound received, or disease contracted, while in the service of the United States, in the line of duty.

The scheduled rate for service-connected total disability as provided in the law was as follows:

Lieutenant-colonel and all officers of a higher rank $30 per month; major, $25 per month; captain, $20 per month; first lieutenant, $17 per month; second lieutenant, $15 per month; and all noncommissoined officers and grades lower, $8 per month. The total disability rate for officers, warrant or petty officers, and others employed in the naval service of the United States was: $30 per month for grades higher than a lieutenant; $25 per month for grades of lieutenant, surgeon, passed master, and chief engineer; $25 per month for passed assistant surgeon; $20 per month for professor of mathematics, master, assistant surgeon, assistant paymaster, and chaplain; $15 per month for first assistant engineer and pilots; $10 per month for passed midshipmen, midshipmen, captains, and paymaster's clerk, second and third assistant engineers, master, mate, and all warrant officers; $8 per month to all petty officers, and all other persons employed in the naval service.

The rate award for all ranks and grades of the above for an inferior disability (partial disability) was an amount proportionate to the highest disability, to commence as required by law, and continue during the existence of such disability.

The maximum rate for total disabilities for all commissioned officers and those ranking with commissioned officers was $30 per month. The maximum rate for noncommissioned officers, and grades lower, petty officers, and all other persons in the naval service was $8 per month.

Under this act the awards for service-connected disabilities were to commence on the date of discharge instead of on the completion of testimony, as under previous laws. But to seek this, an application had to be made within 1 year from the date of the discharge. Otherwise the award was to commence on the date of the application.

Section 8 of the act provided for biennial examinations, by civil surgeons, of the disabled veteran placed upon the disability rolls. The appointment of the civil surgeon was at the discretion of the Commissioner of Pensions.

The surgeon appointed by the Commissioner also examined the applicants for initial adjudication of the claim whenever the Commissioner deemed it necessary.

In the implementation of the General Law the Commissioner of Pensions, on July 21, 1862, issued instructions for the administration of the law. The medical instructions required the surgeon's certificate for discharge to show the character and degree of the claimant's disability; but when this was wanting and the certificate of an Army surgeon was not obtainable, a certificate of two "respectable civil surgeons" would be received, in accordance with the authorized form as indicated in his instructions. He required the surgeons to give in their certificates a "particular description of the wound, injury, or disease, and specify how and in what manner" the claimant's "present condition and disability are connected therewith." The surgeons were also required to state "the degree of disability for obtaining subsistence by manual labor." [33]

The examining physician was, further, required to state in his opinion on the form, the degree of disability in terms of, "three-fourths," "one-half," "one-third,— and so forth or, "totally," as the case merited.[34]

November 1, 1864

The Commissioner of Pensions in his annual report for 1864 considered the problem of rating disabilities by the medical profession in and out of the service.[35] He decried the lack of uniformity in rating of disabilities between the services due to lack of instructions in rating disabilities, nor had it been found an easy matter to adapt instructions to all the varied cases arising, even for the guidance of the civil surgeons under the immediate supervision of the Commissioner. In his report he continues:

> * * * Under such general instructions as have been given, it is improbable that any two surgeons can be found who would, acting separately, fix the same degree in each of these several cases. While the act of July 14, 1862, does not distinctly state that the disability to be taken into account is that for procuring a subsistence by manual labor, such has been the construction of its meaning, in accordance with the express language of the act of April 10, 1806, and with the uniform precedents in this office. In estimating the degree, reference is not had to the particular employment of the applicant before entering the service, but his capacity for manual labor of any kind. The loss of a limb, or extremity, has always been rated as a total disability; and the other effects of wounds have been estimated proportionably, as nearly as may be. In regard to this latter class of disabilities, however, and still more for the manifold diseases and injuries on account of which pensions are claimed, a more definite system is desirable, such as may best be matured by a commission of surgeons experienced in the service. One of the first duties of such a commission would be to discriminate between causes of disability on account of which pensions should be granted, and those which cannot properly be regarded as incident to the service. It may well be questioned whether all those included in the above list belong to the former class. It is equally doubtful whether, assuming a given disability from a particular cause, at the time of the soldier's discharge, a like rate should be fixed for that cause in every case. There should manifestly be some distinction between permanent and temporary disabilities; between those properly incurable and those that would yield to professional treatment; between diseases that are organic and those which are functional; between those superinduced by the service and those which are partly constitutional; between the unavoidable results of climate, exposure, or battle, and the casual effects of carelessness and

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[33] Anon., Manual of the Pension Laws of the United States (Washington: W. H. & O. H. Morrison, 1862), pp. 95–96.

[34] Ibid., pp. 103 and 116.

[35] Report of the Commissioner of Pensions, 1864, pp. 656–658.

self-neglect, if indeed the last named class, in each of these instances, should not be altogether excluded.

Whether the much-needed revision of these matters, thus imperfectly indicated, is to be best attained through the invited cooperation of the War Department, by further legislative action, or by this department independently, in the exercise of authority which it already possesses, is submitted for your consideration. * * *

CONSOLIDATION ACT, MARCH 3, 1873

A change in the method of rating disabilities under the General Law was introduced by a provision in the so-called Consolidation Act of March 3, 1873.[36] The Commissioner of Pensions recommended, in his report for 1872, the establishment of intermediate rates between $8 and $18.[37] Among the new provisions were a rate of $13 a month for total deafness, and a section permitting the rate of $18 a month to be proportionately divided by the Pension Bureau for any degree of disability that should be established for which the second section of the proposed act made no provision. The second section reenacted the total disability rate of $8 a month for a private soldier contained in the act of July 14, 1862. A Senator of Indiana, in charge of the bill, said that the proposed division of the $18 rate (a Senate amendment) would meet "the claims of a large number of cases where the claimants are disabled to a greater degree than that for which pension is provided in the second section, but those disabilities are not equivalent to the loss of a hand or foot. This section is proposed as a remedy, especially in the case of private soldiers for the wide difference between the rate of pension now fixed by law, $8 per month, and that provided for the disability arising from the loss of a hand or foot."[38]

After the Consolidation Act of 1873 became law, the following was the general scheme of disability rates in force. For the highest grade of permanent specific disabilities the statutory rate remained at $31.25 a month. The second grade of such disabilities was rated at $24 a month, and the third grade (equivalent to the loss of a hand or foot) at $18 a month. For total disability (at the time construed by the Pension Bureau to mean "total disability for the performance of manual labor requiring severe and continuous exertion") the rate under the act of July 14, 1862, of $8 a month for a private soldier was retained. A new statutory rate of $13 a month was in force for total deafness. And the Commissioner of Pensions was empowered to fix, in his discretion, rates amounting to some proportion of $18 a month for any degrees of disability not sufficient to warrant the $18 rate for which the $8 total disability rate did not make provision.

The section in the Consolidation Act conferring the above rate-fixing power upon the Commissioner of Pensions became section 4699 of the Revised Statutes. Under it the Commissioner of Pensions fixed a large number of rates for certain disabilities not specified by law. Examples of such rates are: $17 a month for the loss of 1 eye; $10 for anchylosis (stiffening) of elbow; $14 for loss of middle, ring, and little fingers; $8 for anchylosis of wrist; $8 for loss of thumb; $4 for loss of index finger; $6 for loss of great toe; $2 for loss of any other toe; and $10 for loss of all toes of 1 foot. The discretionary powers of the Pension Bureau were further increased by the act of August 27, 1888, which established a $30 rate for total deafness and authorized the Secretary of the Interior to grant such proportion thereof in cases of

[36] 17 Statutes at Large, 566.
[37] Report of Commissioner of Pensions, for 1871, 1872.
[38] Congressional Globe, 3d sess., 42d Cong. (1872-73), pt. 2, 1283.

partial deafness as he might deem equitable. Eight grades have been established ranging from $6 a month for nearly total deafness of one ear, or slight deafness of both ears, to $27 a month for deafness of both ears existing in a degree nearly total.[39]

In rating cases, the Pension Bureau acted under the authority of the provision of the Revised Statutes (sec. 4699), that the "rate of $18 per month may be proportionately divided for any degree of disability established for which" the "total disability" rate of $8 a month makes no provision. The rates were fixed upon the evidence, and upon the results of medical examinations on the basis of disability for the performance of manual labor. They ranged from eight-eighteenths to seventeen-eighteenths, according to the degree of disability shown. When a disability is shown in excess of seventeen-eighteenths and equivalent to the loss of a hand or foot, the rate was $24 (third grade) but if the disability was not equivalent to the loss of a hand or a foot, even if it was in excess of seventeen-eighteenths, no higher rate than $17 a month could be allowed.[40] Lesser rates than eight-eighteenths were awarded. Rating of a chronic disease or diseases in terms of eighteenths of disability for the performance of manual labor equivalent to the loss of a hand or a foot was a very technical and complicated matter.

CIVIL WAR VETERANS' ACT OF JUNE 27, 1890

The act of June 27, 1890, provided disabled veterans of the Civil War with awards (including non-service-connected) to claimants with disabilities regardless of origin:[41] (except that disabilities caused by vicious habits were not granted an award). The requirements were military service of 90 days or more during the Civil War and honorable discharge. The vital part of the act was section 2.

Veterans already drawing disability compensation under the General Law were permitted to apply under this act, and those under this act might apply under the General Law system. But no person could receive more than one award covering the same period of time. It was expected that a large number of the disabled veterans already receiving low rates under the General Law would find it possible to receive larger awards under the act of 1890, because under the latter law they could be rated for disabilities not of service origin.

Under the act of 1890 awards were granted to veterans of the Civil War for incapacity to perform manual labor in such a degree as to render them unable to earn a support. Rates of from $6 to $12 a month were provided, proportioned to the degree of inability to earn a support. A veteran could be employable and in receipt of an income from his services as a skilled worker, salesman, clerk, lawyer, physician, public official, businessman, or banker without thereby being ineligible for a pension. The law required only as to the ability of the applicant to perform crude manual labor, and rated in an arbitrary manner those physical and mental ills which, when of a permanent character, would hamper a man in performing such labor.

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[39] The rates fixed for partial deafness are shown in Report of the Commissioner of Pensions, 1899, and in table No. 5 in this report.

[40] A Treatise on the Practice of the Pension Bureau (Washington, 1898), p. 126.

[41] 26 Statutes at Large, 182–183.

An act of March 2, 1895, provided that—

* * * All pensioners now on the rolls, who are pensioned at less than $6 a month, for any degree of pensionable disability, shall have their pensions increased to $6 per month; and that hereafter, whenever any applicant for pension would, under existing rates, be entitled to less than $6 for any single disability or several combined disabilities, such pensioner shall be rated at not less than $6 per month. * * *

After the passage of the act of 1895 the slightest disabilities recognized under the General Law became payable at $6 a month.

The act of June 27, 1890, introduced another system of rating disabilities. The act established the ratings from $6 to $12 a month to be determined by the Pension Bureau in proportion to the disability. In the implementation of the act, the Commissioner, on October 15, 1890, issued Order No. 164.[42] This order provided veterans qualified under the act who had disabilities which under the general law system would be rated at or above $6 and less than $12 should receive the same rates as though their disabilities were of service origin. Claimants were also permitted to combine low ratings for slight disabilities to entitle them to minimum awards of $6, or more, to a maximum of $12. This procedure soon became a matter of controversy. On January 7, 1893, a decision of the Assistant Secretary of the Department of Interior directed that future adjudications of claims under the act of June 27, 1890, be made in accordance with the views expressed in the decision.[43] Accordingly, a new order was issued on May 27, 1893, which revoked Order No. 164 of October 15, 1890. The new order, No. 225, established a board of revision whose duties were to determine whether the claims allowed under Order No. 164 were in accordance with the act of June 27, 1890. Order No. 225 is as follows:

ORDER NO. 225[44]

DEPARTMENT OF THE INTERIOR,
Washington, D. C., June 9, 1893.

As to adjudicating and fixing rates of pensions under the act of June 27, 1890:

1. A claim for pension under the second section of the act of June 27, 1890, can only be allowed upon proof of mental or physical disability of a permanent character, not the result of the claimant's own vicious habits, incapacitating him for the performance of manual labor in such a degree as to render him unable to earn a support.

2. No specific injury or disability can, as such, have a pensionable rating under that act, nor be considered otherwise than as it affects the capacity of the claimant to perform ordinary manual labor.

3. Proof that the disability is not the result of the claimant's own vicious habits is requisite; and therefore the causes and circumstances of the origin of the disability should be shown by the evidence furnished in support of the claim for pension, so far as can be done, and by persons other than the claimant.

4. To give the claimant a pensionable status under this act the disability must be such as to incapacitate him for the performance of manual labor in such a degree as to render him unable to earn a support; yet the act recognizes differences in the degree of such pensionable disability, giving $12 per month in case of the greatest, and $6 per month in case of the lowest degree of such pensionable disability rendering the claimant unable to earn a support by manual labor. It also provides

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[42] Order No. 164 may be found in Report of the Commissioner of Pensions, 1899, p. 30.

[43] The Assistant Secretary of the Interior expressed the views that ratings made under the law of June 27, 1890, were to be proportioned from $6 to $18 (6/18) but where the rate exceeded $12 the award would be payable at $12. Ibid., p. 30–32. See appendix G of this report.

[44] Report of the Commissioner of Pensions, 1899, pp. 32–33.

for intermediate ratings proportioned to the intermediate degrees of such pensionable disability. The proper ratings under this act will, therefore, be made in accordance with such rules for rating as the medical referee shall prescribe, subject to the approval of the Commissioner.

Approved:

WM. LOCHREN, *Commissioner.*
HOKE SMITH, *Secretary.*

Under the operations of Order No. 225 many veterans were dropped from the rolls and the rates of many others were reduced. The work of readjustment of the awards granted under Order No. 164 was only partially done by 1899, and no revisions done during the administration of the affairs of the Bureau under the Commissioner of Pensions that year. The Commissioner of Pensions in 1899 stated that—

> the two separate and distinct systems of pensioning (both for disability) alone, one for disability of service origin, the other for disability regardless of origin, afford a wide field for comparison and misunderstanding.[45]

In his annual report, the Commissioner of Pensions in 1899 made a comparison of the rating systems in use at the time. The act of June 27, 1890, established two systems of rating disabilities. Ratings were made under this act and under the General Law. A comparison of the two systems may be found in table 5 of this report.[46]

The variations in the character of the work done by the local boards of examining surgeons in 1899, and by the medical examiners in Washington added to the problem. The medical referee in his 1899 annual report to the Commissioner stated these additional problems. The medical referee's report may be found in appendix H of this section.

At the close of the 19th century, ratings for service-connected disabilities were adjudicated under the General Law, as amended, for disabled veterans of all wars subsequent to the Civil War. The entry of the United States into World War I, April 6, 1917, disclosed that disabled veterans of this war would come under the provisions of the General Law. However, due to the rapid progress of social insurance, and particularly workmen's compensation, the administration at the time considered that the paying of disabled veterans under the pension system was not what the country needed. A change in the system of awarding veterans' benefits was in the making.

CHAPTER II. EVOLUTION AND DEVELOPMENT OF RATES AND SCHEDULE FOR RATING SERVICE-CONNECTED DISABILITIES DURING WORLD WAR I PERIOD

WAR RISK INSURANCE ACT AS AMENDED BY ACT OF JUNE 12, 1917

After the United States entered the war on April 6, 1917, Congress amended the War Risk Insurance Act of 1914 and provided an indemnity for death or disabilities to the personnel of American vessels in the act of June 12, 1917.[47] This law provided a form of social insurance to qualified personnel.

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[45] Ibid., p. 40.
[46] Ibid., pp. 33–34; also see table 1, p. 70 of this section, cols. (f) and (g).
[47] 40 Statutes at Large, 102.

ARTICLE III: DIVISION OF MILITARY AND NAVAL INSURANCE, BUREAU OF WAR RISK INSURANCE, ACT OF OCTOBER 6, 1917 (PUBLIC NO. 90, 65TH CONGRESS)

After the entry of the United States into World War I, in the absence of new legislation, the provisions of the General Law system for rating service-connected disabilities would have applied. However, Congress amended the War Risk Insurance Act in the act of October 6, 1917, by establishing in the Bureau of War Risk Insurance, under the Secretary of the Treasury, a Division of Marine and Seamen's Insurance and a Division of Military and Naval Insurance, each in charge of a Commissioner.

The act of October 6, 1917, established four articles pertaining to organization, rules and regulations, allotments and family allowances, and insurance. Article III of this act provided for compensation for death and disability and provided, for the first time, a schedule for rating service-connected disabilities on a percentage basis.

A new system for rating disabilities was devised and incorporated in section 302 of article III of H. R. 5723.[48] The bill and section 302 in article III (compensation for death and disability) became law after changes and conference between the Senate and the House of Representatives on October 6, 1917.[49] Section 302 of article III reads as follows:

* * * That if disability results from the injury—

(1) If and while the disability is total, the monthly compensation shall be the following amounts:

(a) If he has neither wife nor child living, $30.

(b) If he has a wife but no child living, $45.

(c) If he has a wife and one child living, $55.

(d) If he has a wife and two children living, $65.

(e) If he has a wife and three or more children living, $75.

(f) If he has no wife but one child living, $40, with $10 for each additional child up to two.

(g) If he has a widowed mother dependent on him for support, then, in addition to the above amounts, $10.

To an injured person who is totally disabled and in addition so helpless as to be in constant need of a nurse or attendant, such additional sum shall be paid, but not exceeding $20 per month, as the director may deem reasonable: *Provided,*[50] *however*, That for the loss of both feet or both hands or both eyes, or for becoming totally blind or helplessly and permanently bedridden from causes occurring in the line of duty in the service of the United States, the rate of compensation shall be $100 per month: *Provided further*, That no allowance shall be made for nurse or attendant.

(2) If and while the disability is partial, the monthly compensation shall be a percentage of the compensation that would be payable for his total disability, equal to the degree of the reduction in earning capacity resulting from the disability, but no compensation shall be payable for a reduction in earning capacity at less than 10 per centum.

A schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries of a permanent nature shall be adopted and applied by the Bureau. Ratings may be as high as 100 per centum. The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations and not upon the impairment in earning capacity in each individual case, so that there shall be no reduction in the rate of compensation for individual success in overcoming the handicap of a permanent injury. The Bureau shall from time to time readjust this schedule of ratings in accordance with actual experience.

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[48] 65th Cong., 1st sess., House Committee on Interstate and Foreign Commerce, hearings on H. R. 5723, Aug. 17, 1917.

[49] Public No. 90, 65th Cong., 1st sess., approved Oct. 6, 1917.

[50] This paragraph was subsequently amended by changing the last proviso to read: "*Provided further*, That where the rate of compensation is $100 per month, no allowance shall be made for a nurse or attendant."; and the entire paragraph incorporated as a new subdivision (h). Public No. 175, 65th Cong., approved June 25, 1918.

This system of rating service-connected disabilities in disabled veterans was a radical departure from other systems that prevailed in the Pension Bureau. Existing practices in the Pension Bureau were not disturbed, however, and their administration continued under the Commissioner of Pensions in the Department of Interior. The new system was to be administered by the Bureau of War Risk Insurance in the Division of Military and Naval Insurance, in the Department of Treasury. This system has been in operation since that date to the present with only slight changes in the basic concept.

PRESUMPTION OF SOUND CONDITION INTRODUCED. ADDITIONAL STATUTORY AWARDS

Section 10 of the act of June 25, 1918 (Public No. 175, 65th Cong.), amended section 300 of Public No. 90, 65th Congress, and established by legislation for the first time in this new system of compensation for veterans' disabilities, a presumption of sound condition in a serviceman on acceptance and enrollment for service. He was considered to have been in perfect physical condition on entry into the service. Due to the inadequacies in physical examinations, at the time of mobilization, protection of the veteran was provided in this manner.

Section 12 of the act of June 25, 1918, also amended subdivision (1) of section 302 of the War Risk Insurance Act by the addition of subdivision (1), (h), as follows:

> (1) * * * (h) If he is totally disabled and in addition so helpless as to be in constant need of a nurse or attendant, such additional sum shall be paid, but not exceeding $20 per month, as the director may deem reasonable: *Provided, however,* That for the loss of both feet or both hands or both eyes, or for becoming totally blind or becoming helpless and permanently bedridden from causes occurring in the line of duty in the service of the United States, the rate of compensation shall be $100 per month: *Provided further,* That where the rate of compensation is $100 per month, no allowance shall be made for a nurse or attendant.[51]

1919: THE FIRST TENTATIVE SCHEDULE FOR RATING DISABILITIES

Following the Armistice, November 11, 1918, and the rush of demobilization, disability claims increased, producing a backlog in their processing and adjudication. A number of individual bills were introduced in Congress to alleviate the situation, and some for extending, and increasing disability benefits, particularly for obvious disabilities. The accumulation of these bills necessitated action by the House of Representatives, and on June 18, 19, and 28, 1919, hearings were held, House of Representatives, before the Subcommittee of the Committee on Interstate and Foreign Commerce, 66th Congress, 1st session, on a proposed omnibus bill to amend the War Risk Insurance Act.[52] Some of the proposals were incorporated into subsequent laws such as the act of August 6, 1919, and December 24, 1919.

During the hearings a tentative schedule for rating disabilities was introduced into the record.[53]

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[51] Allowance for attendant or a nurse was later provided.
This was amended by inserting the following at the end of subdivision H: "Except in case of loss of both hands and both eyes, or in cases of both feet and both eyes, or in case of loss of both hands and both feet, in which cases there shall be an allowance of $100 per month for a nurse or attendant, the same in addition to the $100 per month allowed in this act for the loss of both feet, or both hands, or both eyes." Public No. 26, 66th Cong., approved August 6, 1919.

[52] 66th Cong., House Subcommittee of the Committee on Interstate and Foreign Commerce, hearings (bill unnumbered), pts. 1 and 2, June 18, 19, and 28, 1919.

[53] The tentative schedule may be found in table No. 6 of this paper. This schedule is the first of record. Ibid., pp. 33–36.

ACT OF DECEMBER 24, 1919, AMENDING THE WAR RISK INSURANCE ACT, AS AMENDED: PARTIAL TEMPORARY, PARTIAL PERMANENT, TOTAL TEMPORARY, TOTAL PERMANENT, AND DOUBLE TOTAL DISABILITIES

Congress amended and modified the war risk insurance law by the act of December 24, 1919.[54] Among others, the act continued the presumption of soundness from April 6, 1917.

Section 302 of the War Risk Insurance Act was amended by increasing the monetary rate for a single veteran to $80 and for a married veteran with 2 or more living children to $100, with intermediate awards for other married veterans with children.

The act established for the first time rates for partial and temporary disabilities; partial and permanent disabilities, both to be paid a monthly award in accordance with a percentage of the compensation for his total and temporary, or permanent disability, equal to the degree of reduction in earning capacity resulting from the disability. No compensation was payable for a reduction in earning capacity rated at less than 10 percent. For permanent total disability the rate was $100 per month. The act specified certain disabilities to be deemed as total.

The act further established for the first time a new concept in disability rating. It established "double total disability" payable at $200 per month, for any 2 of the specified total disabilities existing together and entitled the veteran to double compensation.

The act reiterated the requirement for the adoption and application by the Bureau of a schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries of a permanent nature. Section 302 of the War Risk Insurance Act, as amended, was made retroactive and in effect as of April 6, 1917.

Amended section 302 in this act reads:

> SEC. 302. That if disability results from the injury—
>
> (1) If and while the disability is rated as total and temporary, the monthly compensation shall be the following amounts:
>
> (a) If the disabled person has neither wife nor child, $80.
>
> (b) If he has a wife but no child living, $90.
>
> (c) If he has a wife and one child living, $95.
>
> (d) If he has a wife and two or more children living, $100.
>
> (e) If he has no wife but one child living, $90, with $5 for each additional child.
>
> (f) If he has a mother or father, either or both dependent on him for support, then, in addition to the above amounts, $10 for each parent so dependent.
>
> (2) If and while the disability is rated as partial and temporary, the monthly rate of compensation shall be a percentage of the compensation that would be payable for his total and temporary disability, equal to the degree of the reduction in earning capacity resulting from the disability, but no compensation shall be payable for a reduction in earning capacity rated at less than 10 per centum.
>
> (3) If and while the disability is rated as total and permanent, the rate of compensation shall be $100 per month: *Provided, however,* That the loss of both feet, or both hands, or the sight of both eyes, or the loss of one foot and one hand, or one foot and the sight of one eye, or one hand and the sight of one eye, or becoming helpless and permanently bedridden, shall be deemed to be total, permanent disability: *Provided, further,* That for double, total, permanent disability the rate of compensation shall be $200 per month.
>
> (4) If and while the disability is rated as partial and permanent the monthly compensation shall be a percentage of the compensation that would be payable for his total and permanent disability equal to the degree of the reduction in earning capacity resulting from the disability, but no compensation shall be payable for a reduction in earning capacity rated at less than 10 per centum.

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[54] Public No. 104, 66th Cong., approved December 24, 1919.

A schedule of ratings of reductions in earning capacity from specific injuries or combinations of injuries of a permanent nature shall be adopted and applied by the Bureau. Ratings may be as high as 100 percent; the ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations and not upon the impairment in earning capacity in each individual case, so that there shall be no reduction in the rate of compensation for individual success in overcoming the handicap of a permanent injury. The Bureau in adopting the schedule of ratings of reduction in earning capacity shall consider the impairment in ability to secure employment which results from such injuries. The Bureau shall from time to time readjust this schedule of ratings in accordance with actual experience.

(5) If a disabled person is so helpless as to be in constant need of a nurse or attendant, such additional sum shall be paid, but not exceeding $20 per month, as the Director may deem reasonable.

ACT OF AUGUST 9, 1921, ESTABLISHING THE VETERANS BUREAU; MODIFIES THE WAR RISK INSURANCE ACT. THE 1921 SCHEDULE FOR RATING DISABILITIES

In addition to establishment of the Veterans' Bureau, this act instituted a presumption of service-connection for active pulmonary tuberculosis and neuropsychiatric diseases developing within 2 years after separation from service to a degree of 10 percent or more.[55] This act established a cutoff for benefits under the War Risk Insurance Act, for peacetime servicemen to be at the termination of 6 months after the passage of this act. Section 300 pertinent to tuberculosis and neuropsychiatric disease is quoted:

> SEC. 300. * * * *Provided further*, That an ex-service-man who is shown to have an active pulmonary tuberculosis or neuropsychiatric disease (of more than 10 per centum degree of disability in accordance with the provisions of subdivision (2) of section 302 of the War Risk Insurance Act, as amended) developing within two years after separation from the active military or naval service of the United States shall be considered to have acquired his disability in such service, or to have suffered an aggravation of a preexisting pulmonary tuberculosis or neuropsychiatric disease in such service, but nothing in this proviso shall be construed to prevent a claimant from receiving the benefits of compensation and medical care and treatment for a disability due to these diseases of more than 10 per centum degree (in accordance with the provisions of subdivision (2) of section 302 of the War Risk Insurance Act as amended) at a date more than two years after separation from such service, if the facts of the case substantiate his claim. This section shall be deemed to be in effect as of April 6, 1917.[56]

Rating disabilities and the awarding of compensation was decentralized by this act. Prior to this act, rating disabilities was done in the central office by a Board of Medical Referees in the Medical Division of the Bureau of War Risk Insurance. The bulk of the work therein was in the following sections: general medical section; surgical section; neuropsychiatric section; ear, nose, and throat section; dental section; amputation and fracture section; tuberculosis section.[57]

Decentralization of rating compensation claims was delegated to the manager of the district offices following the act of August 9, 1921. Rating boards in the district offices were created by assignment of medical officers familiar with the rating of claims from the central office.[58] After decentralization the rating of individual cases was reduced to a minimum and the central office was concerned with ratings mainly as a central supervising and coordinating agency for the estab-

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[55] Public No. 47, 67th Cong., approved Aug. 9, 1921.

[56] Sec. 300 was further amended by the addition of the words "shall be conclusively held" and taken to have been in sound condition when examined, etc. The presumption for service-connected active pulmonary tuberculosis was changed by deleting the word "pulmonary," and with neuropsychiatric disease the presumptive period was extended to 3 years. Public No. 542, 67th Cong., approved Mar. 4, 1923.

[57] Veteran Bureau, Annual Report (Medical Division), 1922, p. 26, and U. S. Veterans Bureau, Disability Rating Table, September 22, 1921, p. 10.

[58] Veterans Bureau, Annual Report, 1922, p. 26–27.

ishment of rating procedure and policies, and for the general direction of all rating activities in the field.[59]

A rating section was created in the Medical Division, Central Office, for the general supervision of policies governing ratings, the rating of individual cases being made by the medical board of review.

WORLD WAR VETERANS' ACT OF 1924. THE 1925 SCHEDULE FOR DISABILITY RATINGS

This act repealed many provisions of the War Risk Insurance Act, as amended, and promulgated new rules and regulations through the authority granted to the Director of the Veterans Bureau subject to the general direction of the President.[60]

There were six titles in the act. Title II pertained to compensation. In section 200 there was a proviso for an award of compensation to a veteran, as qualified therein, suffering from paralysis, paresis or blindness, or constitutional lues requiring hospitalization as a result of the disease. The presumption of soundness on entrance into the service was retained.[61]

An ex-serviceman who was shown to have or, if deceased, to have had, prior to January 1, 1925, neuropsychiatric disease, an active tuberculous disease, paralysis agitans, encephalitis lethargica, or amoebic dysentery developing a 10 percent degree of disability or more, had suffered an aggravation of a preexisting neuropsychiatric disease, tuberculosis, paralysis agitans, encephalitis lethargica, or amoebic dysentery in such service between the dates stated were presumed to be service-connected except that the presumption for active tuberculosis disease was conclusive and in the other diseases the presumption was rebuttable by clear and convincing evidence.[62]

This act provided for new rates and awards for specific disabilities. A schedule of ratings or reductions in earning capacity from injuries was to be adopted, based upon the average impairments of earning capacity resulting from such injuries in civil occupations similar to the occupation of the injured man at the time of enlistment and not upon the impairment in earning capacity in each individual case, and there was to be no reduction in the rate of compensation for individual success in overcoming the handicap of an injury. The bureau in adopting the schedule was to consider the impairment in ability to secure employment which results from such injuries.

Pertinent portions of section 202, title II of this act are as follows:

> SEC. 202. That if disability results from the injury—
>
> (1) If and while the disability is rated as total and temporary, the monthly compensation shall be the following amounts, payable monthly or semimonthly as the director may prescribe:
>
> (a) If the disabled person has neither wife nor child living, $80.
>
> (b) If he has a wife but no child living, $90.
>
> (c) If he has a wife and one child living, $95, and $5 for each additional child.
>
> (d) If he has no wife and one child living, $90, with $5 for each additional child.
>
> (e) If he has a mother or father, either or both dependent on him for support, then, in addition to the above amounts, $10 for each parent so dependent.

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[59] Ibid., p. 27.

[60] Public No. 242, 68th Cong., approved June 7, 1924.

[61] The provision for compensation for "constitutional lues" was deleted in an amendment. Public No. 628, 68th Cong., approved March 4, 1925.

[62] To this list of diseases was added "spinal meningitis." Public No. 448, 69th Cong., approved July 2, 1926.

(2) If and while the disability is rated as partial and temporary, the monthly compensation shall be a percentage of the compensation that would be payable for his total and temporary disability, equal to the degree of the reduction in earning capacity resulting from the disability, but no compensation shall be payable for a reduction in earning capacity rated at less than 10 per centum.

That any ex-service man shown to have had a tubercular disease of compensable degree, and who has been hospitalized for a period of one year, and who in the judgment of the director has reached a condition of complete arrest of his disease, and who shall be discharged from further hospitalization, shall be rated as temporarily totally disabled, and such rating shall not be decreased within a period of six months.

(3) If and while the disability is rated as total and permanent, the rate of compensation shall be $100 per month: *Provided, however,* That the permanent loss of the use of both feet or both hands, or both eyes, or of one foot and one hand, or of one foot and one eye, or of one hand and one eye, or the loss of hearing of both ears, or becoming permanently helpless or permanently bedridden, shall be deemed to be total, permanent disability: *Provided further,* That the compensation for the loss of the use of both eyes shall be $150 per month, and that compensation for the loss of the use of both eyes and one or more limbs shall be $200 per month: *Provided further,* That for double total, permanent disability the rate of compensation shall be $200 per month.[63]

That any ex-service man shown to have a tuberculous disease of compensable degree, and who has been hospitalized for a period of one year, and who in the judgment of the director will not reach a condition of arrest by further hospitalization, and whose discharge from hospitalization will not be prejudicial to the beneficiary or his family, and who is not, in the judgment of the director, feasible for training, shall, upon his request, be discharged from hospitalization and rated as temporarily totally disabled, said rating to continue for the period of three years: *Provided, however,* That nothing in this subdivision shall deny the beneficiary the right, upon presentation of satisfactory evidence, to be adjudged to be permanently and totally disabled.

(4) If and while the disability is rated as partial and permanent, the monthly compensation shall be a percentage of the compensation that would be payable for his total and permanent disability equal to the degree of the reduction in earning capacity resulting from the disability, but no compensation shall be payable for a reduction in earning capacity rated at less than 10 per centum.

A schedule of ratings of reductions in earning capacity from injuries or combinations of injuries shall be adopted and applied by the bureau. Ratings may be as high as 100 per centum. The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations similar to the occupation of the injured man at the time of enlistment and not upon the impairment in earning capacity in each individual case, so that there shall be no reduction in the rate of compensation for individual success in overcoming the handicap of an injury. The bureau in adopting the schedule of ratings of reduction in earning capacity shall consider the impairment in ability to secure employment which results from such injuries. The bureau shall from time to time readjust this schedule of ratings whenever actual experience shall show that it is unjust to the disabled veteran.

(5) If the disabled person is so helpless as to be in constant need of a nurse or attendant, such additional sum shall be paid, but not exceeding $50 per month, as the director may deem reasonable.

The act of June 7, 1924, called for the construction of a new rating schedule which was placed into operation on January 1, 1926. A rerating of awards under the revised schedule placed into operation was accomplished in 62.2 percent of the 226,484 cases affected by the schedule.[64] The net result of this action, according to the Director of the Veterans' Bureau, together with the establishment of claims and rating boards in regional offices, had been a gradual, though material, increase in the average value of awards, becoming especially

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[63] To the list of permanent total disability was added "the organic loss of speech." Public No. 448, 69th Cong., approved July 2, 1926.

[64] Veterans' Bureau, Annual Report, 1926, p. 1.

pronounced in those disability awards designated as "temporary partial." [65] He stated that there were three definite results which had been observed in bringing the benefits of the World War Veterans' Act: First, the long delays which had previously been due to the indirect rating procedure were eliminated. Heretofore it had been required that evidence be submitted in detailed, documentary form, to a central board, which made the rating, frequently, only after protracted correspondence to secure necessary evidence. Second, the true rating of individuals' disabilities had been by methods which insured that in all cases, where practicable for the members of the rating board to meet the claimants in person, the rating would be based upon facts determined by actual observation and further examination. Third, the direct determination of facts relating to claimants' physical condition by medical members of the board, and further determination of occupational and employment facts by qualified occupational members, made possible combined judgments based upon simultaneous consideration of these facts to determine the effects of the claimant's disabilities in impairing his earning capacity.

Up to 1930, benefits to disabled veterans of World War I were awarded and rated in accordance with a schedule for rating disabilities as required by law based on service connection. A pressing need for liberalization of benefits for disabled veterans who acquired disabilities subsequent to January 1, 1925, was under consideration at the time. How this was solved and yet stayed away from the concept of pensions is discussed in the following chapter.

Chapter III. Evolution and Development of Rates and Schedule for Rating Disabilities Subsequent to 1925

Act of May 24, 1928. Emergency Officers Retirement Act. Disability of 30 Percent or More Entitles to 75 Percent of Pay of Rank

The General Law of 1862, as amended, awarded benefits for service-connected disabilities according to rank. The War Risk Insurance Act, as amended in 1917, made no such distinction. Subsequent amendments to the War Risk Insurance Act and the World War Veterans' Act of 1924, also did not distinguish between officers and enlisted men. The question arose as to why disabled emergency officers of World War I should not receive the same disability retirement benefits as those granted to the Regular Army. Emergency Army Officers were the only ones not granted this disability retirement benefit but were awarded benefits under laws administered by the Veterans Bureau and its predecessor. Shortly after World War I a group of nonregular officers initiated action to equalize retirement benefits to those of retired regular officers. In 1928 the Tyson-Fitzgerald bill was passed by Congress over a Presidential veto.[66] In his veto, the President said: [67]

> What this bill proposes is to compensate a limited number of emergency officers not according to their disability but according to the rank which they held in the World War. It breaches the fundamental principles of our Government. * * * The most sacred duty of our citizenry is to enroll in the defense of the country in

[65] Ibid.
[66] Public No. 506, approved May 24, 1928.
[67] 76th Cong., 1st sess., S. Doc. 153, May 22, 1928.

time of need. * * * Both the commissioned officer and the enlisted man who entered the service for this emergency were serving in the same duty. * * * (The bill) is a gross discrimination against the enlisted man.

Prior to the passage of the bill an effort was made to prove that officers should receive higher disability benefits than enlisted men by showing that officers were older. The average age of disabled officers was much greater than that of disabled enlisted men; captains and first and second lieutenants, the youngest group of officers, averaged 41 years, or 8 years older than the average of all veterans in 1925.[68]

The act granted retirement pay at 75 percent of the pay of rank, to these emergency officers who had been or who would, within 1 year after the passage of the act, have incurred physical disability, rated in accordance with law at not less than 30 percent permanent disability by the Veterans' Bureau. And those emergency officers rated less than 30 percent were to be placed upon an emergency officers' retired list, created by the act, without retired pay, and were entitled only to such compensation and other benefits as were provided by laws, or regulations of the Veterans' Bureau.

Boards for the adjudication and the implementation of the law were established in the Veterans' Bureau. Applications for retirement under this act, by 1931, were 13,924.[69] Of this number 812 were filed after the act had expired. Retirement with pay had been awarded to 6,773 officers and retirement without pay to 959 (disability less than 30 percent). On June 30, 1931, retirement payments were being made to 6,364 former officers, while the total amount disbursed for such purpose during this fiscal year was approximately $11 million. The average monthly payment was $140, which represented an increase of $88 per month over the average amount of disability compensation received prior to retirement under this act. In addition to retirement pay 134 former officers were receiving an allowance for nurse and 939 were being paid insurance for permanent total disability. During the fiscal year of 1931, 436 additional officers were retired with pay.

An analysis of the disabilities for which retirement with pay was granted indicated that 15 percent were suffering from diseases of the nervous system, 12 percent from tuberculosis, and 11 percent from diseases of the circulatory system.[70]

The act specified that rating of the disability was to be in accordance with law. How the 1925 schedule of rating disabilities was used in the Veterans' Bureau for rating purposes is not known. The 1925 rating schedule was constructed on the basis of occupation and disability variants. It was by law the only rating schedule in use, and was presumably used as a guide by the boards for these cases. In looking over the 1925 Schedule of Disability Ratings, it is found that under "Neuropsychiatric Disabilities," that ratings for the degree of disability for the psychoses, psychoneuroses, epilepsies, and the endocrinopathies was determined, in general, by the extent of social inadaptability, i. e., the extent to which a claimant suffering from such conditions is unable to adjust himself to his social and industrial environment.[71]

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[68] Dillingham, op. cit., p. 174.
[69] Veterans' Bureau, Annual Report, 1931, p. 35.
[70] Ibid., p. 36.
[71] Veterans' Bureau, Schedule of Disability Ratings (1925), p. 87.

DISABILITY ALLOWANCE ACT OF JULY 3, 1930. SCHEDULE OF PAYMENTS; CREATIVE ORGAN—STATUTORY RATE FOR ARRESTED TUBERCULOSIS AND PERMANENT PARTIAL RATING OF 25 PERCENT

Statutory awards and the presumption of service-connection for certain diseases before January 1, 1925, liberalized the service-connection requirements. Agitation for disability benefits not of service origin, created a situation that was feared by the Administration in 1917, that is, a trend toward pensions and away from the theory of compensation. On July 3, 1930, an act of Congress, providing non-service-connected pensions for World War I veterans, was approved.[72] A new term was found for this act called "disability allowance" for disabilities of nonservice origin. The act amended the World War Veterans' Act of 1924, and provided: that any serviceman who served between April 6, 1917, and November 11, 1918, and had served 90 days or more, and who was suffering or who may suffer from a 25 per centum or more disability permanently, and as otherwise qualified, which was not acquired in the service during World War I, was entitled to receive a disability allowance at the monetary rates stated therein for permanent disabilities of 25 percent; 50 percent; 75 per cent; and total.

With respect to service-connected disabilities, the act included among other things an amendment to subdivision (3) of section 202 of World War I Veterans' Act, providing additional compensation of $25 per month independent of any other compensation to any person who suffered the loss of the use of a "creative organ" or one or more feet or hands as the result of an injury received in the active service in line of duty between April 6, 1917, and November 11, 1918, with the proviso that if such injury was incurred while the veteran was serving with the United States military forces in Russia, the dates were to be extended to April 1, 1920.

This act amended subdivision (7) of section 202 by adding the following statutory award and permanent rating for tuberculous disease:

> * * * That any ex-service person shown to have had a tuberculous disease of a compensable degree, who in the judgment of the Director has reached a condition of complete arrest of his disease, shall receive compensation of not less than $50 per month: *Provided, however,* That nothing in this provision shall deny a beneficiary the right to receive a temporary total rating for six months after discharge from a one year's period of hospitalization: *Provided further,* That no payments under this provision shall be retroactive, and the payments hereunder shall commence from the date of the passage of this Act or the date the disease reaches a condition of arrest, whichever be the later date.
>
> The Director is hereby authorized and directed to insert in the rating schedule a minimum rating of permanent partial 25 per centum for arrested or apparently cured tuberculosis.

At the end of the fiscal year, June 30, 1933, there were 44,260 veterans receiving the $50 statutory award for arrested tuberculous disease. As of the same date there were 5,566 veterans receiving the award for the permanent minimum rating of 25 percent for arrested tuberculosis.[73]

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[72] Public No. 522, 71st Cong. In the year 1930, the Canadian Parliament enacted for the first time to Canadian Veterans, a pension for non-service-connected disabilities.

[73] Veterans' Administration, Annual Report, 1933, p. 22.

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The number of claims filed under the disability allowance through June 30, 1931, were a total of 541,943 applications of which number 448,441 had been adjudicated. Of the total claims adjudicated 239,073 were allowed and 209,368 were disallowed.[74]

The principal diseases for which disability allowance was paid and the percent each formed of the total awards are as follows: Neuropsychiatric, 15 percent; joints and bursae, 14 percent; circulatory system, 13 percent; and tuberculosis, 12 percent. Approximately 37 percent of the tuberculosis and 25 percent of the neuropsychiatric cases received the maximum allowance of $40 per month. The average age of veterans receiving disability allowance payment was 38 years.[75]

Approximately 60 percent of the cases denied this benefit were disallowed because the permanent disability was less than 25 percent 17 percent were already in receipt of disability compensation; and 6 percent had less than 90 days' service. Only 2 percent were disallowed because the veteran was not entitled to exemption from payment of income tax.

There were no statistics in this report on the disabilities for loss of use of the creative organ, one or more hands, or feet.

A step taken to accelerate the adjudication of the disability allowance cases was the promulgation of instructions to field offices on August 4, 1930, that rating boards for this purpose might be set up where the facilities would permit with two members each, a rating specialist, medical, and either a rating specialist, claims, or a rating specialist, occupational. For disability compensation—a rating board consisted of the three specialists named.[76]

The standards for rating disabilities of nonservice origin were based on the 1925 schedule of disability ratings, and in the evaluations of degree of disability for allowance purposes, the variant 5 in all cases was used. This schedule had been constructed on the foundation of the State of California Industrial Commission schedule of rating permanent disabilities.[77] The California schedule was formulated on a percentage of average weekly earnings allowed for a percentage of incurred permanent total disability; in determining percentages of permanent total disability account was taken in the California schedule of the nature of the physical injury or disfigurement, the occupation, and age of the injured employee. An unskilled workman or a common laborer of age 39 was taken as the basis for a standard worker in the California schedule; a rating being scaled downward if the age of the employee was under 39 years and scaled upward for an employee who was over that age.[78] The 1925 Veterans' Bureau Schedule of Disability Ratings included the occupation and injury factors in the composition of the schedule. Whether the age factor in rating permanent disabilities was taken into consideration cannot be determined, but according to the act of July 3, 1930, a veteran of World War I, if otherwise qualified, required only a 25 percent permanent disability or more to qualify for a disability allowance regardless of age, or occupation.

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[74] Veterans' Administration, Annual Report, 1931, p. 36.
[75] Ibid., p. 37.
[76] Ibid.
[77] In devising the Veterans' bureau schedule of disability ratings, the Bureau had received valuable aid of the experts of the California Industrial Accident Commission. Veterans Bureau, Schedule of Disability Ratings, (1925), p. 14.
[78] California Legislature, regular session, Partial Report of Senate Interim Committee to the Senate on Workmen[8]s Compensation, 1951, p. 58.

ACT OF MARCH 20, 1933, THE ECONOMY ACT. VETERANS' COMPENSATION REDUCED—DISCONTINUES AWARDS FOR PENSIONS AND PRESUMPTIVE SERVICE-CONNECTED DISABILITIES—NEW RATES AND SYSTEM OF RATING DISABILITIES ESTABLISHED

On March 10, 1933, the President, in his message to the Senate and House of Representatives, requested extensive and flexible Executive authority in the exercise of administrative control in attaining greatly needed economies in the Federal budget: [79]

> * * * Provision for additional saving is essential, and therefore I am asking the Congress today for new legislation laying down broad principles for the granting of pensions and other veteran benefits and giving to the Executive the authority to prescribe the administrative details. * * *

Spirited debate on both sides developed for this proposal.

Finally, on March 20, 1933, Public No. 2, 73d Congress, the Economy Act was approved.

The act repealed all laws granting medical or hospital treatment, domiciliary care, pension, disability allowance, or retirement pay and compensation for presumptive service-connected disabilities to veterans and dependents of veterans of the Spanish-American War, the Boxer Rebellion, Philippine Insurrection, and World War I, except to veterans with actual service-connected disability, or their dependents if their deaths were directly service-connected.

This act set forth the basic conditions of entitlement to benefits for service-connected and non-service-connected disabilities and other benefits. The President was authorized to prescribe by regulation the minimum degrees of disability and such higher degrees of disability, as in his judgment should be recognized and prescribe the rate of award payable for each such degree of disability. The President was authorized to fix rates as he deemed just and equitable to be paid for: (1) Disabilities and death resulting from disease or injury incurred or aggravated in line of duty in war-time service; (2) disabilities and deaths resulting from disease or injury incurred or aggravated in line of duty in peacetime service; (3) disabilities and deaths not incurred in service.

The monetary rate for disability was: minimum $6, maximum $275 per month. The monetary rate for death was from $12 to $75 per month.

The President was directed to determine the beginning and termination of each war, subsequent to the Civil War, for purposes of this act, and to specify the required number of days of service for entitlement to benefits.

Section 10 of the act amended the Emergency Officers Retirement Act of May 24, 1928, so that no former officer could continue to draw retirement pay unless the disability for which he was retired resulted from disease or injury or aggravation of a preexisting disease or injury which was incurred in line of duty between April 6, 1917, and November 11, 1918.

The act further provided that the decisions made by the Administrator of Veterans' Affairs, under the provisions of title I, or the regulations issued pursuant thereto, were final and conclusive on all

[79] 84th Cong., 1st sess., The Provisions of Federal Benefits for Veterans. House Veterans' Affairs Committee Print No. 171 (Washington, 1955), p. 27.

questions of law and fact, and no other official or court of the United States could have jurisdiction to review by mandamus or otherwise any such decision.

In section 8 of the act, the Administrator of Veterans' Affairs was authorized in carrying out the provisions of title I to delegate authority to render decisions to such person or persons as he found necessary. Within the limitations of such delegations, any decisions rendered by such person or persons was to have the same force and effect as though rendered by the Administrator of Veterans' Affairs.

The President was required to transmit to Congress, as soon as practicable after the date of their issue, copies of all regulations issued in accordance with the act.

The President prescribed by Executive order between March 20, 1933, and March 19, 1935, the expiration date set in the act, 12 regulations and 29 amendatory regulations.[80] After March 20, 1935, all regulations promulgated by the President, and in existence, became law and could be changed only by acts of Congress. Section 19, of the Economy Act, reads:

> The regulations issued by the President under this title which are in effect at the expiration of 2 years after the date of enactment of this Act shall continue in effect without further change or modification until the Congress by law shall otherwise provide.

Veterans' regulations, as promulgated by the President, are not to be confused with Veterans' Administration regulations. The latter, Veterans' Administration regulations, are administrative regulations published by the Administrator of Veterans' Affairs.

SEQUENCE OF EVENTS AFTER APPROVAL ON MARCH 20, 1933, OF PUBLIC NO. 2, 73D CONGRESS

March 31, 1933

By Executive Order No. 6089, the President promulgated Veterans' Regulation No. 1. There were four parts to this regulation:

Part I provided compensation to veterans and the dependents of veterans for disabilities or death resulting from active military or naval service during the Spanish-American War, Boxer Rebellion, Philippine Insurrection, and/or the World War (wartime service). This part established presumption of sound condition on entry into the service and presumptive service-connected disability due to a chronic disease becoming manifest to a degree of 10 percent or more within 1 year from the date of separation. Service aggravation of a preexisting disease was defined. Disability ratings were graded as 10 percent, 25 percent, 50 percent, 75 percent, and total. The monetary value of total disability was established at $80 per month, and corresponding proportions for partial disabilities, less than total. Specified amounts for specified disabilities were stated at monetary values higher than total, from $100 per month for loss of both hands or both feet or of 1 hand and 1 foot, or in need of regular aid and attendance, to $250 per month for anatomical loss of both feet and both hands, or blind in both eyes, and had also suffered the anatomical loss of both hands or both feet, or of 1 hand and 1 foot.

Part II provided for the payment of compensation for disability or death incurred during peacetime service. This part established pre-

[80] Elmer A. Lewis, Laws Relating to Veterans (Washington, 1950), pp. 259–329.

sumption of sound condition on entry into the service after 6 months of service. There was no presumption of service connection for chronic diseases. Disability ratings were graded the same as wartime service, except that the monetary value was considerably less, $30 per month for total disability with corresponding amounts for disabilities less than total. Likewise, monetary values granted for specified disabilities were less than for wartime service-connected disabilities, about one-half the wartime rates for similar specified disabilities.

Part III provided for payment of pensions for disabilities or death not the result of service (wartime service only). To veterans and their dependents who qualified, a monthly amount was granted; to the veteran for permanent total disability, and to the dependent or dependents of a deceased veteran. Permanent total disability was defined and taken to exist when "there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantial gainful occupation and where it is reasonably certain that such impairment will continue throughout the life of the disabled person."

Part IV authorized the combination of disability ratings to wartime veterans, and peacetime veterans who suffered disability in line of duty in each period of service. For an award for pension purposes under part III authorization was granted to combine ratings of service-connected disabilities with ratings for non-service-connected disabilities for the purpose of determining permanent total disability.

Veterans Regulation No. 2 was promulgated by Executive Order No. 6090 on March 31, 1933. There were two parts to this regulation. Part I established the effective dates of awards of disability and death pensions. Part II established procedures for filing claims and review of claims on appeal.

Veterans Regulation No. 3 was promulgated by Executive Order No. 6091.

Schedule for Rating Disabilities: The President authorized and directed the Administrator of Veterans' Affairs—

> * * * To adopt and apply a schedule of ratings of reductions in earning capacity from specific injuries or combination of injuries. The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations. The schedule shall be constructed so as to provide 5 grades of disability and no more, upon which payments of pension shall be based, namely, 10 percent including those 10 percent but not 25 percent; 25 percent including those 25 percent but not 50 percent; 50 percent including those 50 percent but not 75 percent; 75 percent including those 75 percent but not total; and total, 100 percent. The Administrator of Veterans' Affairs shall from time to time readjust the schedule of ratings in accordance with experience.

Veterans Regulation No. 4 was also promulgated on March 31, 1933, by Executive Order No. 6092. This regulation protected the awards granted to direct service-incurred disabilities, except where under the law the rate of disability or requirement as to time of entry into active service has been changed or payment was based upon a statutory allowance. The protection afforded in the law was not applicable to any claim wherein the injury or disease causing the disability or death had been connected with active military service or naval service by virtue of any statutory or regulatory presumption of service connection.

Before Veterans Regulation No. 1 went into effect, and after the new schedule for rating disabilities had been reviewed by veterans' organizations, protest arose over the low evaluations placed into the new schedule,[81] since the impact on the service-connected disabled was heavier than had been expected in the sharp cuts in compensation.[82]

The Administrator of Veterans' Affairs stated in his report for the fiscal year ended June 30, 1933, that:[83]

> At no time in the history of pensions in the United States had a task of such great magnitude devolved upon any department of the Government handling veterans' relief as that which followed the National Economy Act of March 20, 1933, and subsequent executive regulations issued in conformity with that legislation. The Veterans' Administration was confronted with the task of taking action in over 1 million cases with adjudicatory review in approximately 650,000 cases, and the necessity for subsequent rereview of many thousands of these claims. In addition, there has been the duty of acquainting the veterans with their rights and giving the public a general understanding of the provisions of the recent law and regulations.
>
> Manifestly, imperfections and errors in a task of such magnitude were bound to arise. Directions for careful study and review were given upon signing of the first regulation. As early as June 1933, after most careful consideration of the report showing the effect of the application of the initial regulations under Public No. 2 of the 73d Congress, the conclusion was reached that certain changes should be made. While these studies did not indicate any lack of soundness in the fundamental principles upon which the initial regulations were founded, it was apparent that reductions in rates of payment to veterans suffering from direct service-connected disabilities were greater than had been anticipated. Consequently, there was recommended, and the President approved, the supplanting of the 5-step rating schedule by a 10-step rating schedule, thus permitting a higher evaluation in the degree of disability. It was also recommended and approved that the basic rate of wartime service-connected disabilities be increased. The rates for specific disabilities were increased, and other related liberalizing action was taken. While others benefited by these changes, they were essentially intended to limit reductions in service-connected cases.

On June 6, 1933, the President amended Veterans Regulations No. 1 and No. 3, by No. 1 (a) and No. 3 (a). Veterans Regulation No. 1 (a), Executive Order No. 6156, amended Veterans Regulation No. 1, and changed the monetary ratings for the percentages and statutory awards for specific disabilities, in paragraph I, of parts I and II. There was added to the specific disabilities, "loss of use of" in addition to the anatomical loss of an extremity. Ten grades of disability ratings were substituted for the previous five grades. Except for monetary amounts there were no changes made in part III.

A new part IV was added. A combination of service-connected, and non-service-connected disabilities, for purposes of benefits of non-service origin was provided. The Administrator was authorized and directed to provide for the combination of ratings and to pay a pension to those veterans who had wartime service-connected disabilities with peacetime service-connected disabilities suffered in line of duty in each period of service.

The Administrator was directed to provide, for the purpose of determining whether a veteran was suffering from permanent and total disability, ratings for disabilities incurred in active military or naval service and in line of duty were to be combined with ratings for disabilities which were not shown to have been incurred in active military or naval service. A proviso provided:

> * * * That in those cases in which the veteran, by virtue of the above provision, is found to be entitled to an award for non-service-connected disability, and is

[81] Dillingham, op. cit., pp. 74–76.
[82] Dillingham, op. cit., p. 95.
[83] Veterans' Administration, annual report, 1933, pp. 2–3.

entitled to an award for a service-connected disability, the Administrator is authorized and directed to pay the greater benefit to the veteran. * * *

Veterans Regulation No. 3 (a), June 6, 1933, Executive Order No. 6157, made two changes in and superseded Veterans Regulation No. 3:

I. The Administrator of Veterans' Affairs is hereby authorized and directed to adopt and apply a schedule of rating of reductions in earning capacity from specific injuries or combination of injuries. The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations. The schedule shall be constructed so as to provide 10 grades of disability and no more, upon which payments of pension shall be based, namely, 10 percent, 20 percent, 30 percent, 40 percent, 50 percent, 60 percent, 70 percent, 80 percent, 90 percent, and total 100 percent. The Administrator shall from time to time readjust this schedule of rating in accordance with experience.

II. In connection with the review directed by section 17 of Public No. 2, 73d Congress, the schedule of ratings provided for herein shall not operate to reduce by more than 25 per centum (exclusive of special statutory allowances) the payments being made to any veteran who on March 20, 1933, was properly rated on a permanent basis and who meets the requirements of Regulation No. 1, part I. (Note: This paragraph was added as new, and pertains to service-connected disabilities.)

Executive Order No. 6231 canceled paragraph II of Veterans Regulation No. 3 (a), on July 28, 1933.

June 16, 1933

On this day, Public No. 78, 73d Congress, was approved. This act contained amendments affecting veterans' benefits under the Economy Act, and necessitated amendatory Veterans Regulations. Among others, authority was given the President to establish a number of special boards (the majority of the members of which were not in the employ of the Veterans' Administration at the date of the enactment of this act), as he deemed necessary to review all claims (where the veteran entered service prior to November 11, 1918, and whose disability was not the result of his own misconduct), in which presumptive service-connected disability was previously granted under the World War Veterans' Act of 1924, as amended, and where payments were being made on March 20, 1933, and which were not held to be service-connected under regulations issued pursuant to the provisions of the Economy Act. Such special boards were to determine, on all evidence, the question whether service-connection for a disability was to be granted under the regulations pursuant to the Economy Act, (notwithstanding the evidence did not clearly demonstrate the existence of the disease or any specific clinical findings of a chronic disease becoming manifest to a degree of 10 percent or more within 1 year from the date of separation from active service, and notwithstanding there was no record of such disease during the period of active service; provided the veteran served 90 days or more in active service in World War I).

To the special review boards, established in the act of June 16, 1933, were referred the cases of World War I veterans who entered the service prior to November 11, 1918, whose disabilities were presumptively of service origin. That is, where awards had been granted on the basis of the presumption of soundness at the time of entering the service, unless otherwise officially recorded; and the presumption of service connection in World War I for certain chronic diseases showing a 10-percent development before January 1, 1925, and these

chronic diseases being limited to neuropsychiatric diseases, any active tuberculous disease, spinal meningitis, paralysis agitans, encephalitis lethargica, and amoebic dysentery.

The Special Review Board had authority to grant service connection under Public No. 2, 73d Congress. The Review Board was to resolve all reasonable doubt in favor of the veteran and the burden of proof in such cases being placed upon the Government. The decisions of such boards was to be final, subject to such appellate procedures as the President prescribed.

Under Public No. 78, 73d Congress two groups of World War I veterans were involved in monetary awards: (*a*) Where the Special Review Board granted service connection, the veteran was entitled to receive full monetary payments under the 1933 schedule, only; (*b*) This act further provided that in no event were the rates of compensation payable for directly service-connected disabilities to those World War I veterans in active military or naval service prior to November 11, 1918, if otherwise qualified, and in receipt of compensation on March 20, 1933, be reduced more than 25 percent (this group was entitled to receive compensation under the 1933 schedule, but reduction of compensation, if involved, could not exceed 25 percent of the former rate). Although reducing the monetary award by 25 percent under the rating schedule of June 6, 1933, many veterans were still insured receipt of monetary awards greater to that which they formerly received.

July 28, 1933

The President promulgated Executive Order No. 6930 Veterans Regulation No. 2 (a) implementing the provisions of Public No. 78, 73d Congress. In part III of this regulation provisions were made for rules and procedures for the special review boards for the review of claims for presumptive service-connected disabilities.

Public No. 78, 73d Congress (1933) made certain provisions for veterans of the Spanish-American War, Boxer Rebellion, and the Philippine Insurrection, who served 90 days or more, honorably discharged from the service, were 55 years of age or over, had 50 percent disability, and in need. These veterans were paid a pension of $15 per month. Further, by Presidential Executive Order No. 6229, Veterans Regulation No. 1 (b) amended Veterans Regulation No. 1 (a) part III by providing for this group of veterans.

The Economy Act proposed in principle to bring into uniformity the several and diverse laws for veterans' benefits, including awards for service and non-service-connected disabilities, to those of all wars. The Economy Act was not restricted to benefits for wartime service connected or aggravated, as is prevalent in principle in European countries. The act provides for benefits to peace time disabled veterans, and to war veterans with non-service-connected disabilities. Thus, the Economy Act and the act of June 16, 1933, Public No. 78, 73d Congress, and the accompanying Veterans Regulations, gave an old-age pension to Spanish American War, the Philippine Insurrection, and the Boxer Rebellion, if otherwise qualified. For these veterans, a broad regulatory presumption was made and permitted the continuance of the award being received prior to the approval of the Economy Act. There were further liberalizations to this class of veterans during the fiscal year of 1934. At first payments for non-service-connected disability of 50 percent or more and age 55 years

were made, and later without regard to age, or, without specific disability, on attaining age 62 years, in both cases at $15 per month or one-half the rate prescribed for total disability ($30 per month).[84]

In the administration of Public Laws Nos. 2 and 78, disabilities previously classed as directly service connected were handled as regards their service connection on the same basis as under the World War Veterans' Act, except that persons who enlisted after November 11, 1918, and before February 9, 1922, under the War Risk Insurance Act, or July 2, 1921, under the World War Veterans' Act of 1924, who had previously had all the rights of world war veterans with respect to compensation, were regarded as having only peacetime service connection entitled to approximately one-half rates, for their disabilities.[85] The first Presidential regulation promulgated under Public No. 2, which was not substantially altered as to service connection, granted rebuttable presumption of service origin for diseases approved by medical advisers as chronic diseases (previously conclusive as to certain diseases indicated above) in the event of 90 days' active war service. Under instructions promulgated May 19, 1933, approximately 1 month before the enactment of Public No. 78 in that year, service connections previously granted for diseases on the basis that they existed prior to enlistment (and were aggravated by service) or during service, or within 1 year following discharge, where veterans served 90 days or more during the war, were continued unless medical judgment supported by a showing of clear and unmistakable error that the continuance of such connections was clearly erroneous and unwarranted. All disabilities connected under any of the preceding rules were considered directly service connected and were entitled to be rated under the rating schedule adopted pursuant to Public No. 2, with first $90 a month, and after January 19, 1934, $100, for total disability and proportionate parts for partial disability in multiples of 10 percent, or alternately, to receive compensation at three-quarters of the rates provided as of March 19, 1933, if this provided a greater benefit. Disabilities for which service connection was allowed by the special boards of review were entitled to the full benefit of the 1933 schedule, but protection of 75 percent of the former rate was not continued.[86]

In the review of cases within the Veterans' Administration, in accordance with the recent laws, it was the policy to remedy defects of the program by Presidential regulation and otherwise. Presidential regulations restoring former presumptive cases to the rolls pending review by the final appellate agency had been promulgated March 27, 1934.[87]

On the next day, March 28, 1934, Public No. 141, 73d Congress, restored to the compensation rolls those veterans removed as a result of the previous reviews, provided they served before November 11, 1918, and provided their service connection had not been established through fraud, mistake, or misrepresentation, or, if established by presumption, could not be rebutted by a clear and unmistakable showing of inception prior or subsequent to service, and not aggravated thereby, and the disabilities were not due to misconduct. This act also prohibited reductions in compensation as compared with the

[84] Veterans' Administration, Annual Report, 1934, p. 20.
[85] Ibid., p. 21.
[86] Ibid., p. 22.
[87] Ibid.

former World War Veterans' Act rates in all wartime service-connected cases as long as the physical condition remained unchanged, except certain presumptive cases retained on the rolls and except as to reductions in the event of hospitalization. This act also in main, restored the provisions of section 200 of the World War Veterans' Act as to service connection as of March 28, 1934, except that all presumptions were rebuttable, and authorized compensation under that act in such cases. The act further provided, that whenever there was a change in the degree of disability of any such veteran the amount of compensation to be paid was to be determined under the provisions of the World War Veterans' Act, as amended, and the rating schedule in effect on March 19, 1933, which was the 1925 schedule of disability ratings, and that such amount was not to be discontinued or reduced.

Public No. 141, 73d Congress, required the Veterans' Administration to adjudicate claims under the laws in effect on March 19, 1933, and under the Economy Act to determine under which laws the veteran or his dependents were to be paid the greater benefit. Certain special awards and allowances in effect on March 19, 1933, were restored under Public No. 141.

Section 33 of Public No. 141, 73d Congress, defined service-connected money benefits payable to World War Veterans as "compensation" and not "pensions." Public No. 494, 79th Congress, approved July 9, 1946, repealed the foregoing section 33, and stated: That under laws administered by the Veterans' Administration monetary benefits, other than retirement pay, for service-connected disabilities or death shall be designated "compensation," and not "pension."

Subsequent legislation did not affect the system of rating disabilities from the standpoint of basic percentage awards. Future legislation concerned itself with liberalizing the presumptions, statutory awards for specific disabilities, establishing peacetime rates for service-connected disabilities and further restoration of world war veterans to the rolls. For reference, a pamphlet with title I, Public No. 2, 73d Congress, and the 12 Veterans Regulations, as amended up to October 25, 1954, containing the numerous changes therein made by many separate acts of Congress, was prepared for the use of the House of Representatives Committee on Veterans' Affairs. Express amendments are reflected in the body of the Economy Act, in this pamphlet, and are cited in the margin of the applicable section. Public Laws impliedly amending the same are indicated in footnotes.[88]

Totally disabled veterans of World War II by causes not connected with service were not entitled to pension benefits prior to May 27, 1944. On that date Public No. 313, 78th Congress, was enacted, amending existing law by extending benefits to these totally disabled World War II veterans who met the requirements with regard to length of service and limitations of income, and the requirements of the Veterans' Administration for total disability, as contained in extension No. 4, dated November 15, 1941, to the 1933 Schedule for Rating Disabilities, and later in the revised schedule of 1945, in paragraphs 16 and 17, as amended by extension No. 5 to the 1945 schedule, dated October 7, 1948. Briefly, these requirements stipulate that when the requirements of permanence are met, total disability ratings may be assigned without regard to the specific provisions of the rating schedule when the disabled veteran has reached a certain age with a

[88] 83d Cong., 2d sess., House Committee on Veterans' Affairs, House Committee Print No. 294 (Government Printing Office, Washington, 1954).

specified degree of disability, or without the specification of age and based solely on the attainment of specified degrees of disability, and unable to secure or follow a substantially gainful occupation. The Administrator of Veterans' Affairs in his annual report in 1946 stated that:

> The full effect of this law will probably not be felt until the veterans of World War II reach middle age, when the so-called degenerative diseases manifest themselves. On June 30, 1946, slightly more than 2 years after the passage of this legislation, there were 1,463 World War II veterans on the rolls. The average veteran in this group was 37 years of age and the greatest incidence of disability was shown at 48 years of age. There were 6 veterans over 65 years of age thereby entitled to the $60 rate.[89] There were 95,234 veterans of World War I on the rolls on June 30, 1946, in this same category.[90]

In 1945 the Veterans' Administration revised the 1933 Schedule for Rating Disabilities. On June 27, 1946, Public No. 458 was approved. This act was enacted to govern the effective dates of ratings and awards under the Veterans' Administration revised Schedule for Rating Disabilities, 1945, and for other purposes, as follows:

> * * * That on and after the first day of April 1946, all initial ratings in claims for disability compensation or pension and awards based thereon under Public Law 2, Seventy-third Congress, March 20, 1933, and the Veterans Regulations issued pursuant thereto, as amended, shall be determined under the Veterans' Administration revised Schedule for Rating Disabilities, 1945, whether the claim covers a period before or after that date. In any case in which the revised schedule authorizes an increase in the rating previously made by a rating board of original jurisdiction under the Schedule for Rating Disabilities, 1933, such increased rating and award based thereon will be effective as of the first day of April 1946.
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> * * * * * * *
>
> SEC. 3. The Administrator of Veterans' Affairs shall from time to time readjust the Schedule for Rating Disabilities, 1945, in accordance with experience.

At present, the monthly benefit rates paid for the various degrees of partial disability for wartime service-connected disabilities are as follows:

10 percent disability	$17	60 percent disability	$109
30 percent disability	33	70 percent disability	127
30 percent disability	50	80 percent disability	145
40 percent disability	66	90 percent disability	163
50 percent disability	91	100 percent disability	181

These awards are continuing in nature for as long as the specified degree of disability exists.

The monetary rates for peacetime service-connected disabilities are 80 percent of the wartime rates (Public No. 876, 80th Cong., July 2, 1948). Wartime rates are payable in peacetime cases where the disability resulted from injury or disease received in line of duty as a direct result of armed conflict or while engaged in extrahazardous service, including service under conditions simulating war (Public No. 359, 77th Cong., December 19, 1941).

CHAPTER IV. DESCRIPTION OF THE SCHEDULES FOR RATING DISABILITIES

1919 SCHEDULE FOR RATING DISABILITIES

As mentioned earlier in this report, the first statutory provision to prepare, adopt, and from time to time amend, and readjust a schedule for rating disabilities, in accordance with experience, appeared in Public No. 90, 65th Congress, approved October 6, 1917.

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[89] Veterans' Administration, Annual Report, 1946, p. 14.
[90] Ibid., p. 16.

* * * A schedule of ratings of reductions in earning capacity from specific injuries or combination of injuries of a permanent nature shall be adopted and applied by the bureau. Ratings may be as high as one hundred per centum. The ratings shall be based, as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations and not upon the impairment in earning capacity in each individual case, so that there shall be no reduction in the rate of compensation for individual success in overcoming the handicap of a permanent injury. The bureau shall from time to time readjust this schedule of ratings in accordance with actual experience. * * *

The record shows that sometime between October 6, 1917, and June 18–19, 1919, such a schedule was in preparation. There were comparatively few compensation laws in existence and almost no data on permanent injuries based on scientific analysis and factual field studies. There were no lists of diseases upon which an evaluation and standards of the degree of partial disability could be established and incorporated into the schedule. There was no supply of readily available survey literature suitable for guidance, training, and educational purposes for those who were to adjudicate and administer the law. There was no time given for a gradual building of an organization with practical experience in adjudicating a system based upon an intended substitute for and in lieu of pensions; indemnities for total and partial disabilities; from the best experience of all States which had compensation and indemnification laws, and on the obligation of the Government to rehabilitate the disabled veteran to as perfect a physical condition as upon entry into the service, and to optimal family, social, and economic life. There were no data, based on sound scientific principles, established to base the ratings in the schedule "upon the average impairments of earning capacity resulting from injuries in civil occupations." Nevertheless, the Advisory Board to the Secretary of the Treasury, authorized in the act of October 6, 1917, and established for the purpose in adjusting claims for compensation for disability and death, compiled, with the assistance of surgeons in New York, a tentative schedule of ratings.[91]

In the hearings on H. R. 5723 the actuaries who prepared an estimate of the expenditures for the Secretary of the Treasury for compensation for death or disability, as contained in the bill, based their estimates on certain assumptions:[92]

(*a*) The assumption that 50 of each 1,000 men exposed to the hazard of war would be "totally disabled," and predicated on fragmentary information obtained from the British, Canadian, and German war records.

(*b*) The schedule of allowances for compensation for partial disability were approximately the average allowance for the four States of California, Kentucky, New Jersey, and Wisconsin, under the workmen's compensation laws.

(*c*) The assumption, from the same sources as in (*a*), that 75 per 1,000 would be partially disabled.

(*d*) That the average allowances for the various types of partial disability would be 40 percent of those totally disabled.

(*e*) That the average percent of disability was 40 percent.

(*f*) That the estimate would be wide of the mark if a scale of compensation differing materially from the one assumed should be adopted.

The 1919 tentative schedule of ratings for partial permanent disability, as submitted to Congress in that year, indicates that the formulation was a beginning. There was no statement upon which the basis of the percentage ratings were established. There was no

[91] 66th Cong., House Subcommittee of the Committee on Interstate and Foreign Commerce, hearings (bill unnumbered), pt. 1, p. 32, June 18, 19, 1919.

[92] 65th Cong., 1st sess., House Committee on Interstate and Foreign Commerce, hearings, H. R. 5723 August 17, 1917, p. 52.

statement of authority for the schedule; no policy statement as to interpretation and rating of disabilities; no rules of procedure; no instructions; no definitions; no code numbers for the various disabilities listed; very little descriptive medical criteria for the determination of a specific degree of disability, and very few diseases listed. The emphasis of this schedule was primarily placed upon objective conditions, such as amputations, ankyloses, hernia, visual defects and eye disabilities, defective hearing, and so forth. Epilepsy was given 4 ratings starting at 20 to 100 percent in increments of 20 percent depending upon the frequency of "fits." Mental deterioration was awarded a rating of 10 to 80 percent, but how the in-between ratings were to be awarded was not specified. Under the heading "Subjective conditions" were listed two disabilities: Insanity, total, 100 percent, and epilepsy (again listed), fits occurring several times a day, 100 percent. Under the heading "Objective conditions," in addition to those listed above, was included under "III, The trunk," pulmonary tuberculosis, 10 to 100 percent, but how the rating was to be awarded was not specified. For tuberculosis of bone and joint a footnote was added explaining that this disease "will automatically fall in the regional disabilities and the rating in each case will not exceed the percentage for the loss of the limb at the level of tuberculosis." How the rating agency was to make an award in the case of multiple disabilities was not stated.

Percentages of partial disabilities were listed at anywhere from 0 to 100 percent; some were listed at 5, 15, 25, 35 percent, etc.; others were listed at 10, 20, 30, percent, etc. Loss of the index finger, middle finger, little finger, all at the proximal joint of the minor extremity were listed each 7.5 percent. Loss of thumb, involving the metacarpal bone of the major extremity was listed at 17.5 percent. Loss of thumb, involving the metacarpal bone in the minor extremity, and loss of thumb, at the proximal joint in the major extremity were each listed at 12.5 percent. Chronic bronchitis was rated as 0 to 10 percent.

1921 DISABILITY RATING TABLE

The 1921 disability rating table consists of 84 pages printed on both sides and bound by two staples between covers of manila folder paper. The schedule was approved September 22, 1921, by the Director of the United States Veterans' Bureau, C. R. Forbes. The schedule had no table of contents. There were no code numbers for listed disabilities. There was no index.

The first 11 pages are devoted to instructions, definitions, descriptions, and establishing policies for examinations of claimants, and procedure of rating disabilities by the Medical Division of the Bureau of War Risk Insurance, as well as organization and duties of the district supervisors, district offices, and field organizations.

On page 1 Preface to Disability Rating Table the applicability of the rating table is stated in the first paragraph, that is, in determining the degree of disability for compensation, term insurance, and under the definition provided for in converted insurance policies. It goes on to say:

> Whenever the medical evidence is insufficient to determine which of two disability ratings should be given, the higher rating should be made and should continue until such time as it is definitely and unquestionably shown that this rating was consistent with the facts. Difficulty will frequently be encountered

in connecting present disabilities with the military or naval services. If there be any doubt in the minds of those whose duty it is to rate such cases here again the benefit of the doubt must be given the claimant. Even though it is not definitely and clearly shown that the disability from which he suffers is of service origin, it should be so considered, if the possibility that such condition could have originated in or have been aggravated by the service is reasonable when considered in the light of clinical and pathological experience. It is believed that the Congress and the public at large would be more willing to condone possible errors in favor of ex-servicemen than those in favor of the Government.

On page 5 disability was defined to be a mental or physical condition which would cause to the average person an impairment of earning capacity in civil occupation. Disabilities were classed as: Temporary—partial—or total; permanent—partial—or total.

On page 6, temporary—partial—or total—and permanent—partial—or total—disabilities were defined as follows:

> Certain specific disabilities are called statutory as they are provided by law. For example: "A claimant is considered to be totally and permanently disabled when he has suffered the loss of both feet or both hands, or the sight of both eyes, or the loss of 1 hand and 1 foot, or 1 foot and the sight of 1 eye, or 1 hand and the sight of 1 eye, or becomes helplessly and permanently bedridden."

Double total permanent disabilities

The law provided that for double total permanent disabilities "the rate of compensation shall be $200 per month." Claimants who had lost both eyes and both arms, both eyes and both legs, or 1 foot and 1 hand and both eyes, were considered to be in this class. Only three cases of double total permanent disability were on record in the Bureau at that time. Two had lost both arms and both eyes and one had lost both hands and both eyes. There were no cases on record either in the United States Army or the British Army of men who had lost both arms and both legs.

The basis for ratings, as found on page 7, were made upon the claimant's actual physical or mental condition at the time his application was made, as shown by a report of examination made by a physician or physicians designated by the Bureau of War Risk Insurance or the United States Public Health Service to examine the claimant. Ratings were made in accordance with the attached rating table. Service connection or aggravation was to be established for the disability before compensation could be awarded. Service connection and service aggravation were then defined.

Definitions for "discharged from service", "discharged from draft", "latent defects", and "patent defects" were given.

"Minimum compensable disability" was considered to be compensation for a reduction in earning capacity rated at less than 10 percent. The Medical Division, Bureau of War Risk Insurance was delegated the rating of disabilities in the following sections: General Medical Section; Surgical Section; Neuropsychiatric Section; Eye, Ear, Nose, and Throat Section; Dental Section; Amputation and Fracture Section, and the Tuberculosis Section.

Cases were referred to medical referees of the appropriate sections and ratings were thus made in each instance by specialists in each of the above branches of medicine. Claimants having disabilities involving two or more specialties were rated for each disability by a specialist in the respective sections, the combined rating being the concurrent action of two or more sections.

Permanent and total disability cases

All cases which had been rated as permanently and totally disabled were referred to a Medical Board of Review consisting of five members. The rating was either confirmed or disapproved by this Board and the case was sent to the Board of Appeals for approval or confirmation. If the action of the Medical Board of Review was confirmed by the Board of Appeals, no further action was necessary.

In the case of disagreement between the two boards, the case was referred to the Assistant Director of the Compensation and Claims Division and the Medical Adviser; and in case of disagreement between them, to the Director.

Rules for the disallowance of claims are stated.

Rules for the discontinuance of compensation are laid down, as well as for reexaminations of claimants.

The disability rating tables proper are covered in sections from pages 13 to 84. Each section encompasses the medical specialty that was to be rated in the corresponding and appropriate section within the central office of the Medical Division Bureau of War Risk Insurance, and used by the medical referees within that section of specialized medicine. They are: neuropsychiatric disabilities, from pages 13 to 23, inclusive, subdivided into psychoses-psychoneurosis, and peripheral nerve subsections; surgical disabilities from pages 25 to 37; amputations, fractures and their sequelae, pages 39 to 44; general medicine, pages 45 to 57; eye, ear, nose, and throat disabilities, pages 57 to 74; section for ratings for tuberculosis, pages 75 to 81; and ratings for dental conditions, pages 82 to 84.

Ratings for neuro-psychiatric disabilities

The foreword to this section stated that in compiling the appended schedule of ratings for these disabilities, opinions of leading neuro-psychiatrists of the United States, the rating schedules of France, Canada, England and Belgium, and the accumulated experience of the Bureau of War Risk Insurance had been utilized.

Disability from psychoses was to be determined by the degree of social inadaptability, e. i., the degree to which the claimant is unable to adjust himself to his social and industrial environment. The average disability from disease or injury was not to be determined by the degree of vocational handicap (the amount of hindrance from resuming former occupations), but the degree to which the claimant was incapacitated from carrying on any substantially gainful occupation.

The degree of disability from epilepsy was to be determined by the type and frequency of seizures, their cause, and associated psychic change. The degree of disability resulting from endocrine disorders was to be determined as disability from actual physiological disfunction or hyperfunction, certain psychoneurotic symptoms and the degree of disability from social inadaptability.

Functional heart disorders were to be rated under the psychoneurotic disorders.

Special consideration was given to alcoholism, in that it was required to determine whether the alcoholism was the cause or effect of disability. "Prolonged alcoholic indulgence prior to enlistment resulting in disability from chronic alcoholism, such disability arising in the service, is ratable." In a similar manner rules for drug addiction were made.

Ratings for organic and inorganic psychoses were:

Complete social inadapatability.—Temporary total to permanent total.

Partial social inadaptability requiring supervision.—Temporary partial, 50 percent, to permanent partial, 50 percent.

Partial social inadaptability but requiring no supervision.—Temporary partial, 25 percent, to permanent partial, 25 percent.

With complete social adaptability.—Less than 10 percent to temporary partial, 10 percent.

Ratings for constitutional psychotic inferiority and mental deficiency, without psychoses:

With partial social adaptability but requiring supervision.—Temporary partial, 10 percent, to permanent partial, 10 percent.

With partial social adaptability but requiring no supervision.—Less than 10 percent.

Ratings for epilepsy without psychoses:

Traumatic.—Dependent upon frequency of seizures, social adaptability, neurological manifestations, and social adaptability, 25 percent to permanent, total.

Idiopathic:

Grand Mal.—Temporary partial, 10 percent, to permanent partial, 10 percent, to permanent total.

Petit Mal.—Less than 10 percent to temporary partial, 15 percent, to permanent partial, 15 percent.

Psychoneuroses-hysteria, psychasthenia, neurasthenia, and anxiety neurosis with—

Complete social inadaptability.—Temporary total.

Partial social inadaptability requiring supervision.—Temporary partial, 25 percent, to permanent partial, 25 percent.

Requiring no supervision with complete adaptation.—Less than 10 percent to temporary partial, 10 percent, to permanent partial, 10 percent.

Ratings for organic diseases of the central nervous system varied from 10 or 15 percent temporary partial to permanent total. For myelitis, primary sclerosis, syringomyelia, tabes, and multiple sclerosis, ratings were permanent partial, 25 percent, to permanent total.

Ratings for the endocrinopathies, listed on page 18, were: From less than 10 percent to temporary total, or partial to total permanent, "depending upon the type and degree of the disability presented as shown by functional impairment and social inadaptability."

Ratings for functional cardiac diseases were from less than 10 percent to temporary total; and from permanent partial to permanent total, depending upon the type and degree of the disability presented.

Cranial nerve disabilities were rated on a permanent basis, as: Permanent partial 10–25 percent, or 10–50 percent.

Neuralgia or neuritis was rated less than 10 percent to temporary partial, 25 percent.

Peripheral nerve ratings, pages 21–23, in the upper extremity depended upon the major or minor arm involved, from 10 percent, or 15 percent, or 20 percent, or 25 percent, or 30 percent, or 35 percent, or 40 percent, or 50 percent to a maximum of 80 percent, for the musculo-spiral nerve. Ratings for brachial plexus involvement were from 30 percent to 75 percent, and total radicular paralysis of the upper extremity was given a single rating of 90 percent for the major

arm and 85 percent for the minor arm. All ratings for peripheral nerves were upon a permanent basis. An instruction on page 21 stated that in making ratings for peripheral nerve injury where there was an associated rating for a surgical disability for the wound causing nerve injury, the combined rating for functional loss was not to be greater than the surgical rating for amputation at the level of the injury.

Ratings for surgical conditions

The foreword to this section read:

In arriving at the following schedule or ratings for surgical disabilities, the various opinions of leading surgeons in the United States, and the schedule of ratings of Belgium, France, Canada and England now in effect have been taken into consideration.

Ratings under the surgical section sometimes duplicated, or were at variance with the ratings in the medical section. For example:

A. CREATIVE ORGAN

	General surgical disability ratings	Percent	General medicine disability ratings	Percent
Testicle:				
Orchitis (inflammations, infections, or injuries).	(1) Active:			
	Temporary partial	10	Temporary partial	10
	To temporary total	------	To temporary partial	20
	(2) Healed: Rate on sequelae.	------	------	------
Loss of:				
1	Permanent partial	10	------	------
2	do	50	------	------
Atrophy of 1:				
Complete	------	------	Temporary partial	15
Incomplete	------	------	do	10
Not specified	Less than	10	------	------
Atrophy of both:	With loss of function	25	------	------
Complete, under age 45	------	------	Temporary partial	90
Incomplete, under age 45	------	------	do	40
Penis:				
Acute (injuries, inflammations, and infections).	Temporary partial	25	------	------
	To temporary total	------	------	------
Chronic	Less than	10	------	------
	To temporary partial	10	------	------
Loss of:				
Glands	Permanent partial	15	------	------
½	do	25	------	------
½ to complete	do	25	------	------
	To maximum	60	------	------
Deformity of:				
With resulting permanent loss of erectile power.	Permanent partial	40	------	------
Severe, preventing coitus	do	40	------	------
Impotence due to injury (irremediable).	do	25	------	------

B. ABDOMINAL CAVITY

Gastroenteroptosis:				
Slight	Less than	10	------	------
Moderate	Permanent partial	10	------	------
Irremediable	do	10	------	------
Severe	do	25	------	------
Irremediable	do	25	------	------
Interoptosis	------	------	Less than 10 percent	10
Not specified	------	------	Temporary partial	20

C. HEPATITIS (CIRRHOSIS OF THE LIVER)

Both general surgical disability and general medical disability ratings are in general agreement for hepatitis.

General surgical ratings for the following disabilities are listed: Tumors, injuries and infections of the abdominal wall; intraabdominal conditions, such as of the peritoneum, stomach, liver, gall bladder and ducts, pancreas, intestines, appendix, kidney, bladder, prostate, and hernia.

Hernia was rated at less than 10 percent when it was considered reparable; and when not so considered, but requiring a belt or truss, permanent partial 25 percent to 50 percent. Extensive destruction of abdominal support with hernia was rated as permanent total, and an "internal hernia" was rated as temporary total.

Adhesions were rated from less than 10 percent to temporary and permanent partial 10 percent.

Hemorrhoids and prolapse of the rectum were rated from less than 10 percent temporary partial to temporary total.

Disability ratings of the thoracic wall were for scars, tumors, fractured ribs and sternum, pleura, lungs, mediastinum, pericardium, and great blood vessels; and varied from less than 10 percent for scars not limiting movement, to temporary total and permanent partial.

Under ratings for disabilities of the great blood vessels, there was one awarded a rating for "arteriosclerotic, arrested traumatic," of permanent partial 25 percent to 50 percent.

General surgical ratings varied from less than 10 percent temporary partial, to temporary total, and permanent partial of 10 percent to permanent total.

Ratings for amputations, fractures, and their sequelae

The foreword to this section worded the same as in the general surgical section.

The first sentence to this section, on page 40 states "in general, loss of muscle substance, cicatrices and atrophies, when having an effect upon functions, from 10 percent to 25 percent should be added to the specific rating.

The section starts with the upper extremity at the shoulder, then to the elbow, wrist, and fingers. For the lower extremity ratings start at the hip, then go to the knee and ankle. Disabilities were rated for ankylosis, and limitation of motion to the parts named. The lowest ratings were awarded to limitation of motion of either the 4th or 5th finger irrespective of the major or minor arm, and whether the digit was at a favorable or an unfavorable angle. For limitation of motion at a favorable angle of the third finger a 30 percent rating was allowed, and for limitation at an unfavorable angle 5 percent. Limitation of motion of the thumb and index fingers at a favorable angle were rated 10 percent each, and at an unfavorable angle 25 percent each. However, ankylosis (solid healing at the joint) and at a favorable angle the index finger was rated at 5 percent, and at an unfavorable angle, 8 percent. Ankylosis of the thumb at a favorable angle was rated at 10 percent and at an unfavorable angle 25 percent.

The highest disability rating for ankylosis of the extremities was 50 percent for an ankylosis of the elbow at an unfavorable angle. Even, an ankylosis of the shoulder at an unfavorable angle did not rate higher at 45 percent.

Permanent partial ratings from 10 percent to 60 percent for shortening of the lower extremity were provided.

Ratings were listed for amputations of the fingers, hand and arm at different levels, as well as in the lower extremity. A 2-percent disabil-

ity rating was awarded for the amputation of any second, third, fourth or fifth toe, or at the distal joint of any finger, except the thumb. Disability rating for a single fourth or fifth finger was 5 percent for each, and where the fourth and fifth finger was amputated on the same hand, the rating was 11 percent.

The highest rating for the upper extremity was 94 percent for disarticulation of the major arm at the shoulder joint. The highest rating for lower extremity amputation was 80 percent for a disarticulation at the hip joint.

Ratings for general medicine

Some of these ratings have been compared above with the general surgical disabilities. Cardiovascular disabilities rated temporary and from temporary partial 10 percent to temporary total 100 percent, except for angina pectoris, aortic insufficiency with symptoms of angina pectoris, and aneurysm of the aorta, which were given a permanent total rating. Arteriosclerosis with symptoms not markedly increased, slight weakening of mental or bodily vigor with renal or cardiac complications was rated from 10 percent temporary partial to 25 percent temporary partial; and with symptoms of increased tension, pallor of skin, marked loss of mental and bodily vigor with cardiac or renal complications, 25 percent temporary partial to permanent total.

Disability ratings for skin conditions were included in the general medicine ratings section; all were temporary ratings from less than 10 percent temporary partial to temporary total.

A subdivision, under the general medicine section, constitutional and specific infections, included: rheumatic fever, acute and chronic; myalgia; arthritis deformans; diabetes mellitus; diabetes insipidus; syphilis; leprosy, and parasitic diseases. Ratings were from temporary partial 10 percent to temporary total, and permanent total being assigned to specified degrees of involvement in rheumatoid arthritis and leprosy, osteoarthritis was listed by a cross reference note to the surgical rating, and was not found in the surgical section, nor in the table.

Ratings for eye, ear, nose and throat disabilities

The foreword to this section was the same as for the general surgical section. There were two pages of instructions to guide the medical officer in rating eye, ear, nose and throat conditions. Refractive error was considered to be congenital and not compensable. At the bottom of page 58 this is stated:

> * * * There will doubtless appear for some time, but in a continually diminishing number, patients for whom authority has been given on a temporary partial rating of 10 percent for a limited period for the purpose of permitting them to obtain glasses, for the removal of tonsils, septum and turbinates at the expense of the Bureau. This, we are advised by the General Counsel, is not permissible under the act, and will be discontinued. * * *

A chart of refractive errors of various degrees, after correction by proper lenses is supplied to determine the percentage rating for visual disability; a corrected vision of 20/40 in one eye and with 20/50 vision in the other was entitled to a 5 percent disability rating; in the same situation, 20/40 in one eye and 20/70 in the other eye, the disability rating was 7 percent. To these ratings were added 10 percent, or 20 percent, or 15 percent, or 30 percent provided, special conditions were met, such as; corneal opacity, deformed pupils, central choroiditis,

lenticular opacity, detachment, and lens extraction. Rules for establishing blindness in one or both eyes were stated. Disability ratings were given to specified eye conditions; eyelids; eyeball; paralysis of muscles of the eye; the vast majority of ratings were permanent partial.

Hearing defects were rated as permanent partial from 0 percent to a maximum of 65 percent. Disabilities of the nose and throat were from less than 10 percent to temporary total, and a few permanent partial to permanent total.

A subdivision for surgery of the head and neck disabilities with ratings was listed. This subdivision included the skull and cranial bones, loss of skull bone, face, buccal cavity and adnexia, tongue, salivary glands, tonsils, esophagus, and scars.

Loss of skull bone was rated at 10 percent for loss of one-half square inch; 15 percent for loss of one-half to one and one-half square inches; and 10 percent for each square inch over one and one-half square inches.

Ratings for tuberculosis

The wording of the foreword was the same as for general surgical disabilities. There were two pages of general principles in rating pulmonary tuberculosis. A few are extracted:

> Where no respiratory disability is shown to have occurred in military service, pulmonary tuberculosis developing at a date more than 12 months after separation from service will not be considered compensable (i. e., not incident to service).
>
> * * * * * * *
>
> Where any disability is found to have resulted from tuberculosis the minimum rating for this disability shall be 25 percent. However, our experience in dealing with many cases of tuberculosis claimants would lead us to believe that after the condition has been arrested for a long period of time it is found that no industrial disability exists; in such cases a rating of 10 percent, or even less than 10 percent, is justified.
>
> * * * * * * *
>
> Claimants who have suffered no active tuberculosis during their military service and are discharged from service with arrested tuberculosis showing no activity for a period of 18 months to 2 years, should not be compensated for any reactivation of a tuberculous lesion occurring later. It is not considered in such cases that the military service has had no bearing on the reactivation of the tuberculosis process. However, claimants who have suffered with active tuberculosis during service and are discharged with an arrested condition should be compensated for any future reactivation of the disease because it is considered that the activation suffered during service might tend to a subsequent reactivation, or that the diagnosis of arrested tuberculosis upon discharge from service might have been in error.

Certain forms of extrapulmonary tuberculosis were rated as permanent total, such as: Acute miliary, meningeal, adrenal, spinal, articular. The ratings listed were:

Pulmonary tuberculosis

Patient undergoing institutional treatment—temporary total.

Not requiring institutional treatment, rated according to the average impairment of earning capacity; incipient—temporary partial 15 to 25 percent; incipient with definite signs—temporary partial 25 to 50 percent; moderately advanced—temporary partial 75 percent, or less if the average impairment of earning capacity proves less than three-fourths; far advanced—temporary total.

Arrested pulmonary tuberculosis

For 6 months after arrest—75 percent temporary partial.

After 6 months the rating was based upon the average impairment of earning capacity.

Not showing any activity at any time after discharge—temporary partial 10 percent or less than 10 percent if no impairment of earning capacity exists.

Other forms of extrapulmonary tuberculosis were rated as temporary partial—20 to 90 percent, such as laryngeal and genitourinary. Tuberculosis of the bones and peritonitis were rated as temporary partial 0 percent to temporary total.

Dental ratings

Missing teeth as specified—temporary partial, 10 to 15 percent.

Pyorrhea—temporary partial, 10 percent.

Vincent's stomatitis—temporary partial, 10 percent.

Loss of part or all the aveolar ridge of the superior or inferior maxilla or both—permanent partial, 10 to 50 percent.

Structural or functional loss of the mandible between the angles—permanent partial 50 percent to total.

There were no gynecological conditions listed in this disability rating table.

1925 SCHEDULE FOR RATING DISABILITIES

The United States Veterans' Bureau Schedule of Disability Ratings (1925) was authorized and based upon the World War Veterans' Act of 1924, as amended.

The schedule is a bound single volume, printed in 1931 at the Government Printing Office, but considered to be the 1925 schedule. The volume is 9½ by 12 inches, and contains 162 pages; an index in front of the general material, an alphabetical index of injuries, a statement of authority for the schedule made by the Director; general policy in rating disabilities, instructions for the application of the schedule, directions how to use the schedule, an occupational rating table, a disability rating table, a combined rating table, and instructions for its use; United States Veterans' Bureau rating codes, and an appendix of extensions (changes) to the schedule.

Page 14 of the schedule states that the tables were devised through consulting aid of the experts who designed the Schedule of Rating Permanent Disabilities of the California Industrial Accident Commission, data from the Bureau International du Travail, Geneva, Switzerland, and other national and international sources of correspondence; publications of the Department of the Army, Department of Commerce, Census Bureau, and the Department of Labor.

Much has been said about the California Schedule of Rating Permanent Disabilities, and that the Veterans' Bureau Schedule of Disability Ratings was patterned after it. The big difference between the 2 is that the California schedule uses 3 tables in arriving at a disability rating—1 for age, 1 for occupation, and 1 for injuries. The Veterans' Bureau schedule uses only 2 of the tables for a disability rating, 1 for occupations and 1 for injuries; and in addition there is a table for combined ratings of multiple disabilities.

Table I is an alphabetically arranged list of occupations. Opposite each occupation appear 17 injury variants: eye, ear, nose and throat, nervous system, head and neck, chest, back and perineum, abdomen and pelvis, arm, forearm, hand, thumb, fingers, thigh, leg, foot, and systemic.

Table II consists of a list of injuries and diseases arranged, to facilitate reference, into separate schedules: Disabilities from amputations, fractures, dislocations, deformities, and their sequelae, surgical, eye, ear, nose, and throat; general medical, neuropsychiatric, dental and oral; respiratory system and tuberculosis, pulmonary and other forms. Opposite the list of diseases and injuries occurs a series of nine occupational variants which are determined by and carried over from the ratings in table I.

In the application of the schedule the occupation of the claimant at the time of enlistment was determined in accordance with Veterans' Bureau instructions. The occupation at time of enlistment having been satisfactorily determined, the disability was next ascertained. Thereupon the medical rating specialist of the rating board referred first to table I, locating the appropriate occupation. The disability, or disabilities, in the case were then considered with regard to the injury variants. The figures at the reading junction of the occupations with the applicable injury variants were references to the occupational variants (1–9) in table II. The rating specialist turned to table II, and read and assigned the percentage of disability occurring at the junction of the injury list and the column reference (from 1–9) given by table I.

Different variants were assigned the components of a limb, for example, depending upon special job requirements for such parts. In occupations demanding digital dexterity—as typists, and so forth—the variant for fingers was higher than for forearm or arm, for the reason that even where there was very considerable disability of the arm or forearm from ankylosis, limitation of motion, and so forth, the finger function may not have been interfered with. In the case of a lower extremity, occupations, such as certain machine workers, requiring special pedal dexterity which, the ankle joint being intact, could be exercised even if there was ankylosis or limitation of movement in higher levels of the extremity. This was not true of amputation of limbs, or in peripheral nerve paralysis involving wide muscle groups.[93] Therefore, in the case of the upper or lower extremity, when there was an amputation, a widespread peripheral nerve paralysis, or other massive involvement of the extremity. The rating for such affected limb was to be, throughout, the maximum variant assigned any component thereof.

On page 43 of the schedule, permanent total disability is defined:

> A rating of permanent total disability will be made, without regard to the determined occupation, when it is medical opinion that there is present "any impairment of mind or body which continuously renders it impossible for the disabled person to follow any substantially gainful occupation and which is founded upon conditions which render it reasonably certain that it will continue throughout the life of the person suffering from it." It is obvious that a claimant who has a disability which makes it impossible for him continuously to pursue any substantially gainful occupation is, ipso facto, debarred from the continuous pursuit of the particular occupation determined under this schedule. The converse of this is, however, not true; that is, a claimant who under the terms

[93] Veterans' Bureau, Schedule of Disability Ratings (Government Printing Office, Washington, 1931), p. 14.

of this schedule (especially where there are two or more combined compensable disabilities) is held to be permanently and totally disabled for the occupation assigned him, is not necessarily permanently and totally disabled for any substantially gainful occupation.

This system of rating disabilities was not difficult where the disabilities were obvious, such as amputations, limitation of motion, unfavorable or favorable ankylosis, loss of eyebrows, deformed eyelids, etc. In rating disabilities for eye, ear, nose and throat, general medicine, neuropsychiatric, respiratory and tuberculosis, and surgical conditions, many intangible factors were involved. One solution arrived at in this schedule for an equitable rating was to revert to the use of making ratings by the old method used under the 1921 schedule, of ratings for temporary partial, or total; and permanent partial or total. This is analogously summed up to some extent in the difficulty encountered in rating constitutional psychopathic inferiority and mental deficiency cases on page 89 of the schedule—

* * * In effecting this determination it is expected that the examiner will exercise due intelligent and conscientious judgment. * * *

And in paragraph 4 of extension 8, Schedule for Rating Disabilities, dated February 26, 1930, general considerations in rating the psychoneuroses—

Social inadaptability (is), the criterion for rating disability from the psychoneuroses * * *. The disability measured in reduction of earning capacity, must be intrinsic; that is, such extrinsic factors as unemployment because of trade depressions, dissatisfaction with work environment, or domestic difficulties do not enter into the consideration unless secondary to the psychoneurosis * * *. While rating boards can evaluate reduction in earning capacity through social inadaptability from a sufficiently detailed examination report, the examiner may add an opinion as to the relative severity, medically considered, of the clinical picture presented in the individual case. The rating schedule contemplates that the manifestations listed under the pronounced psychoneuroses may appear in mild, moderate, or severe forms, in the less conditions. Thus, with less than the most pronounced symptom combinations, having only mild, moderate, or severe effects upon social adaptability, the lower ratings are in order. To check undue elevation of the ratings for psychoneurosis, that rating for disability from psychoneurosis should be applied which most nearly approximates the relative disabling effect of similar manifestations to organic origin when such a comparison is warranted. Thus, the ratings for impairment of hearing, disturbances of vision, contractures, paralyses, tics, epileptic seizures (grand or petit mal), aphonia, tachycardia, gastritis, etc., should be used as a basis of comparison when pertinent to the individual picture of psychoneurosis.

Multiple disabilities were to be combined in accordance with instructions on page 124 of the schedule. This is a system introduced for the first time from the California schedule. The combined ratings table was applied to the combination of ratings of two or more disabilities, or temporary disabilities, or of permanent and temporary disabilities. The combination was not simple addition. In combining a permanent disability rating with a temporary disability rating, the permanent disability rating was first transformed into a temporary rating by multiplying the permanent rating by 1¼. The totals were then combined, not added. Where there was a permanent partial rating and a temporary partial rating, and the combined rating would be more than temporary total, the rating was made a permanent partial one, by multiplying the temporary partial rating by ⅘ and then combining it with the permanent partial. For example, permanent partial 82 percent combined with temporary partial 20 percent: 20 times ⅘ equals $^{80}/_{5}$, equals 16 percent permanent partial; 16 percent multiplied by 18 percent (i. e., 82 percent subtracted from

100 percent), equals 2.88 percent (3 percent) which added to 82 equals 85 percent. Ratings of less than 10 percent, temporary or permanent, were combined to aggregate a compensable total (i. e., 10 percent or more), or were combined with other associated compensable ratings.

Under this schedule disabilities were rated and compensated in multiples of 1 percent—such as, 10 percent, 11 percent, 29 percent, etc. However, a single disability, or combined disabilities rated at less than 10 percent were not monetarily compensated.

Extension No. 5, to the Schedule of Rating Disabilities, dated June 20, 1928, promulgated new disability ratings, for healed muscle wounds with particular reference to gunshot wounds and including lacerated wounds of the same type due to other trauma. The various muscles of the body were classed into groups I, II, III, etc., up to XXIII and severity described as slight, moderate, moderately severe, and severe.

The Director of the Veterans' Bureau reported upon the application of the 1925 schedule [94]—

> On the technical side, the work of the year centered around the development and application of a schedule of disability ratings to comply with section 202 (4) of the World War Veterans' Act. The preparation of this schedule was pioneer work, and involved research into occupational specifications and into the principles of schedule making which was unfortunately curtailed by the limited number and routine duties of qualified staff members. This schedule as finally released was a combination of 2 extended tables, 1 developed chiefly by occupational specialists evaluating approximately 1,000 occupations separately for each of 17 body parts, the other, developed primarily by a medical expert evaluating approximately 1,600 disabilities, with 9 separate ratings on each, dependent on the occupational importance of the body part as evaluated in the other table.
>
> With respect to the medical evaluations, the adequacy of the previous schedule was in general accepted as applied to average occupations, i. e., to those evaluated in table I as "average" for the body part in question. Changes were made on certain disabilities to bring the ratings more in line with certain statutory total disability ratings.
>
> The fundamental principle considered in the medical portion of the table was that compensation is payable not on account of disease or injury, but on account of functional disability resulting from such disease or injury. Consequently, with respect to certain disabilities, e. g., gunshot wounds leaving little actual residual impairment of functions, ratings were reduced to conform to the degree of impairment.
>
> In the occupational portion of the table, in addition to the meager character of specifications with respect to physical requirements, the chief difficulty was in the conception of similarity. It will generally be recognized that groupings with respect to one principle of similarity will not in general conform to groupings with respect to one or more principles. Consequently it proved entirely impracticable to carry through groupings with respect to industrial similarity and wage similarity, but, instead, the single principle of similarity of physical requirements was adopted. Thus the value "9" assigned to a group of occupations with respect, say, to the eye, indicates that, in the judgment of five vocational specialists, experienced in training disabled men for all types of occupations, the group is similar with respect to the quantity of eye requirements, and that group exceeds in eye requirements all groups rated "8" or lower. A veteran having an eye disability, whose occupation at time of enlistment is evaluated as in the "9" group, will receive the maximum rating for his disability. If his occupation is evaluated in the "5" group, he will receive the average or standard rating for the disability, and if it is evaluated in the "1" group, he will receive the minimum rating.
>
> In determining the upper and lower limits for disability ratings, for particular disabilities, consideration was given to the probable average percentage reduction in earning capacity in the groups making the highest and lowest demands, respectively, upon the part of the body in question. Consideration was also given to the general reduction in employability resulting from the condition,

[94] Veterans' Bureau, Annual Report, 1926, pp. 41, 42.

recognizing that in all industrial fields men constantly change occupations and that a disabled man can, by proper choice, practically always step down the physical scale into a more or less closely related occupation and earn an amount which with his disability compensation will equal or exceed the average preenlistment earnings of his occupational group.

The application of the schedule created a flood of correspondence chiefly on the principle of determining the claimant's occupation at time of enlistment and analogous schedule occupations when his occupation was not listed in the schedule.

In this same annual report, the Medical Service Report commented upon the new schedule of rating disabilities:[95]

The new bureau schedule of disability ratings, prepared in accordance with the provisions of section 202, subsection (4), of the World War Veterans' Act, 1924, was put into operation January 1, 1926; and while necessarily a voluminous technical piece of work which presented many new problems in its preparation, experience with it has vindicated opinion as to its comparative simplicity in application. Rerating under it, through cordial cooperation of regional offices, has progressed in general with expedition, and its reception was gratifying. However, much work remains to be done in amplyfying the list of occupations in table No. 1, so as to cover the widest possible range of occupations in a country industrially so diversified as the United States and its dependencies. Also table No. 2 will be further elaborated to include new delineations of disease conditions, subdivided into various pictures of clinical severity. This contemplated revision, authorized under the provisions of the law, will in the future be handled through a special advisory group on rating policy and procedure, with such special training as will enable the members of this group to study and apply in the work experience of all other organized agencies engaged in similar activities.

1933 SCHEDULE FOR RATING DISABILITIES

Authority for the schedule was given by Executive order and Veterans Regulation No. 3 (a), and approved by the President June 6, 1933 in accordance with Public No. 2, 73d Congress, the Economy Act.

The second edition of the 1933 Schedule for Rating Disabilities is a bound volume of 76 pages, and 6 by 9½ inches in size (Government Printing Office, Washington, 1933). The volume contains a table of contents, a statement of the authority for the schedule, a statement of the general policy in rating disability, definition of total disability, combined rating table, disability ratings classified into extremities, spine, and abdominal musculature, muscle injuries, peripheral nerve injuries, circulatory disturbances of the extremities, the head and neck, neuropsychiatric disabilities, the eye, ear, nose, and throat, general medical and surgical disabilities, tumors, the abdominal cavity, the genitourinary system, the lungs and pleura, the heart and blood vessels, systemic diseases, the blood-forming organs, the lymphatic glands, skin, gynecological conditions, and dental and oral disabilities; rating codes; instructions for reporting statutory awards for specified disabilities; and an alphabetical index.

The general policy is defined as a consistently applied policy of the Veterans' Administration to administer the law under a broad interpretation, and that ratings of disability should be upon a liberal basis, consistent with the facts shown in every case. The claimant is not required to establish the service origin and degree of his disability either to a mathematical or moral certainty, but by preponderance of evidence, and beyond a reasonable doubt.

The Veterans' Administration requires evidence of actual impairment of function affecting the industrial adjustment of the individual, correlated with clinical and laboratory findings indicative of disease, or the residuals of disease or traumatism. Mere congenital or de-

[95] Ibid., p. 7.

velopmental abnormalities do not furnish a basis for determinations of disability, nor the degree of disability is determined in the absence of a clear presentation of the clinical manifestations of the underlying pathology.

The degrees of disability specified in this schedule are correlated, as far as can practicably be determined, with average reduction in earning capacity from permanent or comparatively stabilized chronic diseases, healed injuries, or their residuals. Generally, it may be said that the degrees specified are considered adequate to cover considerable loss of working time from incapacitating exacerbations, or illnesses, proportionate to the severity of the several grades. Increased ratings are not in order pending actual increase in the permanent degree of disability. A permanent disability is a disability which it is reasonably certain will continue unimproved throughout the claimant's life (p. 4).

The Combined Ratings Table starts with a combination of 10 and 19 percent and progress according to the table. To use the combined ratings table, the disabilities are arranged in the exact order of their severity, beginning with the greatest disability. A combined percentage for two or more disabilities is obtained after application to the table according to instructions (p. 8). The combined value is converted to the nearest number divisible by 10, and combined values ending in 5 are adjusted upward (p. 8). Thus, with a 50 percent disability and a 30 percent disability the combined value from the table is 65 percent; therefore, converted to 70 percent. Similarly, with a disability of 40 percent and another disability of 20 percent, the combined value from the table is 52 percent, but this must be converted to the nearest degree divisible by 10, which is 50 percent. Adjustments for temporary and permanent disabilities, as in the 1925 schedule, are not made.

Where there are disabilities of two paired extremities or of paired skeletal muscles, the ratings for the disabilities of the right and left sides are combined as usual, and 10 percent of this value is added, not combined, to the combined value.

Disability ratings for 23 groups of injured muscles were revised by using the variant 5 of the 1925 schedule, to represent the major arm percentage rating in the specified degrees of severity, as slight, moderate, moderately severe, and severe. Muscle disabilities of the minor arm were represented by the variant 3 in the same manner. Adjustments of values ending in 5 were made upward and conversion to the nearest number divisible by 10 was made for a percentage rating in muscle injury. A comparison of the ratings awarded under the schedules of 1925, 1933, and 1945 is made in the description of the 1945 schedule in this report.

Ratings for peripheral nerve disabilities and classification of the degrees of paralysis were revised in the 1933 schedule. The 1925 schedule classed peripheral nerve injuries as either "complete" or "partial" and gave a single rating to each. The 1933 schedule retains the classification of "complete," and modifies "partial" into incomplete, mild, moderate, or severe, with a separate rating to each of these lesser degrees of severity. The criterion for rating neuropsychiatric disability (see above under 1925 schedule) of social inadaptability was amended by adding "industrial inadaptability." Percentages for the various degrees of social and industrial inadapt-

ability are specified depending upon the severity of the social and industrial "incapacity," such as complete, considerable, and definite when in partial remission; and, when in remission, slight social and industrial "incapacity"; and in complete remission or with symptomatology such as to cause no appreciable social and industrial "incapacity" a minimum of 10 percent. The other degrees of severity were given higher percentages accordingly.

There were seven extensions to the 1933 schedule. Extension No. 4, dated November 15, 1941, amended the rule for "total disability." Certain percentages of disabilities were required in addition to "unemployability" for one or more disabilities regardless of age, for a veteran to be considered "totally disabled," such as: For compensation purposes, 1 of 60 percent, or with 2 or more disabilities, 1 disability was to be 40 percent, and the 2 or more brought the combined rating to 70 percent. For benefits for non-service-connected disabilities, "total disability" was considered to be present on the attainment of a specified age and specified percentage requirements, in addition to "unemployability." The above percentage requirements were reduced by 10 percent on the attainment of age 60; and by an additional 10 percent on the attainment of age 65; and no percentage requirements for total disability ratings in the cases of unemployable veterans who attained the age of 70.

1945 SCHEDULE FOR RATING DISABILITIES

In 1945, The Schedule for Rating Disabilities was recognized as official by Public, No. 458, 79th Congress, approved April 1, 1946.

The 1945 Schedule for Rating Disabilities is a bound 8-inch by 10½-inch volume with 141 pages (Government Printing Office, Washington: 1945).

The volume contains: Authority for the schedule, a table of contents, numerical index of disabilities, instructions in the general policy of rating disabilities, combined rating tables, and sections for disability ratings, such as, convalescent ratings from date of discharge, the organs of special sense, systemic conditions, the respiratory system, the cardiovascular system, the digestive system, the genitourinary system, gynecological conditions, the hemic and lymphatic system, endocrine system, skin, neurological conditions and convulsive disorders, psychiatric conditions, and dental and oral conditions; rating codes, and an alphabetical index of disabilities.

New disability code numbers start from 5000 and end with 9913. The numerical index of disabilities lists these numbers under the systems indicated above, each assigned a group of numbers.

The first 27 pages of the schedule are devoted to instructions contained in numbered paragraphs, and into three general headings: (*a*) General policy in rating disability; (*b*) convalescent ratings from date of discharge; (*c*) the musculoskeletal system.

Subject material, discussed under these headings, is contained in the following paragraphs:

(*a*) *General policy in rating disabilities*

(1) Essentials of evaluative rating; (2) interpretation of examination reports; (3) resolution of reasonable doubt; (4) service connected generally; (5) circumstances of service; (6) evaluation of evidence;

(7) the higher of two ratings; (8) residual conditions; (9) aggravation of congenital or developmental defects; (10) functional impairment; (11) reconciliation of diagnoses; (12) relationship of disabilities; (13) effect of change of diagnoses; (14) avoidance of pyramiding; (15) total disability ratings; (16) total disability ratings based on unemployability; (17) special considerations, age in nonservice cases; (18) unemployability; (19) age in service-connected claims; (20) analogous ratings; (21) application of rating schedule; (22) rating disabilities aggravated by active service; (23) attitude of rating officers; (24) correspondence; (25) combined rating table; (26) bilateral factor; (27) use of diagnostic code numbers.

(*b*) *Convalescent ratings from date of discharge*

Ratings are assigned in lieu of ratings prescribed elsewhere. (1) Injuries: requiring hospitalization, or such, 6 months, 100 percent; recent, unhealed, improving, disabling, but able to resume partial employment, for 6 months, 50 percent; (2) diseases; acute or subacute, hospitalization, or such, for 6 months, 100 percent; improving, disabling, but able to resume partial employment, for 6 months, 50 percent.

NOTE.—Above are awarded from date of discharge from service, and the 100 percent rating may be extended no more than 6 months, reduction in ratings, or discontinuance prior to 6 months may be adjudicated.

NOTE No. 2: Extension No. 7, to the 1945 schedule, amends the above by allowing temporary surgical ratings, 100 percent, following major or orthopedic surgery, service connected, preventing return to employment after hospitalization, granted for 20, 60, to maximum of 90 days only, from date of intervention.

(*c*) *The musculoskeletal system*

(1) Functional loss; (2) history of injury; (3) complete medical examination of injury cases; (4) osteomyelitis; (5) the bones; (6) the joints; (7) accurate measurement; (8) effect of missiles; (9) scars; (10) deeper structures; (11) muscle injury; (12) muscle weakness; (13) muscle damage; (14) muscle patterns; (15) muscle groups; (16) principles of combined ratings; (17) evaluations of residual muscle damage, slight, moderate, moderately severe, severe; (18) service incurrence; (19) static foot deformities; (20) arthritis due to strain; (21) atrophic arthritis; (22) atrophic arthritis of the spine; (23) disability factors; (24) hypertrophic arthritis; (25) hypertrophic arthritis of the spine; (26) painful motion; (27) rheumatic fever; (28) examination; (29) circulatory disturbances; (30) loss of use of hand or foot, amended by extension No. 3; (31) nomenclature of digits; (32) venereal disease; (33) sacroiliac joint; (34) pelvic bones; (35) congenital conditions; (36) amputation rule; (37) bilateral factor; (38) major hand; (39) inadequate examinations; (40) drawings showing standardized description of ankylosis and limited motion.

To the 23 muscle group injuries were added: Rupture of the diaphragm; injury to facial muscles, and muscle hernia.

Disability ratings for muscle disabilities were increased in the percentages to the correlated degrees of severity, for example:

Comparison of percentage of disability ratings for indicated muscle groups in the 1925, 1933, and 1945 Schedule for Rating Disabilities

Muscle group	1925 VA schedule	1933 VA schedule	1945 VA schedule
Group I: Elevators of arm above shoulder:			
Major arm disability:	*Percent*	*Percent*	*Percent*
Slight	0	0	0
Moderate	12	10	10
Moderately severe	17	20	30
Severe	25	30	40
Minor arm disability:			
Slight	0	0	0
Moderate	8	10	10
Moderately severe	12	10	20
Severe	20	20	30
Group V: Flexor muscles of the elbow (bend elbow):			
Major arm disability:			
Slight	0	0	0
Moderate	12	10	10
Moderately severe	20	20	30
Severe	30	30	40
Minor arm disability:			
Slight	0	0	0
Moderate	8	10	10
Moderately severe	15	20	20
Severe	25	30	30

NOTE.—The variant 5 was used for the major arm and variant 3 for the minor arm under the 1925 schedule: these variants were used in determining the percentage rating for the same degrees of muscle disability, and the percentage ending in 5 or over was rated upward, and final percentage divisible by 10. The increase in percentages of disability in the 1945 schedule wherever made, cannot be explained, for muscle group percentage ratings.

Disability ratings for psychiatric conditions are based upon the criterion of degree of impairment of social and industrial adaptability, and determined by the adjectives of slight, definite, considerable, severe, nearly complete, and complete.

Nine "extensions" to the 1945 schedule were published, some with subextensions, such as, 4A, and 4B, etc. As an example, extension No. 5, dated October 7, 1948, rescinded paragraph 17, page 6 of the schedule and substituted instructions. Paragraph 17 of the 1945 schedule pertained to the policy determination and special consideration of age in non-service-connected disabilities, which was first introduced in the 1933 schedule by extension No. 4, November 15, 1941. Extension No. 5, 1945 schedule, October 7, 1948, is as follows:

1. Paragraph 17, page 6, Schedule for Rating Disabilities, is rescinded and the following substituted:

For the purpose of Veterans Regulation 1 (a), part III only, the percentage requirements of the preceding paragraph are reduced, on the attainment of age 55 to a 60 percent rating for one or more disabilities, with no percentage requirement for any one disability. The requirement at age 60 will be a 50 percent rating for one or more disabilities. At age 65, there will be no percentage requirement other than one disability ratable at 10 percent or more. When these reduced percentage requirements are met, and the disabilities involved are of permanent nature, rating as permanently and totally disabled will be assigned if the veteran is determined to be unable to secure and follow substantially gainful employment by reason of such disability. In making such determinations the following will be used as guides.

(a) Marginal employment, for example, on own farm, in own business, or at odd jobs, at less than half the usual hours of work or less than half the usual remuneration will not be considered incompatible with a determination of unemployment, unemployability, if the restriction, as to securing or retaining better employment, is due to the disabilities.

(b) The fact that unemployable persons meeting the percentage standards have also physical, mental, or personality defects of congenital or developmental nature, which may be a partial cause of the unemployability, will not preclude favorable rating.

(c) As it is the policy of the Administration that all veterans who are basically eligible and who are unable to secure and follow a substantially gainful occupation by reason of disabilities which are likely to be permanent shall be rated as permanently and totally disabled for the purposes of Veterans Regulation 1 (a), part III—therefore—the cases of all veterans who fail to meet the percentage standards, who meet basic entitlement criteria, but who are unemployable, will be referred to Central Office under R and P R–1142, with statement as to unemployability by the rating board.

Extensions to the schedule for rating disabilities, 1945

Extension No.	*Date*
No. 1. Ratings for pulmonary tuberculosis following hospitalization	July 14, 1947
Amendment to extension No. 1	Nov. 10, 1948
No. 2. Ratings for prolonged exacerbations of service-connected disabilities requiring hospital treatment	Oct. 17, 1947
No. 2–A. Ratings for prolonged exacerbations of service-connected disabilities requiring hospital treatment	Aug. 16, 1948
No. 3. Definition, loss of use of hand or foot; ankylosis; and complete paralysis of external popliteal nerve	June 17, 1948
No. 4. Combined ratings; diagnosistic code numbers; bilateral factor; muscle injury, etc., of additional instructions and changes embodied in 25 paragraphs	Aug. 23, 1948
No. 4–A. Rating pulmonary tuberculosis	July 9, 1954
No. 4–B. Infectious hepatitis (change in rating)	Feb. 17, 1955
No. 5. Permanent and total disability ratings, Veterans Regulation 1 (a), part III	Oct. 7, 1948
No. 6. Ratings for pulmonary tuberculosis	Nov. 8, 1949
No. 6–A. Ratings for tuberculosis	Sept. 12, 1950
No. 7. Temporary surgical ratings; osteomyelitis, arthritis hypertrophic, etc., of additional instructions and changes embodied in 30 paragraphs	July 6, 1950
No. 8. Ratings for hearing impairments	Feb. 27, 1952
No. 8–A. Ratings for hearing impairments	Oct. 27, 1952
No. 9. Permanent total disability ratings, tuberculosis, peripheral vascular disease, etc., of additional instructions and changes embodied in 13 paragraphs	June 9, 1952

Chapter V. Statutory Awards for Disabilities

AMERICAN REVOLUTIONARY WAR TO 1862

On August 26, 1776, the Continental Congress passed a resolution for benefits to be paid disabled veterans of the American Revolution. The act specified that every officer, soldier or sailor "losing a limb" in any engagement of the United States as to render him incapable of earning a livelihood would be paid half his monthly pay for life, and those "not so totally disabled from getting a livelihood" would receive such monthly sums toward his subsistence as was judged adequate but not to exceed half pay.[96]

Specified disabilities were paid similarly until 1785 when the rate was changed to $5 a month for those noncommissioned officers and grades lower. (petty officers included), disabled in the service of the United States so as to be wholly incapable of military or garrison duty, or of obtaining livelihood by labor, and those not so wholly disabled, a proportionate rate corresponding with the degree of their disability, compared with another wholly disabled.[97] The rates remained until the act of 1806 when the half pay of officers was

[96] Ford, Journals of the Continental Congress, XII, 953.
[97] Journals of Congress, IV, 821.

commensurate with their rank but not to exceed that of a lieutenant colonel, and the half pay of a noncommissioned officer and grades lower remained at $5 per month, later changed to $8 per month.[98] This was the status until the enactment of the General Law on July 14, 1862, and the rates for officers were specified according to rank and not to exceed that for a lieutenant colonel, at $30 per month for total disability and $8 per month for a noncommissioned officer and grades lower for total disability.[99]

CIVIL WAR AND THE GENERAL LAW, 1862-1917

Before the Civil War was over the first step was taken to increase the monetary allowance for certain specified disabilities and above the $8 for total disability in service personnel with grades lower than officer rank. Total disability in 1862 was understood to be disability for the performance of manual labor.

The act of July 4, 1864, which was the first of many specific awards, and subsequent acts, granted a monthly award of $25 for loss of sight of both eyes, or loss of both hands, and $20 for loss of both feet.[1]

The act of March 3, 1865, allowed $20 for total disability or the loss of 1 hand and 1 foot.[2]

Additional permanent specific disabilities were granted awards in the act of June 6, 1866: Total disability of both hands—$25; total disability of both feet—$20; loss or total disability of 1 hand or 1 foot—$15; disability equivalent to the loss of a hand, or a foot (third grade)—$15.[3]

An increase in the monetary amount was provided for these statutory awards in the act of June 4, 1872: $31, $31, $18, $18.[4]

The act of June 6, 1866, also, introduced a new concept for statutory rates of $25 a month for disability of such character as to require regular aid and attendance of another person (first grade) and $20 a month for incapacity to perform manual labor (second grade). These rates were also increased to $31.25 and $24 by the act of June 8, 1872.

The consolidation act of March 3, 1873, "an act to revise, consolidate and amend the laws relating to pensions," codified previous statutory rates for specified disabilities previously enacted under the General Law, and added a new one for loss of hearing of both ears. The provisions of the act were retroactive to June 4, 1872. The law provided the following:

(*a*) All persons entitled to a pension, and otherwise qualified, and who lost the sight of both eyes; lost the sight of one eye, the sight of the other having been previously lost; or shall have lost both feet; or have been permanently and totally disabled in same; or otherwise so permanently and totally disabled as to render him utterly helpless; or so nearly disabled as to require the aid and attendance of another person, were granted $31.25 per month.

(*b*) Loss of one hand and one foot; or have been permanently and totally disabled in same; or otherwise so disabled as to be incapacitated for performing any manual labor, but not so much as to require regular aid and attendance, $24 per month.

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[98] 2 Statutes at Large, 376.
[99] 12 Statutes at Large, 566–569.
[1] 13 Statutes at Large 387–389.
[2] Ibid., 499–500.
[3] 14 Statutes at Large 56.
[4] 17 Statutes at Large 335.

(*c*) Loss of one hand; or one foot; or have been permanently and totally disabled in same; or otherwise disabled as to render him incapacitated to perform manual labor equivalent to loss of hand or foot, $18 per month.

(*d*) A proviso added that all persons who, under like circumstances have lost a leg above the knee and in consequence thereof are so disabled that they cannot use artificial limbs, were to be rated in the second class and receive $24 per month.

(*e*) Loss of hearing, both ears, $13 per month.

Another proviso added that the pension for a disability not permanent, equivalent in degree to any provided for in the law, was, during the continuance of the disability in such degree, to be awarded a rate as provided for permanent disability in like degree.

So long as the fixed statutory rates were limited to such very specific injuries as the loss of an arm or leg, or the loss of sight, there was no great difficulty in treating them as exceptions to the normal total disability rate under the General Law. However, there was incongruity between the law which provided that a private soldier should receive $8 a month for total disability to perform manual labor and the other provision of the law which said that he should receive $24 a month for incapacity to perform any manual labor. The Report of the Commissioner of Pensions for 1874 stated this problem as follows:

> * * * the difficulties of the subject (equitably rating disabilities under existing laws) are increased by the fact that under existing law the different degrees of disability, for which rates of pension differing widely are provided, may be confounded. The act of July 14, 1862, provided a pension of $8 per month in the case of a private soldier for a total disability for the performance of manual labor. For a disability incapacitating for the performance of any manual labor, the act of June 6, 1866 provided a pension of $20 per month, which was increased to $24 per month by the act of July 14, 1862, have words "total disability" which occur in the act of July 14, 1862, have been construed by this Office to mean a total disability for the performance of manual labor requiring severe and continuous exertion. The words "any manual labor" occurring in the act of June 8, 1872, and the act of June 8, 1872, have been construed to include also the lighter kinds of labor which require education and skill. It is believed that the construction given by this Office to these acts is in accordance with the intention of their framers; but, as it is difficult to draw a line of distinction between the acts referred to, which renders their execution difficult, and the decisions of the Office thereunder unsatisfactory to claimants. If law could be so amended as to provide more definite standards for the comparison of degrees of disability, the Bureau would be relieved from its greatest source of embarrassment. This Office is not at present prepared to suggest a remedy for the manifest difficulty; but, in justice to itself, the embarrassment from this source ought to be pointed out.[5]

Disabled veterans, with service-connected disabilities, who had loss of sight of both eyes, loss of both feet, or loss of both were granted an increase in the awards to $72 per month in accordance with the act of June 16, 1880. Later legislation had the effect of putting the rates fixed for specific disabilities even more out of line with the "total disability" of the act of 1862. A long series of laws subsequently increased the statutory awards for the various specific disabilities.[6]

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[5] Report of the Commissioner of Pensions, 1874.

[6] A table showing the increases for the various specific disabilities in awards up to 1929 is contained in Federal Laws Relating to Veterans of Wars of the United States, 72d Cong., 1st sess., S. Doc. No. 131 (Government Printing Office, Washington, D. C., 1932), p. 65. A table of statutory awards for specific disabilities is also found in the appendices of section II of this staff report.

WAR RISK INSURANCE ACT, AS AMENDED BY THE ACT OF OCTOBER 6, 1917

The act of October 6, 1917, amended the War Risk Insurance Act and established statutory awards for specific disabilities:

Totally disabled and in addition so helpless as to be in constant need of a nurse and attendant, an additional sum not to exceed $20 per month.

Loss of both feet, or both hands, or both eyes, or becoming totally blind, or helplessly and permanently bedridden, $100 per month.

Allowance for a nurse or attendant was not authorized in the $100 award as amended by the act of June 25, 1918.

Public No. 26, August 6, 1919, 66th Congress, added a subdivision to the War Risk Insurance Act, as amended October 6, 1917:

* * * except in case of loss of both hands and both eyes, or in case of loss of both feet and both eyes, or in case of loss of both hands and both feet, in which cases there shall be an allowance of $100 per month for a nurse or attendant, the same in addition to the $100 per month allowed in this act for the loss of both feet, or both hands or both eyes.

The act of December 24, 1919, made some additional awards to the above specified rates:

Loss of one foot and the sight of one eye; loss of one foot and one hand; or loss of one hand and the sight of one eye, $100 per month.

Double, total, permanent disability, $200 per month.

Public No. 370, 67th Congress, December 18, 1922, amended the War Risk Insurance Act, as amended, by adding:

* * * If the disabled person is so helpless as to be in constant need of a nurse or attendant, such additional sum shall be paid, but not exceeding $20 per month, as the Director may deem reasonable, and if the disabled person is blind, legless or armless and is in constant need of a nurse or attendant, such additional sum shall be paid, but not exceeding $50 per month, as the Director may deem reasonable. * * *

WORLD WAR VETERANS' ACT, JUNE 7, 1924

The World War Veterans' Act of June 7, 1924, provided for a rate of $100 for all disabilities while the disability was rated as total and permanent. The following specific disabilities were deemed to be total permanent:

* * * Loss of both feet, or both hands, or both eyes, or of 1 foot and 1 hand, or of 1 foot and 1 eye, or of 1 hand and 1 eye, or the loss of hearing in both ears, or the organic loss of speech, or becoming helpless or permanently bedridden, $100 per month. * * *

This act also provided for specific disability due to tuberculosis disease of compensable degree. Any ex-service man shown to have tuberculosis disease of compensable degree, and who in the judgment of the Director would not reach a condition of arrest by further hospitalization and whose discharge from hospitalization would not be prejudicial to him or his family, and who was not in the judgment of the Director feasible for training, was discharged from hospital upon his own request and rated temporarily totally disabled for a period of 3 years, and to receive $80 per month for like period without wife or child; $90 per month with wife and no child; $95 per month with wife and one child, and $5 per month for each additional child. The act also provided for a temporary total rating for six months following hospitalization and completely arrested tuberculosis.

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The act also provided the following:

Loss of use of both eyes, $150 per month.
Loss of use of both eyes and 1 or more limbs, $200 per month.
Helpless and in constant need of a nurse or attendant, an additional sum of $50 per month.
Double total permanent disability, $200 per month.
A veteran without wife or parents hospitalized for 6 months or more with a neuropsychiatric disease, and deemed by the Director to be permanently insane, as long as he remained in hospital, $20 per month.
If he recovered his reason and was discharged from hospital as cured, an additional amount was paid to him for each month rate of compensation was reduced, $60 per month.

ARRESTED TUBERCULOSIS AND CREATIVE ORGAN, 1926

An act of July 2, 1926, granted an award to any ex-serviceman shown to have had a tuberculous disease of a compensable degree who, in the judgment of the Director, had reached a condition of complete arrest of his disease, of $50 per month provided that nothing in the law should deny him the right to receive a temporary total rating for 6 months carrying an award of $80 per month after discharge from a 1-year period of hospitalization.

In the act of July 3, 1930, the $50 per month award for arrested tuberculosis was extended and the temporary total period was extended to 3 years, provided that nothing in the law should prevent the veteran from being adjudged permanently and totally disabled.

The act of July 3, 1930, introduced two original enactments. The Director was authorized and directed to insert in the rating schedule a minimum rating of permanent partial 25 percent for arrested or apparently cured tuberculosis. It also provided a specific award independent of any other compensation for the following specified disabilities:

Loss of use of creative organ, and for loss of use of 1 or more feet or hands, $25 per month. (This specific award applied to service-connected injuries between April 6, 1917, and November 11, 1918.)

All monetary awards under the World War Veterans' Act were subsequently increased by acts of Congress. Following the Economy Act in 1933 and enactment of Public No. 78, 73d Congress, June 16, 1933, Public No. 141, 73d Congress, March 28, 1934, certain World War I veterans were protected for benefits under laws in effect on March 19, 1933—that is, under the World War Veterans' Act of 1924, as amended. Some were qualified for continued awards for specific disabilities under the World War Veterans' Act, as authorized by Public No. 141, 73d Congress, and by section 2, Public No. 458, 79th Congress, June 27, 1946. Disabled qualified veterans, under Public No. 141, 73d Congress, had been in receipt of only 75 percent of the award, which was increased to 100 percent by Public No. 339, 81st Congress, October 10, 1949.

STATUTORY AWARDS FOR SPECIFIC DISABILITIES UNDER THE ECONOMY ACT, PUBLIC NO. 2, 73D CONGRESS, MARCH 20, 1933

In accordance with Public No. 2, 73d Congress, March 20, 1933, the President established by Executive Order 6156 specified awards for specific disabilities, in Veterans Regulation No. 1 (a), to wartime and peacetime disabled veterans with directly service-connected disabilities:

[Dollars per month]

Subparagraph of par. II, pts. I and II, Veterans Regulation No. 1 (a)	Wartime rates	Peacetime rates
(k) Anatomical loss or the loss of the use of only 1 foot, or 1 hand, or 1 eye, in addition to percentage awards	$25	$12
(l) Anatomical loss or loss of use of both hands, or of both feet, or of 1 hand and 1 foot, or is so helpless as to be in need of regular aid and attendance	150	75
(m) Anatomical loss or loss of use of both hands and 1 foot, or of both feet and 1 hand, or if the disabled person is blind in both eyes having light perception only	175	87
(n) Blind in both eyes having light perception only, and has suffered the anatomical loss or loss of use of 1 hand or foot	200	100
(o) If disabled person has suffered the anatomical loss or loss of use as provided in (l) to (n) above, and/or blindness in both eyes having light perception only which conditions entitle him to 2 or more of the rates provided in the above, no specified conditions being considered twice	250	125

Public No. 182, 79th Congress, September 20, 1945, changed and amended paragraph II of parts I and II, Veterans Regulation No. 1 (a), to the following wording and rates and added another subparagraph:

[Dollars per month]

Subparagraph	Wartime rates	Peacetime rates
(k) Anatomical loss or loss of use of 1 foot, or 1 hand, or blindness of 1 eye having only light perception, and in addition to the requirements of (l) to (n) below shall be increased	$35	$26.25
(l) Anatomical loss or loss of use of both hands, or of both feet, or of 1 hand and 1 foot, or is blind in both eyes with 5/200 visual acuity or less, or is permanently bedridden or so helpless as to be in need of regular aid and attendance	200	150.00
(m) Anatomical loss or loss of use of 2 extremities, at a level, or with complications, preventing natural elbow or knee action with prostheses in place, or has suffered blindness in both eyes, rendering him so helpless as to be in need of regular aid and attendance	235	176.25
(n) Anatomical loss of 2 extremities so near the shoulder or hip as to prevent the use of a prosthetic appliance, or has suffered the anatomical loss of both eyes	265	198.75
(o) Suffered disability under conditions which would entitle him to 2 or more of the rates provided in 1 or more of the subpars. (l) to (n), no condition being considered twice in the determination, or has suffered total deafness in combination with total blindness with visual acuity of 5/200 or less	300	225.00
(p) In the event the disabilities exceed the requirements for any rates prescribed, the Administrator, in his discretion, may allow the next higher rate or an intermediate rate, but in no event in excess of	300	225.00

These rates were changed by subsequent enactments and the peacetime rates were to be computed at 80 percent of the wartime rates, as specified in Public No. 876, 80th Congress, approved July 2, 1948. The present monetary awards for the above, as enacted in Public No. 695, 83d Congress, approved August 28, 1954, are as follows:

[Dollars per month]

	Wartime rates	Peacetime rates
Paragraph:		
(k)	$47	$37.60
(l)	279	223.00
(m)	329	263.00
(n)	371	297.00
(o)	420	336.00
(p)	420	336.00

Except for changes in rates, the above is the wording in the law today. The maximum monetary award under (p) is $420 per month, wartime rates.

ARRESTED TUBERCULOSIS, 1949

Section 2, Public No. 339, 81st Congress, October 10, 1949, amended Veterans Regulation No. 3 (a) by adding thereto a new paragraph granting statutory rates for arrested tuberculosis:

II. Any ex-service person shown to have active tuberculosis which is compensable under Public Law No. 2 and the Veterans Regulation promulgated pursuant thereto, who in the judgment of the Administrator of Veterans' Affairs has reached a condition of complete arrest, shall be rated as totally disabled for a period of 2 years following such date of arrest, as 50 per centum disabled for an additional period of 4 years, and 30 per centum for a further 5 years. Following far-advanced active lesions the permanent rating shall be 30 per centum, and following moderately advanced lesions, the permanent rating, after 11 years, shall be 20 per centum, provided there is continued disability, dyspenea on exertion, impairment of health, and so forth; otherwise the rating shall be zero per centum: *Provided*, That this act shall not be construed as requiring a reduction of compensation authorized under any other law or regulation: *Provided further*, That no compensation shall be payable under this act for any period prior to its enactment: *And provided further*, That the total disability rating herein provided for the 2 years following a complete arrest may be reduced to 50 per centum for failure to follow prescribed treatment or to submit to examination when requested.

ARRESTED TUBERCULOSIS AND CREATIVE ORGAN, 1952

Public No. 427, 82d Congress, approved June 30, 1952, amended subparagraph (k) of paragraph II, part I, Veterans Regulation No. 1 (a), by adding to the listed disabilities therein, "If the disabled person, as a result of service-incurred disability, has suffered the anatomical loss or loss of use of a creative organ, etc., the rate of compensation shall be $47 per month independent of any other compensation as provided, etc."

Public No. 427, 82d Congress, introduced an original enactment, not provided under Public No. 2, 73d Congress, by adding subparagraph (q) of paragraph II, part I of Veterans Regulation No. 1 (a) to read as follows:

(q) If the disabled person is shown to have had a service-incurred disability resulting from an active tuberculosis disease, which disease in the judgment of the Administrator of Veterans' Affairs has reached a condition of complete arrest, the monthly compensation shall be not less than $67.

Public No. 427, 82d Congress, increased the rate of compensation provided in the World War Veterans' Act of 1924, as amended, for the loss of a creative organ or one or more feet or hands to $47. The rate for arrested tuberculosis under the World War Veterans' Act was also increased to $67. These are wartime rates. Peacetime rates are 80 percent of the wartime rates.

ADDITIONAL AWARDS FOR DEPENDENTS

Public No. 877, 80th Congress, July 2, 1948, as amended by section 4, Public No. 339, 81st Congress, October 10, 1949, provided increases of compensation to certain veterans with service-connected disabilities who have dependents. Veterans in receipt of compensation rated not less than 50 percent (originally 60 percent) are entitled to additional

compensation for dependents in the following monthly amounts for totally disabled (100 percent) veterans:

[Dollars per month]

	Wartime rates	Peacetime rates
Wife, no child	$21.00	$16.80
Wife, 1 child	35.00	28.00
Wife, 2 children	45.50	36.40
Wife, 3 or more children	56.00	44.80
No wife, 1 child	14.00	11.20
No wife, 2 children	24.50	19.60
No wife, 3 or more children	35.00	28.00
Each dependent parent	17.50	14.00

If the veteran is partially disabled, but not less than 50 percent, the additional compensation for dependents is a corresponding proportion of the above rates.

STATUTORY AWARD TOWARD PURCHASE OF AUTOMOBILE

As enacted by Public No. 187, 82d Congress, October 20, 1951, qualified veterans of World War II or of the Korean conflict who are entitled to compensation for the loss or loss of use of one or both hands, or permanent impairment of vision of both eyes, receive a statutory award of $1,600 toward the purchase of an automobile or other conveyance. Only one such allowance is authorized.

STATUTORY PROVISIONS, PURCHASE OF SPECIALLY ADAPTED DWELLING, AS ENACTED BY PUBLIC LAW 702, 80TH CONGRESS, JUNE 19, 1948

Qualified wartime veterans with service-connected disabilities for loss or loss of use of lower extremities such as to preclude locomotion without the aid of braces, crutches, canes, or wheelchairs, may be provided assistance in the form of a grant of not more than one-half the purchase price of a dwelling specially adapted to the veteran's needs with a maximum $10,000 single grant, or if the veteran owns his home, he may secure the grant for the purpose of reducing outstanding indebtedness or to pay for suitable alterations.

Chapter VI. Presumptions

PRESUMPTION OF PERMANENT TOTAL DISABILITY

Presumption of total disability can be traced to some of the original legislative acts for veterans' service-connected disabilities. For example, the loss of a limb or extremity had been rated as a total disability. The act of April 10, 1806, specified that any veteran of the Revolutionary War, and otherwise qualified, who in consequence of "known wounds" had, at any time since, become and continued disabled in such manner as to render him unable to procure a subsistence by manual labor, was placed upon the pension list of the United States, during life, or the continuance of such disability. Subsequently administrative determinations presumed total disability, when there was present any impairment of mind or body which continuously rendered it impossible for the disabled person to follow a substantially gainful occupation.

Public No. 104, 66th Congress, December 14, 1919, contained the provision for presumption of permanent total disability:

* * * That the loss of both feet, or both hands, or the sight of both eyes, or the loss of one foot and one hand, or loss of one foot and the sight of one eye, or the loss of one hand and the sight of one eye, or becoming helpless and permanently bedridden, shall be deemed to be permanent total disability. * * *

There was no change until the enactment of the World War I Veterans' Act, June 7, 1924, which provided in section 202 (3):

* * * That the permanent loss of the use of both feet or both hands, or of both eyes, or of one foot and one hand, or of one foot and one eye, or of one hand and one eye, or the loss of hearing of both ears, or becoming permanently helpless, or permanently bedridden, shall be deemed to be total, permanent disability. * * *

Public No. 448, 69th Congress, July 2, 1926, amended section 202 (3) of the World War Veterans' Act, and added to the disabilities presumed to be total permanent disability "organic loss of speech."

Page 43, of the Veterans' Bureau Schedule of Disability Ratings, 1925, stated an administrative presumption of permanent total disability:

A rating of permanent total disability will be made without regard to the determined occupation when it is medical opinion that there is present any impairment of mind or body which continuously renders it impossible for the disabled person to follow a substantially gainful occupation, and which is founded upon conditions which render it reasonably certain that it will continue throughout the life of the person suffering from it. It is obvious that a claimant who has a disability which makes it impossible for him continuously to pursue any substantially gainful occupation is, ipso facto, debarred from the continuous pursuit of the particular occupation determined under the schedule. The converse of this is, however, not true; that is, a claimant who under the terms of this schedule (especially where there are two or more combined compensable disabilities) is held to be permanently and totally disabled for the occupation assigned him, is not necessarily permanently and totally disabled for any substantially gainful occupation.

By the authority contained in Public No. 2, 73d Congress, March 20, 1933, the President promulgated on June 6, 1933, Veterans' Regulation No. 1 (a). Part III of this regulation, relating to non-service-connected pensions, is the only one that contains a provision for presumption of total disability:

* * * A permanent total disability shall be taken to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation and where it is reasonably certain that such impairment will continue throughout the life of the disabled person. Notwithstanding this definition, the Administrator of Veterans' Affairs is hereby authorized to classify as permanent and total those diseases and disorders, the nature and extent of which in his judgment is such as to justify such a determination. * * *

Following the enactment of Public No. 78, 73d Congress, June 16, 1933, Part III, paragraph I (e) of Veterans Regulation No. 1 (a) was amended by Executive Order, on July 28, 1933, by adding the following:

Any veteran of the Spanish-American War, including the Boxer Rebellion and the Philippine Insurrection, 55 years of age or over, who is 50 percent disabled and who meets the other requirements of part III shall be paid a pension of not less than $15 per month.

An administrative presumption of total disability was made and incorporated in page 5 of the Veterans' Administration Schedule for Rating Disabilities, 1933 edition, for service-connected and non-

service-connected disabilities, and was carried over into page 5, paragraph 15, of the 1945 edition of the schedule:

* * * Total disability shall be taken to exist when there is (or are) any impairment (or impairments) of mind or body which is (are) sufficient to render it impossible for the average person to follow a substantially gainful occupation: *Provided*, That permanent and total disability shall be taken to exist when the impairment (or impairments) is (or are) reasonably certain to continue throughout the life of the disabled person.

The following shall be taken to be permanent total disability: The permanent loss of the use of both hands, or of both feet, or of one hand and one foot, or of the sight of both eyes, or becoming permanently helpless or permanently bedridden. * * *

On November 15, 1941 the administrative presumption of total disability was further extended by Extension No. 4 to the Schedule for Rating Disabilities, 1933 edition:

1. Total disability ratings * * * may be assigned without regard to the specific provisions of the rating schedule when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of his disabilities: *Provided*, That, if there is only 1 disability, this disability shall be ratable at 60 percent or more, and that if there are 2 or more disabilities, there shall be at least 1 disability ratable at 40 percent or more and additional disability sufficient to bring the combined rating to 70 percent or more. Total disability ratings, when the above conditions are met, may be granted for deafness, the organic loss of speech, or the amputation or loss of use of either hand or either lower extremity above the knee when followed by unemployability, as single disabilities, or for other organic disabilities or combinations including organic disabilities.

(NOTE.—This paragraph was incorporated into the revised 1945 edition of the Schedule for Rating Disabilities, p. 5, par. 15 and 16.)

2. For the purpose of Veterans Regulation No. 1 (a), part III only, the above specified 60 percent, 40 percent and 70 percent requirements may be reduced by 10 percent on the attainment of age 60; and by an additional 10 percent on attainment of age 65; and there shall be no percentage requirements for total disability ratings in the cases of unemployable veterans who have reached the age of 70. The attainment of age 70 will not in itself warrant a rating as permanently totally disabled; in addition thereto, disability sufficient to produce unemployability will be required.

(NOTE.—This paragraph was incorporated into the revised 1945 edition of the schedule, p. 6, par. 17.)

Extension No. 4 (supra) contained additional instructions on unemployability, and were later incorporated into the 1945 revised schedule, page 6, paragraph 18.

The 1945 revised schedule was officially adopted by the enactment of Public No. 458, 79th Congress, June 27, 1946.

On October 7, 1948, extension No. 5 to the 1945 schedule rescinded paragraph 17, page 6 of the schedule (supra) and substituted different percentage and age requirements as additional administrative presumption for total disability:

* * * On the attainment of age 55 (requirements are reduced) to 50 percent rating for 1 or more disabilities, with no percentage requirement for any one disability; at age 60, to 50 percent rating for 1 or more disabilities; at age 65, no percentage requirement other than one disability ratable at 10 percent or more; disabilities are of a permanent nature; and veteran is determined to be unable to secure and follow substantially gainful employment by reason of such disability. * * *

PRESUMPTION OF SOUNDNESS

In an act of March 3, 1885, provisions were made for the first time in the history of veterans' disability benefits, that—

all applicants for pensions shall be presumed to have had no disability at the time of enlistment; but such presumption may be rebutted (23 Stat. 362).

The act of October 6, 1917, did not provide any statutory presumptions. It was not until the enactment of Public No. 175, 65th Congress, June 25, 1918, that the first presumption was established. The act of June 25, 1918, amended section 300 of the War Risk Insurance Act by the following provision:

* * * That for the purposes of this section said officer, enlisted man or other member shall be held and taken to have been in sound condition when examined, accepted, and enrolled for service. * * *

Public No. 47, 66th Congress, August 19, 1921, amended section 300 of the War Risk Insurance Act, as amended, by adding an exception to the proviso in this act of June 25, 1918:

* * * except as to defects, disorders, or infirmities made of record in any manner by authorities of the United States at the time of, or prior to, inception of active service, to the extent to which any such defect, disorder, or infirmity was so made of record. * * *

Public No. 542, 67th Congress, March 4, 1923, amended the proviso for the presumption of soundness by adding:

* * * shall be conclusively held and taken to have been sound in condition when examined, accepted, and enrolled for service, except as to defects, etc. * * *

The World War Veterans' Act of June 7, 1924, section 200, continued a conclusive presumption of soundness at enlistment.

By the authority contained in Public No. 2, 73d Congress, March 20, 1933, the President by Executive order promulgated veterans regulations which repealed prior laws that contained the conclusive presumption of soundness at enlistment.

In 1933 Veterans Regulation No. 1 (a), paragraph I (b) part 1, provided for a presumption of soundness:

* * * Every person employed in the active military or naval service for 90 days or more shall be taken to have been in sound condition when examined, accepted, and enrolled for service [wartime] except as to defects, infirmities, or disorders noted at time of the examination, acceptance, and enrollment, or where evidence, or medical judgment is such as to warrant a finding that the injury or disease existed prior to acceptance and enrollment.

For peacetime service, the presumptive time period is 6 months.

Public No. 141, 73d Congress, March 28, 1934, restored certain presumptive service-connected compensation awards which had been severed by Public No. 2, 73d Congress. Public No. 141 did not restore compensation payments to persons "as to whom clear and unmistakable evidence discloses that the disease, injury, or disability had inception before or after period of active military or naval service," unless aggravated thereby.

Public No. 144, 78th Congress, July 13, 1943, amended Veterans Regulation 1 (a), Paragraph 1 (b), part I. The amendment deleted the requirement of 90 days service; and "evidence or medical judgment," and reads as follows:

* * * Every person employed in the active military or naval service shall be taken to have been in sound condition when examined, accepted, and enrolled for service except as to defects, infirmities, or disorders noted at time of the examination, acceptance, and enrollment, or where clear and unmistakable evidence demonstrates that the injury or disease existed prior to acceptance and enrollment and was not aggravated by such active military or naval service. * * *

PRESUMPTION OF SERVICE AGGRAVATION

Veterans Regulation No. 1 (a), paragraph 1 (d), part I, provides that a preexisting injury or disease is presumed to have been aggravated by active service, where there is an increase in disability during active service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease.

PRESUMPTION OF SERVICE-CONNECTION, CHRONIC DISEASES

Public No. 47, 67th Congress, August 9, 1921, enacted a proviso and established for the first time a presumption of service-connection for chronic diseases, by adding to section 300 of the War Risk Insurance Act the following:

> * * * that an exserviceman who is shown to have an active pulmonary tuberculosis or neuropsychiatric disease [of more than 10 per centum degree of disability] developing within two years after separation from the active military or naval service of the United States shall be considered to have acquired his disability in such service, or to have suffered an aggravation of a preexisting pulmonary tuberculosis or neuropsychiatric disease in such service. * * *

Public No. 542, 67th Congress, March 4, 1923, amended section 300 of the War Risk Insurance Act, as amended above for tuberculosis and neuropsychiatric disease, by extending the presumptive period to 3 years and added the requirement that the 10 percent degree of disability be shown upon examination by a medical officer of the Veterans' Bureau or by a legally qualified physician made within 3 years after separation from the service.

World War Veterans Act of June 7, 1924, in section 200 provided:

> * * * that an exserviceman who is shown to have or, if diseased, to have had, prior to January 1, 1925, neuropsychiatric disease, and active tuberculosus disease ,paralysis agitans, encephalitis, lethargica, or amoebic dysentery developing a 10 per centum degree of disability or more in accordance with the Act, or suffered an aggravation while in the service of a preexisting neuropsychiatric, tuberculous, paralysis agitans, encephalitis lethargica, or amoebic dysentery, shall be presumed to have acquired the disability between April 6, 1917, and July 2, 1921, and said presumption shall be conclusive in cases of active tuberculous disease, but in all other cases said presumption shall be rebuttable by clear and convincing evidence. * * *

The requirement of the amendatory act of March 4, 1923, that the showing of active tuberculosis disease or neuropsychiatric disease of 10 percent or more, according to the United States Veterans' Bureau schedule of ratings, must have been made upon examination by a medical officer of the United States Veterans' Bureau or by an equally qualified physician was not made in section 200 of the World War Veterans' Act, which simply required that the claimant be "shown to have, or have had" tuberculosis disease of the degree specified within the time specified.[7]

> * * * Accordingly, such showing [could] be made by reports of physical examination, physicians' statements, or lay affidavits. If the evidence in a case justifies connection with service under the presumptive proviso of section 300 of the War Risk Insurance Act, as amended March 4, 1923, the rating [was] made under that act, the provisions of which [were to] govern. Those provisions [were] precise and restrictive: Active tuberculosis disease, of at least 10 percent degree, must have been shown, within 3 years, by examination of a physician. Lay evidence [was] excluded.[8] * * *

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[7] Veterans' Bureau, Schedule of Disability Ratings, 1925, op. cit., p. 108.
[8] Ibid.

By an administrative determination at that time, "active pulmonary tuberculosis, diagnosticated by approved methods as outlined in regulations, paragraphs 6022 and 6023, will be held to have preexisted the diagnosis 6 months in minimal [incipient] cases; 9 months in moderately advanced cases; and 12 months in far advanced cases."[9] This administrative presumption granted a veteran up to 4 years for service-connection for tuberculous disease.

Section 200 of the World War Veterans Act, June 7, 1924, originated a presumption of service connection for compensation of certain diseases requiring hospitalization:

> * * * That no person suffering from paralysis, paresis, or blindness, or from constitutional lues, shall be denied compensation while a patient in a Veterans' Bureau hospital by reason of willful misconduct. * * *

This proviso was amended by Public No. 628, 68th Congress, March 4, 1925:

> * * * That no person suffering from paralysis, paresis, or blindness, shall be denied compensation by reason of willful misconduct, nor shall any person who is helpless or bedridden as a result of any disability be denied compensation by reason of willful misconduct. * * *

Public No. 448, 69th Congress, July 2, 1926, added "spinal meningitis" to the presumptive service-connected diseases in the above acts, and made this presumption conclusive for spinal meningitis as well as tuberculosis.

Section 206 of the World War Veterans Act, approved June 7, 1924, states:

> * * * That no compensation shall be payable for death or disability which does not occur prior to or within one year after discharge or resignation from the service, except as provided in Section 200 of this Act, and except where there is an official record of the injury during service or at the time of separation from active service, or where within one year from the approval of this Act satisfactory evidence is furnished the bureau to establish that the injury was suffered or aggravated during active service. * * *

Subject to the limitations of section 206 of the World War Veterans Act, an administrative interpretation and determination established a list of chronic constitutional diseases as presumptive service-connection, other than active tuberculosis, or neuropsychiatric disease, paralysis agitans, encephalitis lethargica, or amoebic dysentery as specifically designated in the law, "notwithstanding there is no record evidence of the existence of such disease during the period of active service." This list was published on page 75 of the Veterans' Bureau schedule of disability ratings, (1925) and included:

Acidosis
Anemia primary (all types)
Arteriosclerosis
Beri-beri
Diabetes insipidus
Diabetes mellitus
Gout
Haemochromatosis
Hemoglobinuria (paroxysmal)
Hemophilia
Hodgkins disease
Leukemia (all types)
Obesity
Ochronosis
Pellagra
Polycythemia (erythremia)
Purpura
Rickets
Scurvy
Endocrinopathies

[9] Quoted in; S. Doc. No. 131, 1932, Federal Laws Relating to Veterans of Wars of the United States, op. cit., p. 127.

ANALOGOUS DISEASES

Arthritis deformans
Arthritis chronic
Carcinoma, sarcoma and other tumors
Cardiovascular-renal diseases, including hypertension
Cholecystitis, chronic, proceeding to gall stones
Endocarditis, chronic
Leprosy
Myocarditis, chronic
Nephritis, chronic forms
Nephrolithiasis
Valvulitis, chronic

By the authority contained in Public Law No. 2, 73d Congress, the President promulgated paragraph I (c), part I, Veterans' Regulations No. 1 (a), and provided a presumption of service connection for a chronic disease becoming manifest to a degree of 10 percent or more within the first year after discharge provided that the person suffering from such disease served 90 days or more active service. The presumption is rebuttable by affirmative evidence to the contrary, such as intercurrent disease or injury. The paragraph did not specify the list of chronic diseases that were to be considered. The presumption of service connection for a chronic disease is applicable to veterans with wartime service, and not to veterans with only peacetime service.

Public No. 2, 73d Congress, March 20, 1933, severed payment of compensation for presumptive service-connected disabilities. On March 28, 1934, Public No. 141, 73d Congress, was passed over a Presidential veto. Public No. 141 restored compensation payments for certain presumptive service-connected cases: to veterans with active service before November 11, 1918; excepted cases where the disabilities had existed prior to service, and were not aggravated by active service; excepted cases where the disabilities had been incurred after active service; and excepted cases where fraud, misrepresentation, or error were involved.

Public No. 748, 80th Congress, June 24, 1948, made statutory a list of chronic and tropical diseases as presumptive service connected, and applicable to veterans with wartime service, who meet the requirements of paragraph I (c) of part I, Veterans Regulations No. 1 (a), as follows:

* * * *Provided further*, That the term "chronic disease" as used in this paragraph shall include anemia, primary; arteriosclerosis; arthritis; bronchitis; calculi of the kidney, bladder, or gallbladder; cardio-vascular-renal disease, including hypertension, myocarditis, Burger's disease, and Raynaud's disease; cirrhosis of the liver; coccidiomycosis; endocarditis; diabetes mellitus, endocrinopathies; epilepsies; Hodgkin's disease; leukemia; nephritis; osteitis deformans; osteomalacia; organic diseases of the nervous system, including tumors of the brain, cord, or peripheral nerves; encephalitis lethargica residuals; scleroderma; tuberculosis, active; tumors, malignant; ulcers, peptic (gastric or duodenal); and such other diseases as the Administrator of Veterans' Affairs may add to this list: *And provided further*, That, subject to the limitations of this subparagraph, tropical diseases, such as cholera; dysentery; filariasis; leishmaniasis; leprosy; loiasis; malaria; black-water fever; onchocerciasis; oroya fever; dracontiasis; pinta; plague; shistosomiasis; yaws; yellow fever; and others; and the resultant disorders or diseases originating because of therapy, administered in connection with such diseases, or as a preventative thereof, shall be accorded service connection when shown to exist within one year after separation from active service, or at a time when standard and accepted treatises indicate that the incubation period thereof commenced during active service. Nothing in this paragraph shall be construed to prevent service connection for any disease or disorder otherwise shown by sound judgment to have been incurred in or aggravated by active service. * * *

Peacetime veterans did not receive the same liberal benefits. Public No. 748, 80th Congress, provided service-connection for tropical diseases only as presumptive service connected. The list of tropical

diseases is the same as provided for wartime veterans. However, peacetime veterans are granted presumptive-service-connection when shown to exist within 1 year after separation from active service or at a time when accepted treatises indicate that the incubation period thereof commenced during active service, and the resultant disorders or diseases, or as a preventive thereof originated in service.

The following chronic diseases have been added to the list of chronic diseases provided in the above acts for wartime service, only:

Atrophy, progressive muscular; brain hemorrhage; brain thrombosis; myasthenia gravis; myelitis; bulbar palsy; paralysis agitans; psychoses; purpura, idiopathic, hemorrhagic; sarcoidosis; sclerosis, myotropoic, lateral; sclerosis, multiple; syringomyelia (Veterans' Administration Regulation—Claims, No. 1086 (A)).

Public No. 573, 81st Congress, June 23, 1950, amended paragraph I (c), part I, Veterans Regulations No. 1 (a) by extending the presumption of service connection for pulmonary tuberculosis to 3 years. Veterans' Administration Regulation, Claims, No. 1086 (C) establishes an administrative presumption of an additional year for pulmonary tuberculosis: active tuberculosis "diagnosticated" by approved methods during the fourth year is held to have preexisted the diagnosis 6 months in minimal (incipient) cases; 9 months in moderately advanced cases; and 12 months in far advanced cases.

Public No. 174, 82d Congress, October 12, 1951, provides a presumption of service connection for multiple sclerosis developing a 10-percent disability or more within 2 years following discharge from the service.

Public No. 239, 82d Congress, October 30, 1951, provides a conclusive presumption of service connection for psychosis for hospitalization and outpatient treatment purposes only, if developing within 2 years following discharge from the service. Presumption for purposes of hospitalization and outpatient treatment is not rebuttable.

Public No. 241, 83d Congress, August 8, 1953, extends the period for presumptive service connection for nonpulmonary tuberculosis to 3 years.

ADMINISTRATIVE PRESUMPTION OF SERVICE-CONNECTION; LOSS OF USE OF A CREATIVE ORGAN

Public No. 522, 71st Congress, July 3, 1930, enacted an original benefit to be paid for the loss of use of a creative organ to veterans of World War I as the result of an injury received in active service in line of duty between April 6, 1917, and November 11, 1918. This act amended the World War Veterans' Act. The Director of the Veterans' Bureau published extension No. 9, dated July 12, 1930, and an administrative implementation stating:

> By "injury" is meant personal injury from trauma, proximately resulting in loss of use of a creative organ. Loss of use of a creative organ will be held to exist when there is physical loss of atrophy of a procreative organ, or other complete loss of procreative power (sterility, or complete impotence). The individual testicles and ovaries will be considered as separate organs. An affirmative finding by a board of three medical officers will be sufficient to establish loss of procreative power.

These instructions were amended by extension No. 9–A on October 30, 1930, which stated that "injury" as used above included the term "disease" when the loss of use is—

* * * occasioned by disease incurred in the active service in line of duty between the dates specified in the provision stated above. With disease or injury incurred in service within the stated period, it is not necessary that the loss of use be established during the period of service, provided such loss of use results from and is attributable to the service-connected injury, etc. * * *

After the enactment of the Economy Act, March 20, 1933, and the promulgation of Veterans Regulation No. 1 (a), service connection for anatomical loss or loss of use of a creative organ was not provided, until 19 years later.

Public No. 427, 82d Congress, June 30, 1952, amended subparagraph (k) of paragraph II, part I, Veterans Regulations No. 1 (a) by adding to the list of disabilities therein:

* * * as a result of service-incurred disability, has suffered the anatomical loss or loss of use of a creative organ, etc., the rate of compensation shall be $47 per month independent of any other compensation as provided.* * *

Veterans' Administration Regulations, Claims, Nos. 1130 and 1131, implement the World War Veterans' Act and the act of June 30, 1952, with "Principles Governing Statutory Ratings." Veterans Administration Regulations, Claims, No. 1131 (B) states, in part:

* * * For the purposes of paragraph II (K), parts I and II, Veterans Regulation 1 (a), as amended, the requirements of line of duty, incurrence (or aggravation) between specified dates, and the requirement of direct service connection as contrasted with service connection by statutory presumption do not apply. * * *

Section I. Tables and Appendixes

Table No. 1.

Summary of rates, requirements, and method of adjudication for service-connected disabilities in disabled veterans (colonial wars, American Revolution and subsequent wars, including Spanish-American)

	(*a*) Disabled veterans of the French and Indian Wars prior to American Revolution
Legislative act	Colonial assemblies of Plymouth, Massachusetts Bay, Rhode Island, New York, Virginia, and Maryland.
Requirements and provisions.	Disabled veteran, needing relief, incapable of providing for necessary maintenance and subsistence, or getting a livelihood.
Rates:	
(*a*) Total disability	Not fixed; some awards were yearly; some awarded in local place of residence; some by general court judged meet to be done; some awards during life; some according to place and quality; some during the time of such disabilities.
(*b*) Partial disability.	Colonial Rhode Island awarded an annual rate as "deemed sufficient"; Maryland proportioned the rate to, and for the time of, the disability.
Method of adjudication and processing.	General or local adjudication in each case according to the individual merits.

	(*b*) Disabled veterans of the American Revolution	
Legislative act	Resolution of Continental Congress, Aug. 26, 1776.	Act of Mar. 23, 1792.
Requirements and provisions.	Disabled veteran officer, Army, Navy, and Marines, and private soldier and seaman, lose a limb, or so disabled to render him incapable of getting a livelihood, during his life or continuance of disability, and an official certification of disability.	American Revolution disabled, veteran officer of Army, Navy, Marines, and noncommissioned officers, petty officers, and seamen, in actual service; by wounds or other known cause; produce certificate of disability and service; officers incapable of military duty or of obtaining a livelihood; others incapable of military, or garrison duty, or of obtaining a livelihood by labor; and affidavits of 3 freeholders.
Rates:		
(*a*) Total disability	Monthly award. Maximum: officer, ½ of monthly pay; others, ½ of monthly pay. Minimum: the same, ½ of monthly pay.	Officers, yearly award of ½ of their pay; other military and naval personnel, $5 per month.
(*b*) Partial disability	Though not totally disabled from getting a livelihood, awarded such monthly sums toward his subsistence as judged adequate by the assembly or other representative body of the State of residence.	Officers and other military and naval personnel, not disabled in so great degree as total, allowed a yearly or monthly rate corresponding with the degree of their disability compared with that of an individual wholly disabled.
Method of adjudication and processing.	Official certificate of service-incurred disability reviewed by a State-appointed examiner; each State assembly had final action and awarded payment for total or partial disability as determined in the individual case, on account of the United States, and a quarterly report of such awards submitted to the Secretary of Congress or Board of War.	Adjudication by circuit judge, who proceeded to examine into the nature of the wound, or other cause of disability of the claimant, and, having ascertained the degree thereof, certified same, transmitted the result and their opinion to the Secretary of War. The Secretary of War after review of service records transmitted the list of disabled veterans for final action by Congress. Awards were determined by the judges on the basis of "full pension"; "one-half"; "one-third"; "one-fourth", etc. The moneraty equivalent then paid to the veteran.

TABLE NO. 1.—*Summary of rates, requirements, and method of adjudication for service-connected disabilities in disabled veterans (colonial wars, American Revolution and subsequent wars, including Spanish-American)*—Continued

	(c) Disabled veterans of the American Revolution	
Legislative act	Act of Feb. 28, 1793.	Act of Apr. 10, 1806.
Requirements and provisions.	Disabled veterans of the American Revolution applied upon oath; produce evidence to prove decisive disability to have been the effect of known wounds, in actual line of duty, affidavits of service and disability; produce written sworn report of 2 examining physicians of the disability and in what degree it prevented the claimant from obtaining his livelihood, by labor; affidavits of 3 freeholders; and other requirements.	Disabled veteran of American Revolution; disabled in line of duty of known wounds; disabled in such a manner as to render him unable to procure a subsistence by manual labor; granted an award during life or the continuance of such disability; evidence of service and disability; sworn affidavit of a physician or surgeon stating the nature of the disability and in what degree it prevents claimant from obtaining a subsistence.
Rates:		
(a) Total disability	Same as for act of March 1792.	Officers, ½ monthly pay of his grade at time of incurring the disability, not to exceed half pay of a lieutenant colonel; other military and naval veterans, $5 per month.[1]
(b) Partial disability	Same as for act of March 1792.	For officers and other disabled veterans, proportions, less than total correspondent to half pay or $5 per month.
Method of adjudication and processing.	Adjudication by the judge, United States Circuit Court, sitting as a commissioner with no imposition on judicial duties; degree of disability ascertained by officially appointed physicians stating degrees of disability in terms of "full pension"; "½"; "⅓", etc.; a list of claimants with action and degree of award submitted by the commissioner to the Secretary of War for review of service record and transmittal to Congress for final action.	Adjudication and determination of degrees of disability the same as for the act of Feb. 28, 1793.

	(d) Disabled veterans of wars prior to the Civil War and from 1806 to 1862	(e) Disabled veterans of Civil War; subsequent wars; peacetime, including Regulars, volunteers, and militia (the general law)
Legislative act	Acts of Congress had basis in the provisions of the act of Apr. 10, 1806.	Act of July 14, 1862.
Requirements and provisions.	The specifications and provisions were the same as in the act of 1806.	Disabled veterans of Civil War, or subsequent wars, or peacetime, disabled in line of duty; produce proper proof; claim filed within 1 year after discharge; sworn affidavits of physician or surgeon as to disability and degree; undergo biennial examination.
Rates:		
(a) Total disability	Officers, ½ monthly pay of his grade at time of incurring the disability, not to exceed the half pay of a lieutenant colonel; rates for junior officers were those allowed in the amendment to the act of 1806; other service personnel, $8 per month.	Officers and others with commensurate rank; dependent on rank; $10–$30 per month; the rate not to exceed the $30 of a lieutenant colonel; noncommissioned, petty officers, and grades lower, $8 per month.
(b) Partial disability.	For officers and other disabled veterans, proportions, less than total correspondent to half pay or $8 per month.	For all personnel designated; received for an inferior disability an amount proportionate to the (total) highest disability.
Method of adjudication and processing.	Adjudication and determination of degrees of disability based upon evidence produced by the claimant, surgeon's or physician's sworn affidavits before an official of the Pension Bureau; final action on claim delegated to the Secretary of War and later to the Secretary of the Interior; degrees of disability determined by the physician as "ful pension"; "one-half"; "one-third"; etc.	Adjudication system in the Bureau of Pensions; Secretary of the Interior exercising final action, dependent upon rules and regulations; degrees of disability determined by physicians as "total"; "three-fourths"; "one-half"; "one-half"; etc.

[1] The rates were changed for officers below the grade of captain and others: Full pension: 1st lieutenant, $17; 2d lieutenant, $15; 3d lieutenant, $14; noncommissioned officer and lower, $8 per month; and for disabilities of a degree less than the highest, a sum proportionately less (3 Statutes at Large 296).

TABLE NO. 1.—*Summary of rates, requirements, and method of adjudication for service-connected disabilities in disabled veterans (colonial wars, American Revolution and subsequent wars, including Spanish-American)*—Continued

	(f) Disabled veterans of Civil War; subsequent wars; peacetime, including Regulars, volunteers, and militia (the general law, as amended)	(g) Disabled veterans of the Civil War
Legislative act	Act of Mar. 3, 1873, the consolidation Act.	Act of June 27, 1890.
Requirements and provisions.	Specifications and provisions the same as the act of July 14, 1862.	Veteran of the Civil War; 90 days or more service therein; honorably discharged; suffering from a permanent mental or physical disability, not the result of his own vicious habits, which incapacitated him from his own vicious habits, which incapacitated him from the performance of manual labor in such a degree as to render him unable to earn a support; disability may or may not be of service origin.
Rates:		
(*a*) Total disability	Officers and others with commensurrank, the same as in the act of July 14, 1862; noncommissioned officers, petty officers, and grades lower, $8; intermediate rate, greater than total, up to the equivalent of the loss of hand and foot, from $8 to $18; lesser rates combined up to the equivalent of the loss of hand and foot, $18.	$12 per month.
(*b*) Partial disability	For all personnel designated; received for an inferior disability an amount proportionate to the total; rates combined up to the equivalent of the loss of hand and foot.	Minimum, $6 per month.
(*c*) Other rates	Awards or specified disabilities were provided, the highest being $100 per month for loss of both hands. A rate of $30 per month was provided for those who were entirely incapacitated for performing any manual labor.[2]	Intermediate rate; a proportionate rate between $6 and $12.
Method of adjudication and processing.	Adjudication system in the Bureau of Pensions; Secretary of the Interior exercising final action dependent upon rules and regulations; degrees of disabilities determined by physicians and subject to review in the Medical Division of the Bureau of Pensions, and change dependent upon medical evidence; age not a factor in fixing the rate; rated in proportion to $8 and $18 or as 8 to 18. Lesser ratings than $8 were made and awarded; rates could be combined. Following the act of Mar. 2, 1895, disabled veterans awarded rates at less than $6 per month, the rate was increased to the minimum established in the act of $6.	Adjudication system in the Bureau of Pensions; Secretary of the Interior exercising final action dependent upon rules and regulations; degrees of disabilities determined by physicians and subject to review in the Medical Division; age important factor in fixing rate under this act; award granted only in cases where incapacity to labor joined with incapacity to earn support; proportionate intermediate degrees of disability based upon 6 to 18 but where the rate exceeded $12, it was paid at $12. Under the established rule of the Bureau of Pensions, a claimant age 75 or over was entitled for senility alone, in the absence of ratable disabilities. Under the decisions of the Department, a claimant age 65 was deemed entitled to at least the minimum rate, unless evidence disclosed an unusual vigor for the performance of manual labor in a man of that age. (See Report of the Commissioner of Pensions, 1899, pp. 33-34.)

[2] See table No. 5 for a comparison of some of the rates for specified disabilities under these 2 laws.

Table No. 2

Lists of Rates Awarded to Service-Connected Disabled Veterans (American Revolution) [1]

Communicated to the House of Representatives, December 14, 1792

War Department, *December 14, 1792.*

In obedience to the order of the House of Representatives of the 3d instant, the Secretary of War respectfully submits two lists of names which have been transmitted by the judges of the Circuit Court (in the capacity of commissioners) of the District of New Hampshire, Rhode Island, Connecticut, and Vermont and also by judges of the District of Maine.

The first list marked "A" contains the names of 85 persons who were examined by the circuit courts in the months of April and May last, and who have actually been placed upon the pension list, together with the names of three persons who have been withheld from the said list on account of their having been found as deserters upon examination of the master rolls of the corps to which they belonged in the late war.

And also the name of Peter Charlont, a Canadian refugee, who is recommended "to the notice and benevolence of Congress." The documents on which this recommendation is based are herewith submitted marked "No. 1."

The second list, marked "B," contains the names of 116 persons, examined by judges of the circuit courts in the months of September and October last. This list is under examination, with the muster rolls and documents of the late war, in order to ascertain the proofs of the service alleged; but in many cases no proof of service can be traced, owing to the imperfection or entire deficiency of the muster rolls or other evidences of the early part of the war.

To the names of persons transmitted as aforesaid are added their rank in the late war, the ship, regiment, corps, or company to which they belonged as far as information can be obtained thereof, the courses of disability, and the monthly rate of pension and the arrears which have been allowed.

The whole number of both lists amounts to 206.

The annual allowance, as returned, amounts to $9,067.62.

The arrears, as returned, amount to $23,091.44.

It may be observed that several volunteers and one commissary have been slated for pensions. But, as persons of this description do not appear, by any of the former resolves of Congress, to have been explicitly named for pensions, these cases are submitted to the view and decision of Congress in paper No. 2.

The resolves or laws of Congress, prior to the act upon this subject passed the 23d day of March last, do not allow for the highest disability to a noncommissioned officer or private a monthly pension exceeding $5; but the said act seems to render an allowance of any portion of the monthly pay discretionary with the judges. Accordingly, several monthly pensions exceeding $5 have been reported by the judges of the circuit courts for noncommissioned officers and privates, which are particularly noticed on the list.

The number of noncommissioned officers and privates on the general pension list, prior to the 23d day of March last, amounted to 1,358, none of whom receive a pension exceeding $5 per month.

The entire number of involved pensioners of all descriptions, before the 23d day of March last, amounted to 1,472.

All of which is humbly submitted to the House of Representatives.

H. Knox, *Secretary of War.*

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[1] American State Papers, Claims, pp. 56–57.

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TABLE NO. 2A

List of the invalid pensioners returned by the circuit courts for the hereafter-named districts, and who have been placed on the list transmitted from the War Office to the commissioner of loans for the respective States, and returned to the Secretary of the Treasury for arrearages of pensions

No.	Rank	Disability	Monthly allowance
		NEW HAMPSHIRE	
1	Lieutenant	Ruptured in groin, being thrown from horse while on duty shortly after the evacuation of Ticonderoga.	$3.33⅓
2	Sergeant	Badly wounded in the back, side and groin at Battle of Bunker Hill.	3.33⅓
3	Private	Lamed by wounds in his leg and thigh, on the highlands in 1779.	2.22
4	do	Dangerously wounded in the head Sept. 19, 1777, at the Battle of Bemus Heights and at intervals subject to convlusions and derangement of mind.	1.66⅔
5	do	Taken in retreat from Canada, 1776, with smallpox and by hardships, and lying on the ground while in that disorder and not having proper attendance had lost the use of his left eye.	2.22
6	do	Wounded in the left arm Aug. 16, 1777, at the Battle of Bennington.	1.11
7	do	Wounded in arm by musket ball at Chemory, 1779	1.11
8	do	Wounded in thigh at Battle of Bennington	.83⅓
9	Lieutenant	Wounded July 1777 in an engagement by a ball passing through his left shoulder, and ruptured in his groin at expedition of General Sullivan against the Indians.	5.66⅔
10	Private	His right arm blown off in the act of charging a piece, Mar. 26, 1777.	3.33⅓
11	Ensign	Wounded in 1777 in the shoulder, at the retreat from Ticonderoga, and in 1778 lost the sight of his eye by the inoculation of smallpox.	5.33⅓
12	Lieutenant	Wounded by a ball passing through his left wrist, Aug. 16, 1777.	1.71
13	Private	Wounded in wrist, June 17, 1775, at the Battle of Bunker Hill.	2.22
		MASSACHUSETTS	
14	Captain	One hip dislocated and thigh bone broken while in service in 1777.	7.50
15	Corporal	Wounded with bayonet which entered his left breast and passed through his back, which wound is still open, near Yorktown, Va., 1781.	2.44⅓
16	Private	Wounded in right thigh by a musket ball in 1775	1.11
17	do	Lost 1 thumb and his hand much injured by bursting a gun, April 1775.	1.66⅔
18	do	Wounded by a stroke from the muzzle of a musket, by which he totally lost his right eye in the summer of 1775.	2.66⅔
19	do	Wounded by musket ball which passed through his body, Ticonderoga, 1777.	1.66⅔
20	Lieutenant	Wounded by great exertions and excessive heat, Battle of Monmouth.	5.00
21	Colonel	Ruptured by the rolling of a log over his breast while cutting wood for huts to cover the troops in the winter of 1780.	1.83⅓
22	Private	Wounded by bursting of his gun, arm amputated in 1777 at Saratoga.	1.63⅓
23	do	Being employed in 1779 in transporting public stores to West Point over the ice and in a snowstorm, both feet frozen and lost several joints of his toes.	1.33⅓
24	Captain	Received several wounds and blows, particularly in left leg and left shoulder, the leg thereby rendered lame and the toes of his foot contracted, the heavy blow on the left shoulder depriving him of the free use of his left arm, frigate *Hancock*, 1777.	30.00
25	Private	Lost wholly the sight of 1 eye by inoculation of smallpox, 1777.	2.96
26	do	Ordered out on fatigue on the night of June 16, 1775 at Bunker Hill and continued on fatigue all of next day; by excessive labor on that service was taken with fever, which impaired his health.	1.66⅔
27	Sergeant	Wounded in the right hand and lost part of forefinger at the Battle of Bemus' Heights, October 1777, and further disabled by camp fever.	3.33⅓
28	Ensign	Ruptured in assisting in removing ordnance stores, retreat from Canada.	3.75
29	Sergeant	Wounded by musket ball at the battle of Bunker Hill, June 7, 1775.	1.66⅔

List of the invalid pensioners returned by the circuit courts for the hereafter-named districts, and who have been placed on the list transmitted from the War Office to the commissioner of loans for the respective States, and returned to the Secretary of the Treasury for arrearages of pensions—Continued

No.	Rank	Disability	Monthly allowance
		MASSACHUSETTS—continued	
30	Private	Disabled in considerable degree by excessive heat and exertions at Battle of Monmouth, June 1778.	$2.22
31	do	Wounded in the flesh of the leg, thigh and shoulder, in the back and front of the head, and scalped at Stone Arabia, October 1780.	3.33⅓
32	do	Wounded by a musket ball which entered his right side and passed through his body, between Fort Edward and Fort Miller, June 29, 1777.	1.66⅔
33	do	Wounded in the right ankle and left arm, near the wrist, Kingsbridge, 1781.	1.66⅔
34	Lieutenant	Wounded by the bursting of a shell, June 17, 1775, Battle of Brad's Hill.	3.33⅓
		DISTRICT OF MAINE	
35	Corporal	Wounded in the left arm, Aug. 29, 1779, at the Indian Expedition under General Sullivan.	3.33⅓
36	Private	Dangerously wounded by a musket ball, expedition against Penobscot, 1779.	3.33⅓
37	do	Badly wounded by a musket ball in the jugular artery, Sept. 9, 1777.	3.33⅓
38	do	Nearly lost the use of his right hand and arm by inoculation of smallpox being in the Army at Valley Forge.	3.33⅓
39	do	Contracted an ulcer, or fever sore, settled in his left leg and almost deprived him of the use thereof as consequence of sickness, 1776.	3.33⅓
40	do	Lost the sight of 1 eye and the other much injured by the inoculation of smallpox as consequence of general orders about April 1777.	3.33⅓
41	Lieutenant	Contracted rheumatism and bilious rhind when retreating from Ticonderoga, in 1777.	8.88⅔
		RHODE ISLAND	
42	Private	Wounded by a musket ball in his left arm at Newport, Aug. 9, 1778.	1.66⅔
43	Forge master	Received a violent contusion in his right leg while removing hay from the island of Prudince to the main by order of Col. C. Greene, 1779.	3.00
44	Sergeant	Badly wounded in the left hand by the splitting of a musket.	3.33⅓
45	Private	Wounded on the 2d day of July 1781 in a skirmish with the enemy near Kingsbridge, N. Y., by a musket ball entering his left, passing through the upper jaw, and coming out at the mouth and chin.	1.66⅔
46	2d sergeant	Wounded at Fort Griswald by a musket ball which entered on the lower jaw on the right side and came out at the back side of his neck, 1781.	3.33⅓
47	Sergeant	Received a stroke by a rowman oar which has much disabled him producing an inguinal rupture and is under the continual necessity of wearing a steel truss, August or Sept. 1779.	3.33⅓
48	Corporal	Wounded by a musket ball in the wrist of his hand, which was amputated Oct. 10, 1777.	3.25
49	Sergeant	Wounded in left hand by the bursting of a musket, Feb. ruary 19, 1779.	3.56
50	Fifer	Lost the toes from each of feet, being frozen while prisoner at New York, Feb. 19, 1776.	3.66⅔
51	Private	Infirmity, being a cripple, being cut for the stone at the hospital, 1782.	3.33⅓
52	do	Contracted sickness and consumption while a prisoner at New York, 1776.	4.45
53	Sergeant	His constitution impaired, being overheated at the Battle of Monmouth and wounded June 28, 1778.	3.56
54	Artificer	Wounded by a piece of timber which fractured his breast-bone, Yorktown.	4.00
55	Fifer	Ruptured about his abdomen	3.25
56	1st Lieutenant	Badly wounded by a musket ball which entered his breast and shoulder and is lodged in his shoulder blade, 1777.	6.00
57	Private	Wounded by a musket ball which entered below his breast, broke one of his ribs, and came forth at his back, July 4, 1779.	3.33⅓

List of the invalid pensioners returned by the circuit courts for the hereafter-named districts, and who have been placed on the list transmitted from the War Office to the commissioner of loans for the respective States, and returned to the Secretary of the Treasury for arrearages of pensions—Continued

No.	Rank	Disability	Monthly allowance
		RHODE ISLAND—continued	
58	Private	Lost by sickness while in the service the use of his left eye, the sight of his right being much impaired.	$3.33
59	do	Wounded by a musket ball in the thigh	1.66⅔
60	do	Wounded by a cannon ball which shot away the rim of his belly about 2 inches; expedition Rhode Island.	3.70
61	do	Decrepited by a musket ball in his left leg, Apr. 27, 1977	2.22
62	do	Wounded by Barmore's Corps of light horse, in several places, who rode over him in 1779.	3.33⅓
63	do	Disabled by violent pains and inflammation while in service.	2.22
64	do	Disabled by hardships to which he was exposed, which occasioned lameness.	5.55⅓
65	do	Wounded in leg by a musket ball below the knee, Sept. 19, 1779.	2.22
66	do	Disabled by great cold while in service and in the way of his duty.	3.33⅓
67	do	Wounded by several stabs of bayonets, particularly near his left breast; also wounded by musket balls in his arms and hands.	3.33⅓
68	do	His feet badly frozen on a tedious march from Oswego to Fort Reneselaer on the Mohawk River in February 1783.	2.52
		VERMONT	
69	do	Disabled by hardship, fatigue and sickness, and also loss of one eye.	3.33⅓
70	Captain	Health greatly impaired by the fatigues and hardships he endured defending Fort Stanwix alias Fort Schwyter, when besieged by the British in 1777.	5.00
71	Private	Disabled at Bunker Hill by a wound in his right arm	2.22
72	do	Disabled at Germantown in 1777 by a ventral rupture	2.22
73	do	Disabled by a wound in the left arm which fractured the bone.	.95
74	do	Wounded at the Battle of Bennington in August 1777 by 2 balls; 1 entered his right breast and came out his armpit, the other entered just above the right knee.	1.66⅔
75	Sergeant	Disabled near the White Plains by a wound in his left leg.	1.25
76	Private	Wounded at Bennington, Aug. 16, 1777 by a ball which passed through his breast.	2.50
77	do	Disabled by a wound in his right hand	1.66⅔
78	do	Wounded on an expedition against the British troops at Boston lighthouse by a musket ball, which passed through his leg.	2.22
79	Sergeant	Disabled by hardships and fatigue which occasioned an incurable sore in his leg.	2.50
80	Corporal	Wounded by a musket ball which entered his right breast and came out under his right shoulder blade, was carried to Quebec and remained a prisoner for 6 months.	2.44⅓
81	Sergeant	Lost his health by the fatigue and the want of supplies on an expedition to Jusep's patent, State of New York, by order of General Schuyler, April and May 1777.	3.33⅓
82	do	Wounded by a musket ball which lodged in his shoulder blade in an action with the British troops near Bennington, Aug. 16, 1777.	2.50
83	do	Wounded in his right arm	1.25
84	Private	Disabled leg, a ventral rupture in the service of the United States.	2.50
85	do	Wounded by a musket ball which entered about 3 inches above the anus and lodged in his body.	5.00

TABLE NO. 2–B

List of inva'id pensioners examined by the judges of the Circuit Court for the District of Massachusetts, October term, 1792

No.	Rank	Disability	Monthly allowance
1	Private	Wounded by musket ball in his thigh, battle of Bunker's Hill.	$2.22
2	do	Wounded in hip by cannonball at the capture of General Burgoyne.	2.22
3	do	Disabled by smallpox which injured his sight while retreating from Canada, afterwards by heat and fatigue on the march 4 days previous to the Battle of Monmouth.	3.33⅓
4	Brigade-Major	Wounded in shoulder by a musket ball at the retreat from Ticonderoga and injured by sufferings while a prisoner.	8.33⅓
5	Dragoon	Disabled by a rupture in side occasioned by fatigue	2.08⅓
6	Private	Lost right leg at the Battle of Monmouth	3.33⅓
7	do	Wounded by a musket ball which still remains in his side at the Battle of Behmus' Heights, Sept. 19, 1777.	3.33⅓
8	do	Wounded in his right hand at the battle of Behmus' Heights.	1.11
9	Sergeant	Lost the sight of his left eye by an accidental wound	2.00
10	Colonel	Disabled by diseases contracted in Canada in the year 1775.	16.66⅔
11	Captain	Wounded by musket balls in left leg and near the right hip in the battle of Bunker's Hill.	13.33⅓
12	Private	Wounded by cannonball at the White Plains in 1776	2.22
13	Sergeant	Disabled by wound in throat and shoulder at Province Island, Pa., 1777.	2.00
14	Private	Wounded by a musket ball which passed through his body, White Plains, 1780.	1.66⅔
15	do	Wounded in his head by a ball which passed through the same.	3.33⅓
16	do	Lost the use of 1 of his arms and 1 of his legs	3.33⅓
17	do	Both of his feet frozen in the expedition from Fort Plain on the Mohawk River in Oswego.	2.66⅔
18	Sergeant	Disabled in a great degree in campaign in Canada	2.66⅔
19	Ensign	Injured his constitutions by great exertions in the Army, and particularly in the Battle of Monmouth.	6.66⅔
20	Private	Wounded in the left side at the battle of Bunker's Hill	3.33⅓
21	Lieutenant	Disabled by smallpox while prisoner at New York in 1775.	8.88⅔
22	Colonel	Ruptured by falling on a stake at Dorchester Heights in March 1776.	8.33⅓

List of invalid pensioners examined by the judges of the Circuit Court of the United States for the District of Connecticut, October term, 1792

No.	Rank	Disability	Monthly allowance
1	Private	Wounded in his leg by a stick of timber, and an open ulcer on his leg.	$3.33⅓
2	Corporal	Unfirm, debilitated in his constitution occasioned by hardships and fatigue at the Battle of Monmouth.	4.88⅔
3	Private	Totally disabled by fall which bruised the upper part of his thigh which occasioned deep ulcers, from which several times, pieces of bone have been extracted, 1779.	6.66⅔
4	Corporal	Shot in right arm which broke the bones of his arm, Oct. 19, 1777.	3.66⅔
5	Private	Wounded in his foot, while in service, bu cutting with ax	1.66⅔
6	do	Lost his right eye, and debilitated by the smallpox	1.66⅔
7	do	Wounded in his leg, which occasioned ulcers and lameness, Apr. 27, 1777.	4.44⅓
8	Captain	Wounded by a musket ball which entered his right breast, penetrated to his shoulder, and very much injured the large muscle and principal tendon.	10.00
9	Private	Wholly incapacitated by inoculation of the smallpox which fell into his right leg and ankle and has, in a great measure, withered his leg, 1777.	4.44⅓
10	Captain	Overcome by extreme heat and fatigue at the Battle of Monmouth which occasioned weakness and general debility of body.	6.66⅔
11	Captain	Contracted rheumatic afflictions by severe duty and hardships.	3.33⅓
12	Private	Badly wounded in boarding a sloop of war, and so cut to pieces that the entrails came out of his wounds, Sept. 10, 1781.	1.66⅔
13	do	Disabled by a rupture of the abdomen of a dangerous nature.	3.33⅓
14	do	Contracted a disorder while in service, lost his hearing, and incurred debility.	2.22
15	Sergeant	Disabled and rendered infirm and lame, by an inflammatory rheumatic disorder, 1782.	5.00
16	Private	Ruptured in the scrotum and will never recover	2.22
17	do	Badly wounded in the left leg and both arms, May 23, 1780.	3.33⅓
18	do	Became a cripple by repeated cold and hard service	5.00
19	Corporal	Contracted a disability while in service being overheated on a march on the day of the Battle of Monmouth.	3.66⅔
20	Private	Contracted rheumatic disorders which render him unfit for labor.	2.22
21	Colonel	Contracted various infirmities of the body, with nephritic disorders, and an hydrocele, and a continued disability.	18.75

List of invalids examined by judges of Circuit Court of the United States for the District of New Jersey, October 1792

No.	Rank	Disability	Monthly allowance
1	Captain	Badly wounded in both hands by the explosion of powder	$3.33⅓
2	Private	Disabled in his health and constitution, which in some measure affected the use of his limbs, in 1776 by the smallpox and colds in Canada.	1.33⅓
3	do	Wounded in the breast by a ball which penetrated through his body.	1.66⅔

Table No. 3

List of Rates Awarded to Service-Connected Disabled Veterans of American Revolution [1]

(Submitted to Congress by the Secretary of War, Apr. 25, 1794)

List of certificates transmitted by the judge of the circuit court for the district indicated

MAINE

No.	Rank	Disability	To what pension entitled
1	Private	Received a wound at the siege of Quebec by a musket ball through his right leg which broke and scattered both the bones and carried away some portion of them; that the wounded leg is about 1½ inches shorter than the other, and left the upper end of 1 of the bones out of joint. The said wound must have required a long time to digest and heal. December 1775.	One-fourth.
2	do	Badly wounded in action at Fort Ann on the retreat from Ticonderoga. A ball entered his left shoulder and came out the back part of his neck, in the actual line of duty. July 1777.	Two-thirds.
3	Sergeant	Wounded in left wrist by a musket ball in action at Bunker's Hill, in actual line of duty. July 17, 1775.	Four-fifths.
4	do	Wounded in arm at the battle of Hubbardtown and was made prisoner by the British and carried back to Ticonderoga where he was put under the care of a surgeon who pronounced the wound incurable and would have taken the arm off but attempted a cure without it. In the course of the 15 months he remained a prisoner, the surgeon took out 14 pieces of bone from said wound, and after he retrurned to New Hampshire had 1 piece of bone taken from said wound. July 7, 1777.	One-third.
5	Private	Wounded by a musket ball at the battle of Bennington in his right arm, and has fractured the os-humeri and lost part of it, the muscles are injured and impeded in their operation. August 1777.	Five-eighths.
6	Matross	Hurt by the sudden discharge of a cannon to which he was stationed. He had the misfortune of losing the sight of his right eye. September 1777.	$4.16.

CONNECTICUT

1	Private	Wounded by cannon ball. September 1776	One fourth.
2	Lieutenant	Wounded by musket ball in the back which renders him incapable of getting a living by labor. April 1777.	Seven-eighths.
3	Private	Wound, small of back, musket ball, which disabled him very much. July 1779.	Do.
4	Lieutenant	Wound, right breast, musket ball, renders right arm useless. September 1777.	Six-sevenths.
5	Private	Wound, musket ball, broke 1 of his ribs, and has rendered him ever since unfit for labor. April 1777.	One-half.
6	Mariner	Wounded in right arm by 9-pound shot which fractured the bone of his middle finger and prevents him from having full use of his hand. August 1776.	Do.
7	Private	Wound, musket ball, right wrist extracted half way up to elbow. July 1779.	Do.
8	do	Wound, musket ball, foot, which entered between the 1st and 2d toes and came out some distance above the great toe joint. He lost 1 toe and is very much disabled in consequence of said wound. Oct. 7, 1777.	Do.
9	do	Wound, musket ball, thigh, which at times totally disables him from walking. July 5, 1779.	Three-fourths.
10	Corporal	Wound, musket ball, back, which disables him from performing labor duty. October 1776.	One-fourth.
11	Colonel	Wound, musket ball on right temple which deprives him of hearing in his right ear and at times injures the sight of the right eye. July 6, 1779.	Do.
12	Private	Very much debilitated by a fit of sickness he had while in the service at White Marsh, 1777.	One-half.
13	do	Wound, musket ball, right side and intestines, by which means he is very much disabled. Aug. 29, 1782.	Do.
14	Sergeant	Wound, musket ball, hand and wrist, by which he is very much disabled. July 1778.	One-third.
15	do	Disabled in a great measure by a wound which he received while in actual service. July 1789.	One-half.

[1] American State Papers, Claims, pp. 85–104.

List of certificates transmitted by the judge of the circuit court for the district indicated—Continued

RHODE ISLAND

No.	Rank	Disability	To what pension entitled
1	Private	Inguinal rupture, 1775	Evidence not perfect.
2	do	Lost 1 eye by smallpox while in service, since the war has had 1 leg amputated.	Evidence not complete.
3	Sergeant	Wounded, musket ball, right thigh. Oct. 22, 1777	One-eighth.
4	Private	Wounded while in the service of the United States by loss of the index finger of his right hand occasioned by long and extreme exertion in rowing a boat when removing the regiment from Newport to New Haven; wound has rendered the amputation, 1st of 1 finger—afterward of a portion of the hand, absolutely necessary for the preservation of life. 1776.	One-fourth.
5	Deputy forage master.	Hurt by a fall from a horse while in actual line of duty. April 1779.	One-half.

VERMONT

1	Sergeant	Fistula in ano, occasioned by straining and exceptional exertions and from being overheated at the Battle of Monmouth. 1778.	One-half.
2	Private	Wounded, musket ball, left arm. Aug. 5, 1777	Do.
3	do	Wounded in battle at the Battle of Bunker's Hill. June 1775.	Do.

NEW YORK

1	Lieutenant	2 wounds on his head and under his left eye. April 1777	By supplementary evidence, physicians report no disability by reason of wounds.
2	Sergeant	Wounded left side in action against Indians	None.
3	Private	Wounded in side	Do.
4	Captain	Loss of sight, occasioned by having an eye struck out in assisting some women to draw water out of a well at Fort Stone Arabia, July 1780.	Do.
5	Sailor	Wounded in leg. June 1775	Do.
6	Private	Wounded in left hip. July 1882	None. (Physicians report somewhat disabled.)
7	Sergeant	Ulcer left knee from ——— contracted in service. 1780	Full pension.
8	Private	Lost his eyesight by hardships at Quebec. January 1776	None.
9	do	Ruptured in stretching a chain across the North River. 1776.	None. (no examination by physicians.)
10	do	Wounded by accident with ax. 1778	None.
11	Sergeant	Lameness from swelling and inflamation contracted in service.	Full pension.
12	Private	Wound, back, tomahawk by Indians	None.
13	do	Wounded shoulder. September 1777	Do.
14	do	Wound in knee whilst quelling a riot in winter quarters	None. (Physicians do not designate a disability.)
15	do	Wounded, lost 2 fingers. October 1777	None.
16	Sergeant	Violent contusion received by a fall from a precipice in the night. July 1777.	Do.
17	Private	Bruises and debility contracted in service	No disability.
18	Corporal	Wounded, musket ball, in breast. 1776	Do.
19	Private	Had his leg hurt by a fall from a rock while on scout in woods. 1780.	None.
20	do	Wounded, musket ball, in breast. Sept. 19, 1777	Do.
21	do	Disease contracted in service	Do.
22	do	Wounded, musket ball, with Indians. Nov. 10, 1781	Do.
23	do	Wounded in capture of Fort Montgomery	Do.
24	Ensign	Wounded in shoulder in action with Indians. Aug. 6, 1777.	Do.
25	Captain	Wounded in shoulder at Johnstown	Do.
26	Private	Wounded in neck. June 1781	Do.
27	do	Wounded both shoulders. Aug. 7, 1777	Full pension.
28	do	Had his feet frozen and lost some of his toes	None.
29	do	Wounded by kick from a horse	Do.
30	Lieutenant	Wounded by musket ball in thigh. 1778	Do.

Table No. 4

Intermediate Rates Fixed by the Commissioner of Pensions for Certain Disabilities Not Specified by Law (General Law), 1899 [1]

Anchylosis of shoulder	$12
Anchylosis of elbow	10
Anchylosis of knee	10
Anchylosis of ankle	8
Anchylosis of wrist	8
Loss of sight of one eye	12
Loss of one eye	17
Nearly total deafness of one ear	6
Total deafness of one ear	10
Slight deafness of both ears	6
Severe deafness of one ear and slight of the other	10
Nearly total deafness of one ear and slight of the other	15
Total deafness of one ear and slight of the other	20
Severe deafness of both ears	22
Total deafness of one ear and severe of the other	25
Deafness of both ears existing in a degree nearly total	27
Loss of palm of hand and all the fingers, the thumb remaining	17
Loss of thumb, index, middle and ring fingers	17
Loss of thumb, index and middle fingers	16
Loss of thumb and index finger	12
Loss of thumb and little finger	10
Loss of thumb, index, and little fingers	16
Loss of thumb	8
Loss of thumb and metacarpal bone	12
Loss of all the fingers, thumb and palm remaining	16
Loss of index, middle, and ring fingers	16
Loss of middle, ring, and little fingers	14
Loss of index and middle fingers	8
Loss of little and middle fingers	8
Loss of little and ring fingers	6
Loss of ring and middle fingers	6
Loss of index and little fingers	6
Loss of index finger	4
Loss of any other finger without complications	2
Loss of all the toes of one foot	10
Loss of great, second, and third toes	8
Loss of great toe and metatarsal	8
Loss of great and second toes	8
Loss of great toe	6
Loss of any other toe and metatarsal	6
Loss of any other toe	2
Chopart's amputation of foot, with good results	14
Pirogoff's modification of Syme's	17
Small varicocele	2
Well-marked varicocele	4
Inguinal hernia, which passes through the external ring	10
Inguinal hernia, which does not pass through the external ring	6
Double inguinal hernia, each of which passes through the external ring	14
Double inguinal hernia, one of which passes through the external ring and the other does not	12
Double inguinal hernia, neither of which passes through the external ring	8
Femoral hernia	10

Note.—Section 4699, Revised Statutes, provides that the rate of $18 per month may be proportionately divided for any degree of disability established for which section 4695 makes no provision, thus fixing the highest rating provided by existing laws which can be allowed by considering disabilities separately and compounding so as to allow the full amount which the disabilities, so considered, would aggregate.[2]

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[1] Report of Commissioner of Pensions, 1899, pp. 110–111.

[2] Rating is based on 6/18 up to 17/18 according to degree of disability shown and when disability is in excess of 17/18 and equivalent to the loss of a hand or foot the rate was third grade or $24; if the disability was not equivalent to the loss of a hand or foot, even if it were in excess of 17/18, no higher rate than $17 a month was allowed. See A Treatise on the Practice of the Pension Bureau (Washington 1898), p. 126.

The act of March 2, 1895, provides that all pensioners now on the rolls, who are pensioned at less than $6 per month, for any degree of pensionable disability, shall have their pensions increased to $6 per month; and that, hereafter, whenever any applicant for pension would, under existing rates, be entitled to less than $6 for any single disability or several combined disabilities, the pensioner shall be rated at not less than $6 per month: *Provided, also,* That the provisions hereof shall not be held to cover any pensionable period prior to the passage of this act, nor authorize a rerating of any claim for any part of such period, nor prevent the allowance of lower rates than $6 per month, according to the existing practice in the Pension Office in pending cases covering any pensionable period prior to the passage of this act.

Table No. 5

Corresponding Ratings for Some Disabilities Under the General Law and Act of June 27, 1890 [1]

"The bases of ratings under the two laws are so widely different that it is impossible to fix a parallel except in a general way."

GENERAL LAW		ACT OF JUNE 27, 1890	
The bases for ratings under the general law are:		The basis of ratings under this act is: Incapacity to labor, joined with incapacity to earn a support, and the grades of rating are dependent on these two conditions.	
(1) For minor disabilities, an anchylosed wrist	$8		
(2) For incapacity to perform manual labor equivalent to loss of hand, foot	24		
(3) For incapacity to perform any manual labor	30		
Second grade	30	Minimum rate under this act	$6
Third grade	24	Maximum	12

General Law	Disability	Act of June 27, 1890
$24	Disability equivalent to loss of hand or foot	$12
6–10	Single hernia	6
8–14	Double hernia	8
30	Deafness: Total both ears	12
27	Deafness: Nearly total	10
25	Deafness: Total 1 ear and severe of other	8
22	Deafness: Severe of both ears	6
17	Loss of 1 eye	6
12	Loss of sight of 1 eye	6
10	Anchylosis: Elbow	6
10	Anchylosis: Knee	6
12	Anchylosis: Shoulder	6
10–17	Loss of portions of hand or foot: Rates vary according to extent of amputation	6–10

"In making the above comparisons it may be stated that the rates indicated under the act of June 27, 1890, are the lowest rates allowed for the disabilities mentioned. Cases often occur where, in addition to the loss of part of a member, there are complications which increase the inability to earn a support by manual labor warranting higher rate than that indicated in the above table."

* * * * * * *

"The second section of the act of June 27, 1890, is by many understood to provide for a dependent pension. This is not the case; it pensions only for disability not necessarily of service origin. Disabilities for which pension is asked may have originated prior to the claimant's service, during his service, or since service while engaged in the ordinary avocations of life. It matters not whether the claimant be in a condition of poverty or a millionaire; he must show by medical evidence that he has a physical or mental disability that disqualifies him in whole or in part for earning a support by manual labor."

* * * * * * *

"As a further illustration showing the effect of the two systems of granting pensions created by the laws, a case may be cited where a claimant becomes totally blind from causes incident to his service. The law provides a pension in this case of $72 per month. In the same village another claimant becomes totally blind from causes not connected with his service, and the law grants him only $12 per month. The community, not being familiar with the legal rights of the two claimants, cannot understand why one of these men receives a higher rate of pension than the other for the same disability, and the Pension Bureau is usually held responsible. Few stop to inquire into the facts which confer title in the different cases and to ascertain the fact that these conditions are created by law."

[1] Report of the Commissioner of Pensions, 1899, p. 39.

Table No. 6

1919 Tentative Schedule for Rating Disabilities, United States Veterans, World War I (Submitted to Congress, June 18–19, 1919) [1]

Dear Sir: In accordance with instructions from the Assistant Secretary Love, we now submit the following additions to the schedule of ratings for partial permanent disability.

Ratings for permanent injuries to hearing

	(Remaining hearing—other ear (percent)				
	0	25	50	75	100
Remaining hearing, 1 ear:					
0 percent	50	43	35	26	15
25 percent	43	38	31	21	9
50 percent	35	31	25	16	5
75 percent	26	21	16	9	2
100 percent	15	9	5	2	0

For example, if the remaining hearing in 1 ear were 50 percent and in the other ear 75 percent, that is, 25 percent impairment, the rating would be 16 percent.

	Percent
Mental deterioration	10–80
Hernia, ventral where hernia cannot be kept in place by orthopedic appliance	50
Hernia, where hernia can be kept in place by orthopedic appliance	20
Epilepsy: Fits occurring daily	100
Fits occurring periodically at intervals of from 2 to 4 days	80
Fits occurring periodically at intervals of from 5 to 10 days	60
Fits occurring periodically at intervals of from 11 to 30 days	40
Fits occurring periodically at intervals exceeding 30 days	20

Ratings for permanent injuries to vision

	Remaining vision—other eye							
	0	20/200	20/100	20/70	20/50	20/40	20/30	20/20
Remaining vision, other eye:	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*	*Percent*
0	100	100	95	75	65	60	50	30
20/200	100	100	95	70	60	55	45	27.5
20/100	95	95	70	65	55	50	40	22.5
20/70	75	70	65	60	50	45	35	17.5
20/50	65	60	55	50	45	40	30	12.5
20/40	60	55	50	45	40	35	27.5	10
20/30	50	45	40	35	30	20	20	5
20/20	30	27.5	22.5	17.5	12.5	10	5	0

The foregoing ratings measure the disability after the best possible adjustment of lenses has been applied to the eyes.

The international system of noting visual values has been used in the foregoing table. The numerator indicates the distance in feet of the object from the eyes of the observer, and the denominator the distance (also in feet) at which the object should have been seen. For example, 20/200 means that the individual is seated 20 feet from the object, but sees only that sized object which should have been seen at 200 feet. We are assured by authorities in ophthalmics that these fractions serve all practical purposes, and that it would be inadvisable to adopt any other than the accepted standard for estimating visual power.

[1] 66th Cong., House subcommittee of the Committee on Interstate and Foreign Commerce. Hearings (unnumbered), pt. 1, pp. 33–36.

Permanent injuries to the eyes—Paralysis of extrinsic muscles

All extrinsic muscles of one eye paralyzed:	*Percent*
0 muscles of other eye paralyzed	15
1 muscle of other eye paralyzed	18
2 muscles of other eye paralyzed	20
3 muscles of other eye paralyzed	25
4 muscles of other eye paralyzed	30
5 muscles of other eye paralyzed	60
All muscles of other eye paralyzed	100

It is assumed that the foregoing disability remains after the best possible adjustment of prisms has been applied to the eyes.

The following schedule would apply to permanent injuries to the eye which impaired the visual fields.

Permanent injuries to the eyes—Impairment of visual fields

	Percent
Loss of nasal halves of both fields	0
Loss of nasal half of one field	0
Partial defects of one field	10
Loss of temporal half of one eye	10
Loss of full field of one eye	10
Concentric contraction of one eye	10
Loss of temporal half of both eyes	15
Small concentric contraction of both eyes to 60°	15
Homononymous hennanopsia (sic) right eye or left, superior or inferior	20
Concentric contraction of both fields to 30°	30
Concentric contraction of both fields to 5°	100

Yours very truly,

ARTHUR HUNTER,
_____,
_____,
Advisory Board.

A. SUBJECTIVE CONDITIONS

	Percent
Insanity, total	100
Epilepsy, fits occurring several times a day	100

B. OBJECTIVE CONDITIONS

I. The head:	
(1) The skull—aperture in cranium, unfilled with new bone, no functional results	10
(2) The face—	
Marked paralysis of facial nerve, nonsyphilitic	20
Such injuries to the nasal, cheek bones, or jaws as interfere in a positive degree with the performance of the normal functions of nose (not elsewhere specified)	10–40
Such injuries to the nasal, cheek bones or jaws as interfere in a positive degree with the performance of the normal functions of mouth (not elsewhere specified)	10–40
Loss of tongue, including unintelligible vocalization	70
Such irreparable injury to or loss of teeth as produces malnutrition through deficient mastication of food	25
(3) The eye—Complete loss of sight, both eyes	100
(4) The ear—Deafness, complete in both ears	50
(5) The neck—	
Complete loss of speech	50
Indistinct articulation, due to trauma	10
Chronic bronchitis	0–10

Permanent injuries to the eyes—Impairment of visual fields—Continued

	Percent
II. The upper extremities:	
(1) The shoulder and arm—loss of both hands at or above wrist joints	100
a. The shoulder—	
Disarticulation arm, at shoulder joint (major)	75
Disarticulation arm, at shoulder joint (minor)	70
Flail joint at shoulder (major)	25
Flail joint at shoulder (minor)	20
Ankylosis shoulder joint, resulting in decided limitation of motion of arm (major)	25
Ankylosis shoulder joint, resulting in decided limitation of motion of arm (minor)	20
Ankylosis shoulder joint, not permitting arm to be raised above level with the shoulder (major)	20
Ankylosis shoulder joint, not permitting arm to be raised above level with the shoulder (minor)	15
b. The elbow—	
Loss arm, at or above elbow joint and below shoulder joint (major)	70
Loss arm, at or above elbow joint and below shoulder joint (minor)	65
Complete ankylosis elbow joint, in bad position (major)	55
Complete ankylosis elbow joint, in bad position (minor)	50
Complete ankylosis elbow joint, in good position (major)	30
Complete ankylosis elbow joint, in good position (minor)	25
False joint at elbow (major)	25
False joint at elbow (minor)	20
c. The wrist—	
Loss arm, between elbow and wrist joints (major)	65
Loss arm, between elbow and wrist joints (minor)	60
Ankylosis wrist joint, severely involving fingers (major)	30
Ankylosis wrist joint, severely involving fingers (minor)	25
Ankylosis wrist joint, very limited motion (major)	15
Ankylosis wrist joint, very limited motion (minor)	10
(2) The hand—	
Loss hand at wrist joint (major)	60
Loss hand at wrist joint (minor)	55
a. The fingers and thumb—	
Loss 5 fingers 1 hand, at proximal joints (major)	50
Loss 5 fingers 1 hand, at proximal joints (minor)	45
b. The fingers—	
Loss all fingers except thumb, 1 hand, at proximal joints (major)	40
Loss all fingers except thumb, 1 hand, at proximal joints (minor)	35

Permanent injuries to the eyes—Impairment of visual fields—Continued

	Percent
II. The upper extremities—Continued	
(2) The hand—Continued	
Loss hand at wrist joint (minor)—Continued	
c. The thumb, index and middle fingers—	
Loss thumb, index, and middle fingers, 1 hand, at proximal joints (major)	35
Loss thumb, index, and middle fingers, 1 hand, at proximal joints (minor)	30
d. The thumb and index finger—	
Loss thumb and index finger, 1 hand, at proximal joints (major)	25
Loss thumb and index finger, 1 hand, at proximal joints (minor)	20
e. The thumb—	
Loss thumb, involving the metacarpal bone (major)	17. 5
Loss thumb, involving the metacarpal bone (ninor)	12. 5
Loss thumb, at proximal joint (major)	12. 5
Loss thumb, at proximal joint (minor)	10
f. The index finger—	
Loss index finger, at proximal joint (major)	10
Loss index finger, at proximal joint (minor)	7. 5
g. The middle finger—	
Loss middle finger, at proximal joint (major)	7. 5
Loss middle finger, at proximal joint (minor)	5
h. The ring finger—	
Loss ring finger, at proximal joint (major)	7. 5
Loss ring finger, at proximal joint (minor)	5
i. The little finger—	
Loss little finger, at proximal joint (major)	7. 5
Loss little finger, at proximal joint (minor)	5
III. The trunk:	
(1) The chest—pulmonary tuberculosis	10–100
(2) The abdomen—	
Chronic cystitis	0–50
Hernia inguinal (irreparable)	15
Hernia inguinal	5
(3) The back—	
[NOTE.—There are no ratings assigned for the back in this schedule.]	
IV. The pelvis:	
[NOTE.—There are no ratings assigned for the pelvis in this schedule.]	

Permanent injuries to the eyes—Impairment of visual fields—Continued

	Percent
V. The lower extremities: [2]	
(1) The thigh and leg—	
Loss of both feet at or above the ankle joints	100
Irregular union of fracture in 1 thigh or leg with considerable shortening of limb	15
Irregular union of fraction in 1 thigh or leg with slight shortening of limb, causing sufficient limitation of motion as to produce permanent lameness	10
a. The hip—	
Disarticulation 1 leg, at hip joint	65
Complete immobility, 1 hip joint	55
Complete immobility, 1 hip joint, in extension of thigh	55
b. The knees—	
Loss 1 leg, at or above knee joint	50
Complete ankylosis, 1 knee joint, in bad position	30
Complete ankylosis, 1 knee joint, in good position	10
c. The ankle—	
Loss leg, between ankle and knee joint	40
Complete ankylosis, 1 ankle joint, in bad position	15
Complete ankylosis, 1 ankle joint, in good position	10
(2) The foot—	
Loss of 1 foot, at ankle joint	35
Loss of 1 foot, in tarsus	30
Loss of 1 foot, in matatarsus	20
a. The toes—	
Loss 1 big toe, at proximal joint	10
Loss 3 toes (other than big toe), on 1 foot, at proximal joints	10

[2] Bone and joint tuberculosis automatically fall in the regional disabilities and the ratings in each case will not exceed the percentages for the loss of the limb at the level of the tuberculosis.

APPENDIXES

Appendix No. A

Resolutions of Continental Congress for Wounded and Disabled Veterans Prior to August 1776

Resolution of June 20, 1776 [1]

Resolved, That a committee of five be appointed to consider what provision ought to be made for such as are wounded or disabled in the land or sea service, and report a plan for that purpose.

Resolution of June 26, 1776 [2]

The committee to whom was referred the petition of William Whiting, a soldier who was wounded in the Continental Army at Quebec, brought in their report, which was read: Whereupon,

Resolved, That the sum of twenty dollars be paid out of the Public Treasury to William Whiting, to enable him to return to his family at Norfolk, Conn.

Resolution of June 28, 1776 [3]

A petition of William Poole was presented to Congress and read:

Resolved, That it be referred to the committee for making provision for wounded and disabled soldiers.

Resolution of July 9, 1776 [4]

The committee to whom the petition of William Poole was referred, brought in their report: Whereupon

Resolved, That 20 dollars be paid to the said William Poole for his present support, till regulations are made for the relief of disabled soldiers.

Resolution of July 23, 1776 [5]

Resolved, That twenty dollars be advanced to Isaac Manes, a wounded soldier in Captain Cheeseman's company, and that he be sent to the general hospital.

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[1] Ford, Journals of Continental Congress, V, 469.
[2] Ibid., 484.
[3] Ibid., 489.
[4] Ibid., 530.
[5] Ibid., 601.

Appendix No. B

First National Law of the United States for Benefits to Service-Connected Disabled Veterans

Resolution of August 26, 1776 [1]

Congress resumed the consideration of the report of the committee on disabled soldiers and seamen, which was agreed, as follows: Whereas, in the course of the present war, some commissioned and noncommissioned officers of the Army and Navy, as also private soldiers, marines, and seamen, may lose a limb, or be otherwise so disabled as to prevent their serving in the Army or Navy, or getting their livelihood, and may stand in need of relief.

Resolved, That every commissioned officer and private soldier, who shall lose a limb in any engagement, or be so disabled in the service of the United States of America as to render him incapable afterwards of getting a livelihood, shall receive, during his life, or continuance of such disability, the one-half of his monthly pay from and after the time that his pay as an officer or soldier ceases; to be paid by the committee as hereafter mentioned:

That every commander of any ship of war or armed vessel, commissioned officer, warrant officer, marine or seaman belonging to the United States of America who shall lose a limb, in any engagement in which no prize shall be taken or be therein otherwise disabled as to be rendered incapable of getting a livelihood, shall receive during his life, or the continuance of such disability, the one-half of his monthly pay, from and after the time that his pay as an officer or marine or seaman ceases; to be hereafter mentioned. But in case a prize be taken at the time such loss or other disability shall happen, then such sum as he may receive out of the net profits of such price, before a dividend is made of the same, agreeable to former orders of Congress, shall be considered as part of his half of pay, and computed accordingly:

That every commissioned officer, noncommissioned officer, and private soldier in the Army and every commander, commissioned officer, warrant officer, marine, or seaman of any of the ships or war or armed vessels belonging to the United States of America, who shall be wounded in any engagement, so as to be rendered incapable of serving in the Army or Navy, though not totally disabled from getting a livelihood shall receive such monthly sums towards his subsistence as shall be judged adequate by the assembly or other representative body of the State where he belongs or resides upon application to them for that purpose, provided the same doth not exceed his half pay.

Provided, That no commissioned officer, non-commissioned officer, private soldier, in the Army, Commander, commissioned officer, warrant officer, marine or seaman of any of the ships of war, or armed vessels belonging to the United States of America, who shall be wounded or disabled as aforesaid shall be entitled to his half pay or other allowance, unless he produce to the committee, or officer appointed to receive the same in the State where he resides or belongs, or to the assembly, or legislative body of such State, a certificate from the commanding officer who was in engagement in which he was so wounded or in case of his death, from some other officer of the same corps, and the surgeon that attended him, or a certificate from the commander of the ship of war, or armed vessel engaged in the action, in which any officer, marine, or seaman, received his wound, and from the surgeon who attended him, of the name of the person wounded, his office, rank, department, regiment, company, ship of war, or armed vessel, to which he belonged, his office or rank therein, the nature of his wound, and in what action or engagement he received it.

That it be recommended to the several assemblies or legislative bodies of the United States of America, to appoint some person or persons in their respective States, who shall receive and examine all such certificates as may be presented to them, and register the same in a book, and also what support is adjudged by the assembly or legislative body of their State to those whose care required but a partial support, and also the payment from time to time of every half pay and

[1] Ford, Journal Continental Congress, V, 702–705.

allowance and of the death of said disabled person, or ceasing of such allowance, and shall make a fair and regular report of the same quarterly to the Secretary of Congress or Board of War, where a separate record shall be kept of the same:

That it be recommended to the assemblies or legislative bodies of the several States, to cause payment to be made of all such half pay or other allowances as shall be adjudged to the persons aforenamed on account of the United States.

Provided, That all such officers and soldiers that may be entitled to the aforesaid pension, and are found to be capable of doing guard or garrison duty, shall be formed in a corps of invalids and subject to the said duty; and all officers, marine and seamen of the Navy who shall be entitled to the pension aforesaid, and shall be found capable of doing any duty on board the Navy, or any department thereof, shall be employed:

Ordered, That the above be published.

Appendix No. C

Resolution of June 7, 1785[1]

On a report of a committee, consisting of Mr. (James) McHenry, Mr. Hugh Williamson, Mr. David Howell, Mr. Jacob Read and Mr. Samuel Holten, to whom was referred a report, touching invalids.

Resolved, That it be, and it is hereby recommended to the several states, to make provision for officers, soldiers, or seamen, who have been disabled in the service of the United States, in the following manner:

1. A complete list shall be made out by such person or persons as each state shall direct, of all the officers, soldiers or seamen resident in their respective states, who have served in the Army or Navy of the United States, or in the militia in the service of the United States, and have been disabled in such service, so as to be incapable of military duty, or of obtaining a livelihood by labour. In this list shall be expressed the pay, age, and disability of each invalid, also the regiment, corps or ship to which he belonged, and a copy of the same shall be transmitted to the office of the Secretary at War, within one year after each state shall pass a law for this purpose; and a like descriptive list of the invalids resident in the respective states, shall, from year, to year, be annually transmitted to the Office of the Secretary at War.

2. No officer, soldier or seaman, shall be considered as an invalid, or entitled to pay, unless he can produce a certificate from the commanding officer or surgeion of the regiment, ship, corps or company in which he served, or from a physician or surgeion of a military hospital, or other good and sufficient testimony, setting forth his disability, and that he was thus disabled while in the service of the United States.

3. That all commissioned officers within the aforesaid description, disabled in the service of the United States, so as to be wholly incapable of military duty, or of obtaining a livelihood, be allowed a yearly pension equal to half of their pay respectively and all commissioned officers as aforesaid, who shall not have been disabled in so great a degree, be allowed a yearly pension, which shall correspond with the degree of their disability, compared with that of an officer wholly disabled. That all non-commissioned officers and privates within the aforesaid description, disabled in the service of the United States, so as to be wholly incapable of military or garrison duty, or of obtaining a livelihood by labour, be allowed a sum not exceeding five dollars per month: and all non-commissioned officers and privates as aforesaid, who shall not have been disabled in so great a degree, be allowed such a sum as shall correspond with the degree of their disability, compared with that of a non-commissioned officer or private wholly disabled.

4. That each state appoint one or more persons of suitable abilities, to examine all claimants and to report whether the person producing a certificate, setting forth that he is an invalid, be such in fact, and if such, to what pay he is entitled; and thereupon, the persons appointed to make such enquiry, shall give to the invalid a certificate specifying to what pay he is entitled, and transmit a copy to the person who may be appointed by the State to receive and record the name.

5. That each State be authorized to pay to the commissioned officers, non-commissioned officers and privates, the sum or sums to which they shall respectively be entitled, agreeably to the beforementioned certificates; the said payments to be deducted from the respective quotas of the states for the year on which they shall be made: *Provided*, That no officer who has accepted his commutation for half pay, shall be entered on the list of invalids, unless he shall have first returned his commutation.

6. That any state may form such invalids under the aforesaid description, as are citizens of the same, and are capable of garrison duty, into corps, to be employed in guarding military stores, aiding the police, or otherwise, as the state may direct.

7. That when invalids shall be formed into corps, there be quarterly returns comprehending the pay, age, disability, regiment, ship or corps to which they severally belonged, made out and signed by their commanding officer, and transmitted to such person or persons as the State shall direct, that their pay may ordered according to the said return.

8. * * *.

9. That the affidavits drawn according to the above form, and date and attested by a magistrate be sent by the said magistrate to the person or persons appointed by the state, to receive and record the same, and that a counterpart of the affidavit be preserved by the person taking it, to be exhibited to such persons as shall be appointed by the state to pay invalids.

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[1] Journals of Congress (Washington, 1823), IV, 534–535.

Appendix No. D

Act of March 23, 1792[1]

Be it enacted by the Senate and House of Representatives of the United States in Congress Assembled, That, the operation of the resolutions of the late Congress of the United States passed on the second day of November one thousand seven hundred eighty five, and the twenty third day of July one thousand seven hundred and eighty seven, so far as they leave barred, or may be construed to bar claims of the widows or orphans of any officer of the late Army, to the seven years half pay of such officer, shall etc. * * * .

Sec. 2. *And be it further enacted*, That any commissioned officer not having received the commutation of half pay, and non-commissioned officer, soldier, seaman, disabled in the actual service of the United States, during the last war, by wounds or other known cause, who did not desert from the said service, shall be entitled to be placed on the pension list of the United States, during life or the continuance of such disability, and shall also be allowed such farther sum for the arrears of pension, from the time of such disability, not exceeding the rate of the annual allowance, in consequence of his disability, as the circuit court of the district, in which they respectively reside may think just. *Provided*. That in every such case, the rules and regulations following shall be complied with; that is to say: First, Every applicant shall attend the court in person except where it shall be certified by two magistrates that he is unable to do so, and shall produce to the circuit court, the following proofs to wit: A certificate from the commanding officer of the ship, regiment, corps, or company, in which he served, setting forth his disability and that he was thus disabled while in the service of the United States; or the affidavits of two credible witnesses to the same effect. The affidavits of three reputable free holders of the city, town, county, in which he resides ascertaining of their own knowledge the mode of life, employment, labour, or means of support of such applicant, for the last twelve months. Secondly, The circuit court upon receipt of the proofs aforesaid, shall forthwith proceed to examine into the nature of the wound, or other cause of disability of such applicant, and having ascertained the degree thereof, shall certify the same, and transmit the result of their inquiry, in case, in their opinion, the applicant should be put on the pension list to the Secretary of War, together with their opinion in writing, what proportion of the monthly pay of such applicant will be equivalent to the degree of disability ascertained in manner aforesaid.

Sec. 3. * * *

Sec. 4. * * *

Sec. 5. *And be it further amended*, That all non-commissioned officers, soldiers and seamen, disabled in the actual service of the United States, during the late war, whose disability and rate of allowance have been ascertained, pursuant to the regulations prescribed by the late congress, and have not applied to be placed on the pension list until after the time, limited by the act of Congress for that purpose, was expired, shall now be placed on the pension list, and be entitled to demand and receive their respective pensions, according to the allowances ascertained aforesaid, anything in this act, or any act of the late Congress, to the contrary notwithstanding.

Sec. 6. * * *

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[1] Statutes at Large, 243. This act was amended by act of February 28, 1793, attached as appendix No. E

Appendix No. E

Act of February 28, 1793[1]

An Act to Regulate the Claims to Invalid Pensions.

Whereas the act, passed at the last session of Congress, entitled "An act to provide for the settlement of the claims of widows and orphans barred by the limitations heretofore established, and to regulate the claims to invalid pensions," is found by experience inadequate to prevent the admission of improper claims to invalid pensions, and not to contain a sufficient facility for the allowance of such as may be well founded: Therefore,

Section 1. Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the second, third and fourth sections of the said act, be repealed in the manner following, to wit:

First.—All evidence relative to Invalids shall be taken upon oath or affirmation, before the judge of the district, in which such invalids reside, or before any three persons specially authorized by commission from the said judge.

Secondly.—The evidence relative to any claimant must prove decisive disability to have been the effect of known wounds, received while in the actual line of duty, in the service of the United States, during the late war. That this evidence must be the affidavits of the commanding officer or surgeon of the ship, regiment, corps or company, in which such claimant served, or two other credible witnesses, to the same effect, setting forth the time and place of such known wound.

Thirdly.—Every claimant shall be examined upon oath or affirmation, by two physicians or surgeons to be authorized by commission from the said judge, who shall report, in writing their opinion, upon oath or affirmation, of the nature of the said disability, and, in what degree, it prevents the claimant from obtaining his livelihood, by labor.

Fourthly.—Every claimant shall produce evidence of the time of his leaving the service of the United States. He must also produce evidence of three reputable freeholders of the city, town or county, in which he usually resided for the two years immediately after he left the service, as aforesaid, of the existence of his disability, during that period; and ascertaining of their own knowledge, the mode of life, employment, labour or means of support of the claimant.

Fifthly.—And the said claimant must produce the evidence of two credible witnesses, of the continuance of his disability, from the expiration of the said two years, to the time of his application.

Sixthly.—Each claimant must show a good and sufficient cause why he did not apply for a pension to the person or persons authorized to examine his claim on or before the eleventh of December, one thousand seven hundred and eighty-eight, the time limited for application of this nature.

Seventhly.—No evidence of any claimant shall be admitted whose claim has been examined and rejected, on or before the aforesaid eleventh of December, one thousand seven hundred and eighty-eight.

Sec. 2. And be it further enacted, That the judge of the district shall transmit a list of such claims, accompanied by the evidence herein directed, to the Secretary of the Department of War, in order that the same may be compared with the muster-rolls, and other documents in his office; and the said Secretary shall make a statement of the cases to enable them to take such order thereon, as they may judge proper.

Sec. 3. And be it further enacted, That no person not on the pension list, before the twenty-third day of March, one thousand seven hundred and ninety-two, shall be entitled to a pension, who shall not have complied with the rules and regulations herein prescribed: saving however to all persons, all and singular their rights founded upon legal adjudications under the act, entitled "An act to provide for the settlement of the claims of widows and orphans, barred by the limitations heretofore established, and to regulate the claims to invalid pensions:" But it shall be the duty of the Secretary at War, in conjunction with the Attorney General, to take such measures as may be necessary to obtain an adjudication of the Supreme Court of the United States, on the validity of any such rights claimed under the act aforesaid, by the determination of certain persons styling themselves commissioners.

Sec. 4. And be it further enacted, That no claim to a pension shall be allowed under this act, which shall not be presented within two years from the passing the same.

Approved, February 28, 1793.

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[1] *Statutes at Large*, 243.

Appendix No. F

Claims for Service-Connected Disabilities, Veterans of American Revolution

Communicated to the House of Representatives, April 25, 1794 [1]

War Department, *April 25, 1794.*

The Secretary of the Department of War in obedience to the act entitled "An act to regulate the claims to invalid pensions," respectfully reports to the Senate and House of Representatives of the United States:

That the list hereunto annexed contains names of the applicants for pensions as invalids to the judges of the respective enumerated districts, together with the circumstances of each, as far as the same could be ascertained from the evidences received.

That the number of applicants from the several districts are as follows:

* * * * * *

That of the said number are six who were commissioned officers during the late war who, at the end thereof received the certificates of commutation of the half pay for life; some of these officers have a less sum assigned them as a pension than half their monthly pay while in service and others have not any rate assigned. Having received the commutation, they cannot be placed upon the invalid list until they shall have first returned it, in pursuance of the following clause in the resolves of Congress of the 7th of June 1785: "Provided, That no officer who has accepted his commutation of half pay shall be entered on the list of invalids, unless he shall have first returned his commutation."

The invariable construction of this resolve of the public offices has prevented any officer who had received the commutation from being placed on the pension list whatever may have been the rate of the pension assigned, until the commutation was first returned, excepting David Cook, who was provided for by a particular law passed the 16th of December 1791.[2]

The reasons which operated in his favor, it is also presumed will operate in favor of the present applicants and obtain the sanction of Congress to their admission upon the pension list, provided, they first return such a proportion of their commutation as the pension assigned bears to the full pension.

It is to be understood, that all officers who were deranged after the 31st of December 1780, as well as those who continued in service to the end of the war, were entitled by their wounds and disabilities to be placed on the invalid list, were at the same time entitled by the length of their services, to the commutation of half pay.

And probably there were several of this class who supposed that they should be entitled to both provisions, and accepted of the Commission in 1783 and 1784, under this impression although the act of the 7th of June 1785, convinced them of their error; yet it was too late to be remedied, as the prcuniary distresses of themselves and families constrained them to alienate their commutation certificates, which they have not since been able to return to the public, so as to be entered on the lists of invalids.

The time has nearly arrived when an officer disabled in the highest degree, and having complied with the several acts of Congress relative to invalid pensions, would be enabled, by the arrears of his pension to return the commutation of his half pay. But the case is different with those officers who have less than full pensions assigned them, and who, from the peculiarities of their case seem justly to claim the interference of a law, as in the before recited case of Captain Cook, to enact that they shall return only the proportion of their commutation to the pension assigned as invalids.

That the number of eighty-five certificates of the examining physicians are defective and not according to law, inasmuch as they do not certify the degree of disability of the applicants, which defect will, in a great measure, prevent the precision necessary in the assignment of the pensions.

That of the number of cases on which the examining physicians have given opinions, twenty are full pensions, one nine-tenths; two seven-eights; three five-sixths; one four-fifths; one five-eights; four three-fourths; fifteen two-thirds; forty one-half; fourteen one-third; sixteen one-fourth; two one-sixth; two one-eighth; and one, one-twelfth pensions.

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[1] American State Papers, Claims, 83.

[2] United States, Annals of Congress, III, 39. See also Attachment No. 1 to this Appendix.

That it will appear by the remarks contained in the list, that the proof of the greater part of the applicants having been wounded in the service of the United States must depend upon the affidavits they produce, as very few muster rolls of the militia of the late war deposited in the public offices, and in many cases the muster-rolls even of the regular troops, more particularly of the southern departments, were never received at the said offices.

All of which is respectfully submitted to the Senate and the House of Representatives.[3]

H. KNOX, *Secretary of War.*

Attachment No. 1 to Appendix F

AN ACT For the relief of David Cook and Thomas Campbell [4]

Be it enacted by the Senate and House of Representatives of the United States in Congress Assembled, That, David Cook, a Captain of Artillery in the late war, and who, being shot through the body at the Battle of Monmouth, is rendered incapable to obtain his livelihood by labor, shall be placed on the pension list of the United States, and shall be entitled to one-third of his monthly pay as a Captain of Artillery, Provided, That he return into the Treasury office two-thirds of his commutation of half pay being the proportion of his pension to the amount of his commutation.

Sec. 2 And be it further enacted, Thomas Campbell be placed on the pension list, and that the half pay of a Captain of Infantry be allowed to the said Thomas Campbell, who has been so injured by repeated wounds in the service of his country that he is unable to support himself by labor; the half pay to commence from the 3rd day of November, 1791; anything in the Ordinance of Congress, of the 11th day of July, 1788 to the contrary notwithstanding.

Approved 16, December 1791.

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[3] The list of rates and awards are found in table Nos. 2, and 3.
[4] United States, Annals of Congress, III, 39.

Appendix No. G

Decision of Assistant Secretary of the Interior in the Case of Henry H. Weikie, January 7, 1893[1]

"The basis of rates under the act of June 27, 1890, is inability to earn a support by reason of incapacity for manual labor due to disability not the result of vicious habits.

"Schedule or nominal rates will not be added together to make up a rate under said act, but the rate will be based upon the combined effect of all the causes involved upon the applicant's capacity for manual labor.

"I return herewith the papers in the case of Henry H. Weikie, who is receiving a pension under certificate No. 478173, on account of rheumatism and resulting disease of heart.

"The original application alleging rheumatism was filed April 4, 1887. In April 1890, the claim was allowed for rheumatism and resulting disease of heart at $2 per month from April 4, 1887, and $8 from February 26, 1890.

"October 26, 1890, he filed an application for increase and rerating, and February 24, 1891, he filed an application under the act of June 27, 1890, alleging disability from urinary trouble, dyspepsia, habitual constipation, and rheumatism, which rendered him partially unable to earn a support. Both claims were rejected, from which an appeal is taken.

"The reports of medical examinations and the other evidence in the case fail to show any error has been committed in rating the disability resulting from rheumatism. The rejection of the claim for increase and rerating is, therefore, affirmed.

"The report of a medical examination had since the application under the act of June 27, 1890, was filed, recommends a rating of 8/18 ($8) for rheumatism, and 4/18 ($4) for disease of urinary organs, but does not show the existence of any of the other disabilities alleged. The latter disease is not shown to be the result of vicious habits, and the disability resulting therefrom may consequently be taken into consideration in fixing the rate of pension under said act.

"Conceding that $8 is the correct rate for the disability resulting from rheumatism, the question arises, is the claimant necessarily entitled to a higher rate because another disability is shown to exist? In other words, where more than one disability is involved, should the rate which would be allowed under the old law for each disability be added to the others to determine the total rate?

"The following order (No. 164) was, with the sanction of the Department, issued by you October 15, 1890:

"That all claimants under the act of June 27, 1890, showing a mental or physical disability or disabilities of a permanent character, not the result of their own vicious habits, and which incapacitate them for the performance of manual labor, rendering them unable to earn a support in such a degree as would be rated under former laws at or above $6 and less than $12, shall be rated the same as like disabilities of service origin; and that all cases showing a pensionable disability which, if of service origin; would be rated at or above $12 per month.

"The foregoing order has governed the practice of your Bureau in the matter of rates under the act of June 27, 1890, since the date of its issue. It appears, however, that said order, as understood by the Department when approving it, may have been misconstrued by your Bureau so far as it has been your practice to add the separate nominal and schedule rates allowed for several disabilities in making a rate under this act. This has resulted by reason of the fact that it has been your practice under the old law to combine these rates where the total does not exceed $^{12}/_{18}$. The question as to the correctness of that practice is not now before the Department for decision. It is deemed proper to state the Department, in approving said Order No. 164, did not intend that small rates should be added together—as, for example, three or more rates of $^{2}/_{18}$—in order to make a rate under the provisions of said act. A man may have two or separate afflictions either one of which, considered singly, entitles him to a $2 rate under the old law, and yet in the aggregate they may not disable him for the performance of manual labor to a much greater degree than either of them existing alone. Or he may have one serious disability and one or more slight disabilities, the latter of which do not have any appreciable effect upon the degree of incapacity for manual labor occasioned by the former.

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[1] Report of the Commissioner of Pensions, 1899, pp. 30–32.

"The basis of rates under the act of June 27, 1890, is inability to earn support by reason of incapacity for manual labor due to a permanent mental or physical disability not the result of vicious habits. In determining whether an applicant is entitled to a rate under said act for the character of disability aforementioned the only question is: Is he, from the cause or causes involved—be they one or many—disabled for the performance of manual labor to the extent represented by the fractional rate of $\frac{6}{18}$. If so, he is entitled to the minimum rate of $6. And so on, until the maximum rate of $12 is reached.

"It is directed that the views herein expressed be observed in future adjudications of claims under the act of June 27, 1890.

"In the claim of Mr. Weikie, now under consideration, while it is conceded that a disability from disease or urinary organs exists which alone would be rateable under the old law, if of service origin, it is not believed that this disease, combined with rheumatism, disables him for manual labor to an extent which entitles him to a higher rating than $8 per month. Rheumatisim is his chief disability. There is no albumen nor sugar in the urine, and in fact but little if any objective systems of disease of urinary organs other than hypertrophy of the prostate gland. He is evidently able to perform considerable manual labor.

"The rejection of the claim under the act of June 27, 1890 is affirmed."

Appendix No. H

Report of Medical Division [1]

Bureau of Pensions,
Washington, D. C., July 26, 1899.

Sir: No material change has been made in the general organization or the practice of this division since I had the honor to submit my report at the end of the last fiscal year. The policy indicated by you, when you placed me in charge of the division, that "we will be liberal within the law," has obtained; and, so far as it was permissible under the laws as they exist and the established practice of the Bureau, the benefit of any doubt has been resolved in favor of the claimant.

The clerical and professional force of the division has kept the work "current," so that at the end of the year only 680 claims awaited medical action, exclusive of the cases on appeal.

While this amount of work has been accomplished, it has taxed severely the professional element of the division, and it is my opinion that the duties involved in its performance are too great to permit of that very careful consideration which should be given to the many and varied medical questions that must be settled in the adjudication of claims.

To perform this amount of work during the fiscal year I had to secure by detail from the adjudicating divisions of the office the services of clerks who are doctors of medicine, and who as acting medical examiners have added to the working capacity of this division. These clerks have been carefully selected as far as possible, but have been placed upon the intricate duties that medical examiners must perform without any examination into their professional qualifications, and with little, if any, practical experience in their profession. This source of supply from which help has been drawn in the past is exhausted.

It is the duty of this division not only to dispose of all medical questions, but to determine the rates of pension that shall be allowed. In order that, as far as possible, the same degree of disability shall be rated alike, it is necessary that evidence and medical examinations shall be weighed with great care, and it is my firm conviction that the present number of medical examiners is not sufficiently large to give that careful attention to each claim which it demands and at the same time keep the work "current."

If claims are not promptly adjudicated there is and there always will be complaint, and in order that they shall be promptly and at the same time properly adjudicated the medical force of this Division should be increased. I am satisfied that the work this Division has been called upon to perform has been done as carefully as the professional force could do it in view of the great number of claims that have been submitted for adjudication and the great variety of problems that have demanded solution; but in order that each claim may receive due consideration, and that the interests of claimants and of the Government may be alike subserved, an increase in the number of medical examiners is, in my opinion, absolutely necessary.

For the reasons above given, I do respectfully recommend that Congress be asked to provide for 15 additional examiners "who shall be surgeons of education, skill, and experience in their profession," and that they shall be appointed from civil life through the Civil Service Commission.

The character of the work that medical examiners have to perform demands that they shall be men having general education as well as professional attainments, and their ability to satisfactorily perform the duty required in this Division will also depend largely upon the soundness of their judgment, but the possession of this quality can only be determined by the manner in which the actual work of the division is performed. It is well known by those who have been employed in performing the professional work of this Division during the past 10 years that the duties of medical examiners have grown more and more difficult and complex, and it is, in my opinion, only just that they should receive a compensation of $2,000 a year, at least. Principal examiners in this Bureau receive an annual salary of $2,000 a year, and yet it is not required that they shall have special knowledge of law. The ranks of this class are recruited from the clerical force of the Bureau. Any clerk may aspire, by the faithful discharge of his duties, to a promotion to this class, but medical examiners, who must have a special education, and must be graduates of medicine, and whose duties are as difficult to perform as those of principal examiners, have to look to the position of principal examiner in order to gain any promotion, despite their special scientific

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[1] Report of Commissioner of Pensions, 1899, pp. 92–98.

qualifications. Certainly medical examiners are entitled to a salary equal to that of principal examiners, and it is my duty to urge that Congress be asked to increase their salary to at least $2,000 a year.

I had occasion in my last report to mention two causes of delay in the adjudication of claims, namely, the failure of claimants to appear for examination within the specified time and the necessity of returning many certificates of examination for correction. This latter cause of delay is the faulty work of some of the boards of examining surgeons—faulty in two particulars—first, in giving imperfect descriptions; second, in recommending improper rates.

The work of some of the boards of examining surgeons is very unsatisfactory, for the reason that these boards fail to give such a clear pen picture of claimants' disabilities as will warrant an intelligent adjudication of their claims.

Some boards seem to be under the impression that their duty consists in recommending a high rating, and not in giving a full and clear description of the disabilities.

This is shown by the fact that boards describe disabilities where their pen picture would not warrant more than a nominal rating, yet they recommend as high as $30 per month, the rate which the law allows for disabilities which totally incapacitate for the performance of manual labor.

No amount of correspondence has succeeded in changing the practice of these boards. Apparently no attention is paid to the requirements of the book of instructions. The fact is that these boards do not appreciate the importance of their duties and the necessity for a full description of disabilities.

I would suggest that provision be made by which an experienced medical officer of the Bureau could be sent to instruct boards in the examination of claimants and in the proper construction of certificates.

This would cost the Government much less than the many test examinations which it is necessary to order, obviate the necessity of returning thousands of certificates for proper amendments, and insure certificates of such a character as to allow prompt and intelligent adjudication of claims. It would save much time in the adjudication of claims, for every return of a certificate means a delay awaiting its return to the Bureau, to say nothing of the time of clerks in handling, recording, etc., such certificates. It would also save time, annoyance, and expense to the claimant, who, by reason of the unsatisfactory character of the certificate of examination, is put to the trouble and expense of again appearing before the board.

It is the experience of the medical examiners and reviewers of the Division that too many boards have very little appreciation of their duties and very little regard for the interest of either the claimant or the Government. It is too much a question with them of the number of examinations they make and the amount of fees that may be coming to them at the end of a quarter. The whole system of employment of the members of the boards of examining surgeons is faulty in this, that it fails to guarantee the best talent for these places. And so long as influence shall alone determine who shall be appointed, the Bureau will fail to secure the best results.

It too frequently occurs that one is recommended and receives appointment on the ground that he stands well in his community as a general practitioner, but who by reason of lack of education is totally unfitted for the position; who is not able to construct the simplest sentence correctly, misspells the simplest words, and shows in the description of disabilities an utter lack of professional knowledge, confounding "mensuration" with "menstruation," "Eustachian" tubes with "Fallopian" tubes, etc.

After a surgeon is recommended for appointment to one of these places he should undergo an examination to test his scholastic and professional fitness for the place. After having shown his fitness he should undergo a course of instruction in the examination of a claimant and in the construction of certificates.

Under the practice which now obtains on the appointment of a board of examining surgeons, as soon as assigned to work it proceeds to examine claimants without the remotest idea of what is required and absolutely necessary for the intelligent adjudication of claims by the Bureau, and, as a rule, certificate after certificate must be returned for amendment—for a full and clear description of the disabilities.

No businessman could be induced to place a man in an important responsible position with no prior experience or instruction in a single part of the work which he is called to perform, yet these examining surgeons are appointed and assigned to work, without experience, instructions, or advice, to furnish to the Government the data upon which nearly $150 million is disbursed annually. This slipshod

manner of making examinations is the cause of much dissatisfaction and as long as the present system continues claimants will find fault with their medical examinations, and request examinations by some other board, with the hope that such board may be more thorough. It were far better if the Bureau could employ two experienced physicians in each congressional district and pay them a reasonable annual salary to make these examinations, and assign to each board a competent stenographer and typewriter to record the results of the examinations.

One, at least, of these examining surgeons should be detailed from the list of experienced medical officers in the Bureau; or, if this be considered inadvisable, these boards should be instructed by a competent medical officer of the Bureau.

Two physicians will do the work fully as well as 3, for, as boards are now constituted, 1 of the 3 members—as a rule, the secretary—acts only as a clerk or recorder, while the other 2 members conduct the examination.

In paying an annual salary all temptation to cater to the wishes of claimants and attorneys would be removed, and there would be no inducement to hurry examinations so as to swell the pay account for each day; furthermore, the expense to the Government would be much less and the character of the work would be far better.

In my last report attention was invited to the fact that it frequently occurs that the adjudication of claims is delayed "because examining surgeons either do not understand their duties, fail to conform to the requirements of the Bureau, or neglect to comply with them." While a material improvement is shown in this direction, yet there is still entirely too much complaint on this line, and I am satisfied that most of it is accounted for by reason of examining surgeons not understanding their duties, which will only be remedied when they are properly instructed on assignment to duty.

I desire to invite your special attention to the following statement in my report of last year (1898):

One of the great disadvantages in the adjudication of claims is the requirement that examining surgeons shall rate disabilities, because of the want of uniformity in the rates they recommend. It is the experience of every medical examiner and reviewer that the surgeons' ratings are misleading and unfair, and far better results would be obtained and much greater justice done to claimants if examining surgeons would lay more stress on a thorough examination and less on ratings and omit or restrict the more important matter—a thorough description, a complete pen picture of the claimant's disabilities.

Another year's experience emphasizes this statement. As an assurance to the claimant (who under the law may either in person or by attorney examine the certificates of medical examination) that the members of the board of surgeons are his friends, the ratings of many boards are not only unreasonably extravagent, but perfectly ridiculous. For instance, one board rates a claimant—

For general debility	$30
For deafness	25
For disease of eyes	30
For disease of rectum	30
For disease of liver	30
For crepitation of shoulders and elbows	17
For alleged periodical vertigo	17
For rheumatism	17
For disease of heart	30
For tenderness over spleen	17
Total	190

And yet in another claim—

For thin and flabby muscles and coated tremulous tongue	$17
For thin abdominal walls and tenderness over colon and stomach	17
For practically normal liver	12
For 4 medium-sized piles	17
For a rectal ulcer	17
For slight rheumatism	17
For slight disease of heart	17
For slight gunshot wound of right leg	12
Total	126

"It is the opinion of this board that he should receive full invalid rating." When asked to explain their meaning, they reply "We mean $17 a month."

In reply to a communication from this Bureau in regard to the extravagant ratings in this claim, the president of the board of surgeons stated that the "board had not always been harmonious on the degree of rating," and moreover had given "much more attention to description of diseased conditions than to ratings."

It will be interesting to compare the original rates with the rates as amended:

Original rates:

For thin flabby muscles and coated, tremulous tongue	$17
For thin abdominal walls and tenderness over colon and stomach	17
For practically normal liver	12
For 4 medium-sized piles	17
For a rectal ulcer	17
For slight rheumatism	17
For slight disease of heart	17
For slight gunshot wound, right leg	12
Total	126

Amended rates:

For chronic diarrhea	$8
For disease of liver	2
For disease of rectum (including piles and rectal ulcer)	12
For rheumatism	6
For disease of heart	10
For gunshot wound of right leg	4
Total	42

Again the following ratings are recommended:

For sallow skin and flabby tongue	$17
For normal liver	24
For tenderness over stomach	17
For inflamed rectum, 2 piles ½ inch in diameter, and an ulcer ¾ inch in diameter	24
For alleged eczema and dizziness (none shown on examination)	17
For slight heart murmur	24
Total	123

Another board rates:

For full and prominent abdomen	$14
Enlarged liver with some tenderness	10
For 7 or 8 small piles size of split peas	14
Alleged slight numbness of right leg, no loss of motion or power	6
For disease of heart, slight	17
For a fullness in region of kidneys, urine normal	10
Total	71

Another board closes each of six certificates of examination that were made the same day with the statement that the claimant is totally disabled for the performance of manual labor and recommends a rate of $30 per month, yet in no case was a single disability rated more than $12, and nearly all of them from $3 to $8 per month.

Another board recommends a rating of $30 per month in each of six examinations made the same day, and yet rates the disabilities from $2 to $12 per month.

One board recommends a rating of $17 per month for alleged "total loss of sexual instinct."

Such cases could be multiplied ad nauseam. These are quoted to show that in many instances the ratings made by some boards are absurd.

Either the whole system of ratings by boards should be done away with—and this is by far the better plan—or else boards should be instructed in the proper method of rating both under the laws and the established practice of the office.

This lack of knowledge as to what is required to make a certificate acceptable and of value in the adjudication of a claim accounts for the return of so many certificates for amendment.

In this connection your attention is invited to the fact that out of 211,620 certificates of examination received in the Bureau, 23,916 (over 11 percent) had

to be returned for amendment. During the year 29,160 orders for medical examination were returned to the Bureau for the reason that claimants failed to appear for examination within the specified time. This is over 13 percent of the whole number (223,824) of orders issued during the year.

Claimants are given 3 months from date of order to report for medical examination. It happens very frequently that claimants complain because their claims are not adjudicated, when the delay is due to their failure to report for medical examination. If claimants could be made to appreciate the necessity of complying with the requests of the Bureau, much of the complaint because of the delay and much of the delay would cease.

Certificates of medical examination which have been returned for amendment are called for, if not returned within a reasonable time. This has necessitated the preparing and mailing of 2,500 circulars.

The same course is pursued in the case of outstanding orders for medical examination in which the specified time has expired. About 2,000 circular calls were made for this purpose.

In the case of 18 boards and single surgeons who neglected to forward their certificates or return expired orders, it became necessary to refer lists of outstanding orders and certificates in their hands to the Chief of the Special Examiners' Division, with the request that the papers be secured by a special examiner. Reports have been received relative to all of these boards. By your direction orders to these 18 boards and single surgeons were suspended because of their gross neglect of duty.

During the fiscal year 4,965 original claims under the general law were admitted and 4,270 were rejected. Other claims admitted under this law numbered 19,091, while 24,283 were rejected. The rates in 66 claims were reduced and in 26 the pensioners' names were dropped from the rolls. 19,764 claims were returned with medical opinions and 15,750 examinations were ordered. Under the act of June 27, 1890, there were 27,627 original claims admitted and 19,667 rejected. Other claims admitted under this act numbered 14,334, and 27,706 were rejected, including claims under the act of March 6, 1896; the rates in 21 claims were reduced and in 23 the pensioners' names were dropped from the rolls: 9,738 examinations were ordered and 24,330 claims were returned with medical opinions. The number of appeal claims considered was 1,903.

The total number of orders issued by this division was 223,824, of which number 4,399 were to specialists, 1,615 to civil surgeons, 13 to surgeons of the United States Army, and 617 to foreign surgeons, while 3,223 were for home or special examinations, making 9,867 orders issued with special instructions. Of these 9,867 orders, 8,501 certificates were received and 1,366 are outstanding. There were 187,608 surgeons' certificates accepted, 23,916 returned for amendment, and 96 rejected.

The total number of examinations approved for payment was 149,486, and the amount paid therefor was $766,542.30. 2,841 letters were typewritten and 135,000 envelopes addressed.

During the year 498 books containing records of examinations were returned to the Bureau by boards and single surgeons. About 1,000 circulars were sent in reply to congressional inquiries.

Accompanying this report is a tabulated statement of the work performed during the fiscal year.

Very respectfully,

Hon. H. Clay Evans,
Commissioner of Pensions.
J. F. Raub,
Medical Referee.

SECTION II

MEDICAL APPRAISAL OF THE VETERANS' ADMINISTRATION SCHEDULE FOR RATING DISABILITIES AND RELATED STATUTORY AWARDS AND PRESUMPTIONS

77289—56——8

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SECTION II

MEDICAL APPRAISAL OF THE VETERANS' ADMINISTRATION SCHEDULE FOR RATING DISABILITIES AND RELATED STATUTORY AWARDS AND PRESUMPTIONS

Chapter I. Introduction

THE PROBLEMS—PRESUMPTIONS; VETERANS' ADMINISTRATION SCHEDULE FOR RATING DISABILITIES AND BASIC PERCENTAGE AWARDS; AND STATUTORY AWARDS

One of the major subjects studied by the Commission was the disability compensation program in the Veterans' Administration. In developing this study, it was found necessary to make a comprehensive evaluation of certain statutory provisions concerning awards for specific disabilities, and presumptions of sound condition on entry into the service, service connection for chronic diseases, tuberculosis, psychoses, tropical diseases; and presumption of total disabilities; and the Veterans' Administration Schedule for Rating Disabilities, 1945 edition.

This report provides an appraisal from the medical standpoint of Veterans' Administration standards for rating disabilities; presumptions of service-connected disability; and the medical validity of statutory awards for specific disabilities, which result in different payments to individuals of the same degree of disability. This report is an evaluation of replies to a medical questionnaire in a survey conducted by the President's Commission on Veterans' Pensions, in October and November of 1955. The survey was conducted to determine the extent to which the 1945 Veterans' Administration Schedule for Rating Disabilities, and the related statutory awards and presumptions are medically valid and equitable. The questionnaire was sent to 169 selected eminent members of the medical profession, in and out of the Government service, covering various medical specialties, and in different areas of the Nation. There was transmitted with the questionnaire pertinent material, and a copy of the Schedule for Rating Disabilities in current use, as amended.

Copies of the material sent to the medical specialists are found in appendixes A to D of this report.

The following table indicates the grand total of respondents, the total in each medical speciality, and the employment of the medical respondents:

RESPONDENTS; NUMBER; DISTRIBUTION

In the analytical procedure, the respondents were classified and assigned code letters, as shown in the following:

Number of medical respondents: Classification, total, and assigned code letters

Non-Federal governmental	PP	70
Governmental:		
Veterans' Administration	VA	19
Department of the Navy	NAV	20
Department of the Army	ARM	20
Department of the Air Force	AF	20
Others in Federal governmental agencies	Others	4
Grand total		[1] 153

Total respondents in each selected medical specialty

Medical specialty	*Total*
Psychiatry	8
Neurology	7
Internal and general medicine	13
Tuberculosis	9
Peripheral vascular diseases	4
Cardiovascular diseases	7
Allergy	6
Gastroenterology	6
Tropical diseases	7
Gerontology	6
General surgery	11
Orthopedic surgery	10
Neurosurgery	6
Plastic surgery	6
Audiology and ear, nose, throat	7
Ophthalmology	6
Urology	7
Rehabilitation and physical medicine	8
Dermatology	6
Industrial medicine	9
Others	4
Grand total	[1] 153

Distribution of Federal Government and non-Government medical respondents

Medical specialty	*Total*
A. Non-Government:	
Psychiatry	4
Neurology	3
Internal and general medicine	9
Tuberculosis	5
Peripheral vascular diseases	0
Cardiovascular diseases	3
Allergy	2
Gastroenterology	2
Tropical diseases	3
Gerontology	2
General surgery	7
Orthopedic surgery	7
Neurosurgery	2
Plastic surgery	2
Audiology and ear, nose, and throat	3
Ophthalmology	2
Urology	3
Rehabilitation and physical medicine	4
Dermatology	2
Industrial medicine	5
Subtotal	70
B. 1 each of the above specialties in the Departments: Navy; Army; Air Force; Veterans' Administration, Medicine and Surgery, less 1	79
C. Other governmental agencies	4
Grand total	[1] 153

In addition 2 other responses were received, 1 too late to tabulate and 1 not in usable form.

There were 169 questionnaires mailed by the Commission to a broad distribution of medical specialists in various geographical areas of the United States, and within the Government agencies. A total of 153 responses were received in time for analysis; 1 came in too late and 1 was not in usable form. Only 8 percent of the total number of medical specialists solicited in the survey either declined or did not participate in this project.

The medical respondents participating in the Commission's project (see appendixes E and F) were conscientious, and in some cases revised the section pertinent to their medical specialty in the Schedule for Rating Disabilities. The replies received from the respondents, and accompanying comments, indicated an interest and concern of this group of medical experts in the problem of the rating schedule, the presumptions, and the statutory awards. The opinions expressed in the returned questionnaire, by the medical respondents, are their own, and are not indicative of a position of a professional group; nor are the respondents to be considered as spokesmen. This report is only a sample of expert medical opinion on the problem.

THE QUESTIONNAIRE AND ACCOMPANYING MATERIAL

In order to assemble and develop factual information on the entire scope, structure, standards for rating disabilities, medical validity of the presumptions and statutory awards for specific disabilities, a questionnaire was prepared by the staff of the Commission. A list of questions was composed and grouped under four headings, related to (1) The Veterans' Administration Schedule for Rating Disabilities, which provides the basis for basic percentage disability awards, and corresponding monetary awards by the Veterans' Administration; (2) statutory awards; (3) presumptions; and (4) general matters. Under each of these headings there was a brief description of existing laws and regulations, followed by pertinent questions. The respondent was asked to answer or comment on all questions, including those he considered nonspecific to his medical specialty. Additional comments were also invited. (See appendix C.)

In order to preserve anonymity of the medical respondents, the names were not used for identification of the replies in the Commission's analysis. A permanent code number was given to each, and other precautions were taken throughout the analysis to insure the protection of the medical respondents from identification.

All of the questions and replies submitted by respondents have been analyzed, but for the purpose of this report only certain questions, with accompanying replies, are described. These questions, as selected in the analysis, were given additional coding for the purpose of facilitating the analytical procedure and obviating the necessity for repetition of the question. The body of this report reflects this coding of the questions in the lead question and the tables. For example, a given question, with the reply as analyzed, is referred to in this manner: "Coded question, (A to U)."

Analysis of section IV in the questionnaire, subject heading "General Matters," did not lend itself very readily to tabulation. Analysis of this section and results are incorporated in this report as a composite of the opinions contained in the comments to the specific question in the section.

ANALYTICAL STANDARDIZATION

The formula used in the analysis was based upon the characteristics, definition and classification of a single reply, as submitted by the individual respondent.

A respondent's reply was analyzed as to clarity, meaning, and intent. A reply was then classified into one of the following groups:

"Yes, unqualified." (The reply to the coded question was clear.)

"Yes, qualified." (The reply to the coded question was qualified as to the meaning and intent.)

"No, unqualified." (The reply to the coded question was clear.)

"No, qualified." (The reply to the coded question was qualified as to the meaning and intent.)

"Indeterminate." (The reply was vague and not determinate of a "yes" or "no" classification.)

"Unanswered." (There was no reply to the question; respondent declined to answer for given reasons, or the answer was foreign to the question.)

EXAMPLE OF CLASSIFICATION AND STANDARDIZATION OF REPLIES

Coded question, Q

Do you know of medical data which can be used to set percentages ratings to represent the average impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations?

Answer

(*a*) Data from the ——— unit in ——— State Hospital indicates that most cardiacs can work. Further, large numbers of 'cardiacs' referred to the unit have no heart disease at all.

The foregoing reply was classified as "Yes, unqualified." Also, a simple "yes" answer was classified as "Yes, unqualified."

Answer

(*b*) "Arthritis percentage ratings should be adapted to the classification of the American Rheumatism Association in regard to severity and functional impairment."

The foregoing reply was classified as "Yes, qualified."

Answer

(*c*) "I know of none. They are changeable."

This reply was classified as "No, unqualified." Also, a simple "no" was classified as "no, unqualified."

Answer

(*d*) "I doubt that such information is available."

This reply was classified as "no, qualified."

Answer

(*e*) "No. In many instances professional judgment of the individual case is needed. On the other hand, professional judgment varies from one physician to another. I do not know the answer."

This reply was classified as "indeterminate."

Answer

(*f*) "Average impairment in earning capacity would represent economic rather than medical data. Medical disability and industrial disability are distinct and separate findings."

This reply was foreign to the question and classified as "unanswered." Answer and reply was classified as "unanswered" where there was no answer to the question, or respondent declined to answer the question for given reasons.

STANDARDIZATION OF THE STATISTICAL TABLES

There were three statistical tables prepared and standardized for each question. These three tables are used below and present the statistical data, as obtained from the analysis of the replies. The three standardized tables are as follows:

(*a*) The first table shows the numbers and percentages of the grand total of the respondents' replies classified by "yes," "no," etc.

(*b*) The second table shows the reply distribution in numbers by the respondents' medical specialties.

(*c*) The third table presents the numbers and percentages of the replies classified by agency or employment.

Table 1 of this series of statistical tables has, as a footnote, a classification and definition of the replies. No further reference to the definitions are made in the report although they apply to subsequent tables.

Table 3 of this series of statistical tables has as a footnote a definition of classified respondents with the total in each classification. The classification is made by grouping into code letters, such as: PP; VA, etc. No further references to this definition are made in the report, although it is likewise applicable to the later tables.

GENERAL MAKEUP OF THE REPORT

The general makeup of subsequent chapters is as follows: Introduction, and discussion of all questions in a group; a brief background to the subject matter in the chapter; specific question (from the group) is restated; a brief background to the specific question; statistical data presentation by the use of tables; a short summary and conclusions; and overall summary statistical table to all questions and replies contained in that chapter. The general conclusion of the chapter is combined with the others in chapter VI of this report.

In addition to the statistical tables and appendices, referred to above, extracts of pertinent portions of the Veterans' Administration Schedule for Rating Disabilities on total disability, and extension No. 5 thereto, are included in the appendixes.

Chapter II. Presumptions

	Page
Sound condition on entry into service	113
Service connection:	
Chronic diseases	120
Tuberculosis	125
Psychoses	132
Tropical diseases	136
Total disability	140

INTRODUCTION

The statutory presumptions are certain rules prescribed by law for determining which disabilities are service connected. These include the presumption of sound condition on entry into the service; the presumption of service connection by aggravation of a preexisting disease or injury during service; the presumption of service connection for diseases becoming manifest after discharge in the instance of certain chronic diseases, tropical diseases, tuberculosis, psychoses, and multiple sclerosis; and the presumption of total disability, where the disability makes it impossible for an average person to follow a substantially gainful occupation. Since disabilities of an individual are involved, as well as adjudication of monetary benefits for the disability, the problem of presumptions includes the medicolegal aspect of compensation medicine.

The replies of the medical specialists are analyzed and the results are shown in subsequent pages to this chapter. In order that each question may be identified in the statistical tables pertinent to the question, and to obviate necessity of repetition in the tables, we have given each question a code letter. This code letter has been designed for this analysis and has no relationship to continuity in the medical questionnaire.

QUESTIONS

PRESUMPTION OF SOUND CONDITION

Code letter

A In accordance with present medical principles, is the presumption of soundness on entry into service medically valid?

B Is the presumption necessary under present development of medicine?

PRESUMPTION OF SERVICE-CONNECTION: CHRONIC DISEASES, TUBERCULOSIS PSYCHOSES, TROPICAL DISEASES

C Do you believe the presumptions of service connection for chronic diseases are based on accepted medical principles?

D Have recent developments in methods of diagnosis and treatment for tuberculosis affected the presumptions regarding tuberculosis?

E Is the time interval governing presumption of tuberculosis valid under present status of medicine?

F Should there be presumptions of service connection in psychoses?

G Do you believe the presumption of service connection for tropical diseases is based on accepted medical principles?

PRESUMPTION OF TOTAL DISABILITY

(Par. 16, p. 5; par. 17, p. 6; extension 5 in 1945 schedule, see appendix I)

H What is the medical validity of these yardsticks? (For total disability.)

I What proportion of people would have a degree of disability of 10 percent or more at age 65 on the basis of the standards in the schedule?

J Is there a set percentage or yardstick by which it can be said a person with a single disability and rated some percentage (i. e., 10 percent, 70 percent, 60 percent), is totally disabled?

DEFINITIONS

A disability claim for compensation to the Veterans' Administration must show that the disability was incurred in or aggravated by active service, in addition to other requirements. Service connection may be either direct or by presumption. In determining service-connection

for rating disabilities, the general rule is that the evaluations must be based on accepted medical principles.

There are certain medical principles so well and universally recognized as to definitely constitute fact. Accepted medical principles are fundamental deductions consistent with medical facts and based upon observation of a large number of cases. To constitute accepted medical principles, the deductions must be so reasonable and logical as to create a moral certainty that they are correct. A medical opinion of one expert does not necessarily constitute, or indicate, accepted medical principles.

By direct service connection is meant that the disability is shown, as a matter of fact, to have been incurred in the service, or, if pre-existing service, to have been aggravated during service.

Presumptive service connection means that the disability has been related to the service, that is, considered to have originated in service by legislation, or by decision of the Administrator of Veterans' Affairs i. e., by fiat.

PRESUMPTION OF SOUND CONDITION ON ENTRY INTO THE SERVICE

Two questions were propounded on this subject, and are given there together, as the same background pertains to both, but the replies are analyzed separately.

Coded question A

In accordance with present accepted medical principles is the presumption of soundness on entry into service medically valid?

Coded question B

Is the presumption necessary under present development of medicine?

Background

An act of March 3, 1885, provided:

> That all applicants for pensions shall be presumed to have had no disability at the time of enlistment; but such presumption may be rebutted.

Section 10, of the act of June 25, 1918 (War Risk Insurance Act, as amended) established for the first time by legislation, for compensation purposes, under the new veterans' compensation system, the presumption of sound condition upon entry into the service.

What the impact of the necessity of enlarging the Armed Forces as rapidly as possible was, upon unhurried routine physical examinations and the results following, is best explained by quoting from page 117, of the Federal Laws Relating to Veterans of Wars of the United States (72d Cong., S. Doc. No. 131, Aug. 1, 1932):

> Physical examinations were hurried and, in many instances incomplete. As a consequence men were taken into the service with physical and mental defects. The changed life and rigors of service, whether of an active fighting nature or simple employment in and around the Military Establishment, in many cases, aggravated these defects so that upon discharge these veterans were in need of financial relief and medical treatment. Congress, therefore, amended the law on June 25, 1918 (40 Stat. 609), so as to provide that all would be held and taken to have been in sound condition when examined, accepted, and enrolled for service. The broad effect of this language, on the strength of which men who came into service with amputations and other patent disabilities sought to secure compensation

even when the infirmities were noted on the service record, led to a further amendment on August 9, 1921 (42 Stat. 147, sec. 200), excepting from the presumption defects, disorders, or infirmities made of record by the military authorities at time of or prior to inception of active service.

NOTE.—The present practice of physical examinations for enrollment into the Armed Forces in cases of draftees is recorded at the time of first appearance before the local draft board. This report of physical examination is forwarded with the inductee to the reception center, and the person arrives sometime later subsequent to the physical examination, even months. The recorded physical examination is taken at its face value at the reception center, without reexamination of the person before swearing in.

In 1933, Veterans Regulations 1 (a), paragraph I, (b), part I, stated that the presumption of sound condition would not apply where "medical judgment is such as to warrant a finding that the injury or disease existed prior to acceptance and enrollment." A subsequent

CODED QUESTION A

TABLE 1.—*Distribution of grand total of respondents' replies* [1]

Replies	Number	Percent
Yes:		
Unqualified	50	33
Qualified	16	11
No:		
Unqualified	29	19
Qualified	48	31
Indeterminate	8	5
Unanswered	2	1
Grand total	153	(2)

[1] The following classification and definition of a reply is made in this table and references are made in subsequent tables throughout this report, to table 1 for classification and definition of replies:
"Yes" and "No":
Unqualified: The answer to the coded question was clear.
Qualified: The answer was qualified as to the meaning and intent.
Indeterminate: The answer was vague and not determinate of a "yes" or "no" classification.
Unanswered: There was no reply to the question; respondent declined to answer for given reasons, or, the answer was foreign to the question.

[2] In this and subsequent tables the percentages total 100, except for rounding, but to avoid repetition the figure of 100 has not been shown.

TABLE 2.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	1	----------	2	5	----------	----------
Neurology	7	2	1	3	1	----------	----------
Internal and general medicine	13	5	2	4	2	----------	----------
Tuberculosis	9	5	1	1	2	----------	----------
Peripheral vascular diseases	4	2	----------	1	1	----------	----------
Cardiovascular diseases	7	3	1	2	1	----------	----------
Allergy	6	1	1	----------	3	1	----------
Gastroenterology	6	1	1	1	2	1	----------
Tropical diseases	7	2	1	1	3	----------	----------
Gerontology	6	2	----------	3	1	----------	----------
General surgery	11	3	2	3	3	----------	----------
Orthopedics	10	4	----------	----------	4	2	----------
Neurosurgery	6	1	1	2	2	----------	----------
Plastic surgery	6	2	2	----------	1	1	----------
Audiology and ear, nose, and throat	7	----------	1	2	3	1	----------
Ophthalmology	6	2	----------	2	2	----------	----------
Urology	7	3	----------	----------	3	----------	1
Rehabilitation and physical medicine	8	3	----------	----------	5	----------	----------
Dermatology	6	1	1	----------	2	1	1
Industrial medicine	9	5	1	2	1	----------	----------
Other	4	2	----------	----------	1	1	----------
Total	153	50	16	29	48	8	2

TABLE 3.—*Distribution of replies by employment of respondents* [1]

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	28	40	6	32	7	35	1	5	6	30	2
Qualified	3	4	2	11	1	5	7	35	3	15	----
No:											
Unqualified	14	20	7	36	1	5	3	15	4	20	----
Qualified	20	29	2	11	11	55	8	40	6	30	1
Indeterminate	4	6	1	5	----	----	1	5	1	5	1
Unanswered	1	1	1	5	----	----	----	----	----	----	----
Total	70	(2)	19	(2)	20	(2)	20	(2)	20	(2)	4

[1] Classified respondents and total in each classification; all classed as medical practitioners, and grouped under a code letter:

PP—Self employed, or in an institution, group, or organization which is non-governmental	70
Federal Government employed:	
VA—Veterans' Administration	19
NAV—Navy Department	20
ARM—Army Department	20
AF—Air Force Department	20
Others in Federal Government	4
Grand total	153

[2] In this and subsequent tables the percentages total 100, except for rounding, but to avoid repetition the figure of 100 has not been shown.

amendment made 10 years later deleted the sentence: "Medical judgment is such as to warrant a finding that the injury or disease existed prior to acceptance and enrollment," and substituted "or where clear and unmistakable evidence demonstrates that the injury or disease existed prior to acceptance and enrollment and was not aggravated by such military or naval service."

Discussion, coded question A

Fifty percent of the respondents believe that the presumption of sound condition on entry into the service is not medically valid; 4 out of 10 respondents express the opposite opinion, and believe that the presumption of sound condition on entry into the service is medically valid; 1 respondent out of 20 was vague in his opinion, and 1 respondent out of 100 did not answer the question.

Seven respondents out of eight, practicing in the medical specialty of psychiatry, believed that the presumption of sound condition on entry into the service was not medically valid, and one was of the opposite view.

Respondents, practicing in the specialized field of internal medicine (7 out of 13) believed that the presumption of sound condition was medically valid; the remaining 6 were of the opinion that this presumption was not medically valid.

Six respondents out of nine, practicing in the medical specialty of tuberculosis, believed that the presumption of sound condition, as enacted in the law, was medically valid; the other three respondents practicing in this same specialty were of the opposite view.

A comparison of the percent of classified replies by classified respondents shows that there is unanimity of opinions of the respondents, whether practicing their medical specialty in governmental service, or out of the governmental service.

Representative comments of the majority (presumption of soundness not medically valid)

I am of the opinion that the presumption of soundness on entry into military

service is not medically valid, but see no other manner in which a "base line" for later determination of service-connected disabilities can be established.

* * * * * * *

In general, no. Sound medical principles only should be followed, particularly in regard to presumption. The pressure of mass examining methods prevents really adequate initial physical examinations in many cases, and it is a definite disadvantage to the Government to accept these inadequate examinations as evidence of complete freedom from physical disease upon entry to active service.

* * * * * * *

It would be if the physical examination on entry were dependable. Unfortunately, some serious oversights have been recorded. I would answer no.

* * * * * * *

No. The skill of examiners is too varied to presume that all persons accepted for service are physically sound. Even the most skillful examiners cannot diagnose some physical or mental diseases when necessary subjective information is withheld from them.

* * * * * * *

No. Psychiatric illness has its onset, for the most part, early in life and does not manifest itself clinically until later when the individual becomes subjected to stresses in his adult life situation. Therefore, we cannot presume absolute freedom from psychiatric disorders at the time of induction.

* * * * * * *

No. But it should be. Mass medical examinations incident to mobilization, including large numbers of troops, fail to reveal many physical and psychic defects.

* * * * * * *

No. It presumes that the examining medical officer is capable of and has the time and equipment for diagnosing any and all conditions involving specialties.

* * * * * * *

The presumption of soundness on entry into the service is not medically valid. Many conditions in the field of urology cannot be diagnosed by the ordinary examinations given inductees. In addition, there are many things that affect the accuracy of the premilitary examinations. Applicants for the academies and officer candidate schools minimize disorders, and draftees exaggerate their complaints. Even obvious disabilities are missed by draft-board examination, for example: A teratoma, one that could be seen clear across the room, was completely missed on two separate examinations. Rather than having any presumptions, each case should be decided upon sound medical principles individually, taking into consideration etiologies, incubation etiologies, incubation periods, locality of duties, injuries sustained, and the natural courses of disease.

* * * * * * *

No. This is exemplified by the finding of coronary artery disease in a substantial percentage of battle casualties in Korea. On the basis of experimental studies, it is exceedingly improbable that this arterial disease developed in the short space of time that these young men were in the service.

Representative comments of the minority (presumption of soundness is medically valid)

It seems necessary to presume that, after examination, individuals are sound on entry into service. Obviously, many serious disease conditions can be missed on physical examination, i. e., incipient malignancy of any visceral structure, early disease of the collagen vascular system, subclinical endocrinopathies, etc. The law of diminishing returns would apply long before elaborate studies could be conducted on each examinee to rule out such diseases.

* * * * * * *

The presumption of soundness for service is valid to the extent that the original medical history and examination were thorough and accurate. This examination is necessary and important but its accuracy is affected by the conditions under which it is made, that is, mass production in minimal allotted time during mobilization, frequently under poor physical surroundings, as well as, and regretfully so, the carelessness or lack of acumen on the part of the examiner.

* * * * * * *

Yes, provided however, that a very thorough examination is made of all recruits, especially being aware of psychiatric disabilities.

* * * * * * *

Yes. If on admission to the Armed Forces a man or woman receives a physical examination done by a qualified doctor.

* * * * * * *

Yes. After a careful and complete examination.

* * * * * * *

Yes. In all allergic manifestations, the question of an allergic diathesis must be considered. Where previous medical history and family history cannot be depended upon but the person does show positive reactions by skin testing, the presumption should prevail that there is a diathesis present; that previous exacerbations of asthma, hay fever, urticaria, angioneurotic edema, migraine, or eczema should not be considered automatically service-connected just because they occurred in service. They could have occurred at any time under any conditions in such a patient.

If they occur in battle conditions in severe inclement weather and stress, the question of aggravation in service would make them service-connected. If they occur in ordinary camp conditions in time of peace, they should be considered not service-connected.

* * * * * * *

Summary and conclusions

Summary and conclusions of the analysis of the replies to coded question A, are incorporated with those to question B in the succeeding pages.

Discussion—Coded question B

. Forty-nine percent of the respondents believe that the presumption of sound condition on entry into the service is necessary under present development of medicine; 4 out of 10 respondents are of the opposite opinion, and believe the presumption of sound condition on entry into service is not necessary under present development of medicine; 1 respondent out of 12 was vague in his opinion; and 1 respondent out of 20 did not answer the question.

Seven respondents our of eight, practicing in the medical specialty of psychiatry believed that the presumption of sound condition on entry into the service was not necessary under present-day development of medicine, and one was of the opposite view.

Of the respondents, practicing in the specialized field of internal medicine, only 1 out of 13 was vague in his answer; the remaining 12 were equally divided in their opinions; 6 believed the presumption of sound condition was necessary; and 6 believed the presumption was not necessary.

Seven respondents out of 9, practicing in the medical specialty of tuberculosis, believed that the presumption of sound condition on entry into the service was necessary under present development of medicine, and the remaining 2 did not believe the presumption was necessary.

CODED QUESTION B

TABLE 4.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	56	37
Qualified	19	12
No:		
Unqualified	29	19
Qualified	29	19
Indeterminate	13	8
Unanswered	7	5
Grand total	153	

TABLE 5.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	1		3	4		
Neurology	7	3	1		2		1
Internal and general medicine	13	4	2	2	4	1	
Tuberculosis	9	5	2	2			
Peripheral vascular diseases	4	2		2			
Cardiovascular disease	7	1	1	2		1	2
Allergy	6		3	1	1	1	
Gastroenterology	6	3		1	1	1	
Tropical diseases	7	4		2	1		
Gerontology	6	2	1	2	1		
General surgery	11	5	1	4	1		
Orthopedics	10	5			4	1	
Neurosurgery	6	2	1	1		2	
Plastic surgery	6	3			2	1	
Audiology and ear, nose, and throat	7	1	1	1	2	2	
Ophthalmology	6	3		1	1		1
Urology	7	3		2	1		1
Rehabilitation and physical medicine	8	3	1	2	1		1
Dermatology	6	1			2	2	1
Industrial medicine	9	4	3	1	1		
Other	4	1	2			1	
Total	153	56	19	29	29	13	7

TABLE 6.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	28	40	6	31	8	40	3	15	10	50	1
Qualified	8	11	2	11	1	5	2	10	4	20	2
No:											
Unqualified	12	17	5	26	4	20	5	25	3	15	
Qualified	11	16	2	11	6	30	7	35	3	15	
Indeterminate	7	10	1	5	1	5	3	15			1
Unanswered	4	6	3	16							
Total	70		19		20		20		20		4

One-half of the nongovernmental medical practitioners in this survey were of the opinion that the presumption of sound condition on entry into the service was necessary. Of the remaining one-half, only 33 percent believed the opposite. Of the respondents in the Department of Medicine and Surgery, Veterans' Administration, 3 did not answer the question; 1 answer was vague, and the remainder were about equally divided in their opinion. Seventy percent of the respondents' replies from the Department of the Air Force were of the opinion that the presumption of sound condition on entry into the service was necessary under present development of medicine.

Representative comments of the majority (presumption of soundness is necessary)

I am of the opinion that the presumption of soundness on entry into military service is not medically valid, but see no manner in which a "base line" for the later determination of service-connected disabilities can be established. I believe, therefore, that the presumption is necessary under the present development of medicine.

* * * * * * *

Does this question infer that there is something wrong with everybody if you could only find it? And that 80 percent of the veterans were able to handle what was wrong with them and 20 percent could not? If so, then it is the responsibility of the Government to try to assess the degree of preexisting disability not only in regard to deferment possibilities, but rehabilitation of citizens. Certainly if the Government does not accept the responsibility of taking careful histories of preexisting disabilities, then it should presume that the registrant is sound so far as future disabilities and pensions are concerned.

* * * * * * *

Though there are unavoidable instances of disease missed by the initial examination, for the purpose of rating disabilities and awards, a presumption is necessary.

* * * * * * *

With exception, I believe the presumption of soundness on entry into service is medically valid and I do not think the present development of medicine can materially alter some basic assumption of this sort.

* * * * * * *

Yes, unless the examination conducted at the time of induction is a good deal more extensive than at present.

* * * * * * *

Representative comments of the minority, (presumption of soundness is not necessary)

I definitely do not think so. I realize legislation has imposed some of these principles, but they should be reexamined and brought into a commonsense relation with modern medical knowledge. The inadequacies of wartime entrance physical examinations undoubtedly contributed to this idea and, of course, in such emergencies, it is hard to be thorough. That should not keep us from trying.

* * * * * * *

No. This situation is not greatly affected by the advances of medicine, as it rests basically on individual examinations by physicians, and technical procedure which might make it more accurate could hardly be accurately or effectively applied under the circumstances of the examination.

* * * * * * *

No. The natural courses of most diseases are now sufficiently known to determine whether the process might have been present on entry into service.

* * * * * * *

No. Psychiatric disease presumption is not realistic medically.

* * * * * * *

I do not believe so. Preexisting physical and psychic defects are usually picked up very early in the inductee's military career and should not be charged to his service.

* * * * * * *

No. In many instances the findings can be at least roughly estimated as to duration of the disease process.

* * * * * * *

No. Because with an accurate diagnosis and evaluation, it can be determined in most cases whether or not an individual was sound on entry and, therefore, that the disability was not incurred as a result of service.

Summary and conclusions: Presumption of sound condition

The respondents are in agreement that adequate—complete—thorough—and permanently recorded physical examinations are required on entrance into the service. Though there is some divergence of opinion as to the medical validity for the presumption, it is fair to conclude that the presumption is necessary as a "base line", which is

medically acceptable, as an administrative measure for the protection of the veteran. The nature of both the positive and negative responses is such that it is clear that respondents believe that an individual claim for service-connection for residuals of a disease or injury generally can be determined in accordance with accepted medical principles; that the onset of a disease likewise usually can be predicated on the current status of scientific medicine.

PRESUMPTION OF SERVICE-CONNECTION—CHRONIC DISEASES

Coded question C

Do you believe the presumptions of service connection for chronic diseases are based on accepted medical principles?

If not, what diseases would you exclude, or add?

Background

Presumption of service connection for chronic diseases have their origin in an amendment to the War Risk Insurance Act of August 9, 1921 (42 Stat. 147). This enactment was an effort to bring within the law those veterans who were suffering with pulmonary tuberculosis and neuropsychiatric diseases, and who could not produce sufficient evidence to show direct non-service-connection. These diseases were to be considered service-connected, if it were shown that the veteran' had suffered a 10 percent disability from these diseases within 2 years after separation from the service. This presumption was extended by a later amendment in Public No. 542, (67th Cong., March 4, 1923) to 3 years and added the requirement that the 10 percent degree of disability be shown upon examination by a medical officer of the Veterans' Bureau or by a legally qualified physician made within 3 years after separation from the service. The list of diseases was extended by amendment in the World War Veterans' Act of June 7, 1924, so that veterans shown to have, or to have had, prior to January 1, 1925, neuropsychiatric disease, and "active tuberculous disease," paralysis agitans, encephalitis lethargica, or amoebic dysentery developing a 10 percent degree of disability or more in accordance with the act, were presumed to have acquired the disability between April 6, 1917, and July 2, 1921. These were marked departures from the original theory of the War Risk Insurance Act, as amended in 1917, the theory that monetary benefits should be provided only for those persons, honorably discharged from service in the World War who had suffered a disability which interfered with their capacity to pursue a gainful occupation. No provisions were made for disabled persons whose disabilities were not of direct service origin. Under the act of June 7, 1924, no compensation was payable for disability which did not occur prior to or within 1 year after discharge or resignation from the service, except as provided in the act, or where within 1 year from the approval of the World War Veterans' Act satisfactory evidence was furnished the Veterans' Bureau to establish that the disease was suffered or aggravated during the service. Subject to the limitations imposed by the World War Veterans' Act, in 1924 an administrative determination established an additional list of 31 chronic diseases.

Payment of compensation for presumptive service-connected disabilities was stopped in 1933 and was restored by Congress over a Presidential veto, in Public No. 141, 73d Congress, March 28, 1934, with exceptions.

Veterans regulation No. 1 (a) paragraph I (c), part I, as promulgated by Executive Order No. 6516, June 6, 1933, provided a presumption of service connection for a chronic disease becoming manifest to a degree of 10 percent or more within the first year after discharge, provided that the person suffering from such disease served 90 days or more active service. Specific diseases were not listed.

Public No. 748, 80th Congress, June 24, 1948, made statutory a list of chronic and tropical diseases as presumptive service connected, applicable to veterans with wartime service, who were otherwise qualified. This list of chronic diseases is found in appendix C, page 11, of the questionnaire. The act authorized the Administrator of Veterans' Affairs to add to the list of chronic diseases. Psychoses were added to the list.

Multiple sclerosis is now considered to be service connected when it is shown that a disability of 10 percent or more developed within 2 years after discharge from the service.

Psychoses developing within 2 years is considered as service connected for hospital and outpatient treatment only, otherwise when developing within a 1-year period is considered to be service connected for compensation purposes as well as hospital and outpatient treatment.

Coded Question C

Table 7.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	22	14
Qualified	23	15
No:		
Unqualified	18	12
Qualified	58	38
Indeterminate	24	16
Unanswered	8	5
Grand total	153	

TABLE 8.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	1	2	3	2		
Neurology	7	3		2	1	1	
Internal and general medicine	13		1	2	9	1	
Tuberculosis	9	1	4			3	1
Peripheral vascular diseases	4	1		1	2		
Cardiovascular diseases	7	1	1	2	1	2	
Allergy	6		2		1	3	
Gastroenterology	6		1		4		1
Tropical diseases	7		2		5		
Gerontology	6	1			4		1
General surgery	11	1	2	1	6	1	
Orthopedics	10	1	1	1	4	2	1
Neurosurgery	6			3	2	1	
Plastic surgery	6	2				3	1
Audiology and ear, nose, and throat	7		2		2	2	1
Ophthalmology	6	1		1	3	1	
Urology	7	2	1		3		1
Rehabilitation and physical medicine	8	2	2		4		
Dermatology	6			1	2	2	1
Industrial medicine	9	3	1	1	3	1	
Other	4	2	1			1	
Total	153	22	23	18	58	24	8

TABLE 9.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others,
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	10	14	2	11	4	20			4	20	2
Qualified	9	13	4	21	3	15	2	10	4	20	1
No:											
Unqualified	7	10	4	21	2	10	2	10	3	15	
Qualified	34	49	2	11	6	30	8	40	8	40	
Indeterminate	6	8	4	21	5	25	7	35	1	5	1
Unanswered	4	6	3	15			1	5			
Total	70		19		20		20		20		4

Discussion

One-half of the 153 respondents believed that the presumption of service connection for chronic diseases is not based on accepted medical principles; of the remaining 50 percent, only 29 percent feel that the presumption of service connection is based upon accepted medical principles; 24 of the respondents' replies, or 16 percent, were vague in their answer, 8 of the respondents did not answer the question. Five of the respondents out of eight, practicing in the medical specialty of psychiatry, believed that the presumption of service connection for chronic diseases is not based on accepted medical principles; 11 of the respondents out of 13, practicing the medical specialty of internal medicine were of this same opinion; also, 7 respondents out of 11, who specialize in general surgery, went along with this majority view.

Five respondents, who specialize in tuberculosis, were of the opinion that the presumption of service connection for chronic diseases was based on accepted medical principles, and 3 were vague in their answer, while 1 did not answer the question.

Over one-half of the nongovernmental private medical practitioners believed that the presumption of service connection was not based upon accepted medical principles; 10 out of 20 medical respondents from the Department of the Army, and 11 out of 20 medical respondents in the Department of the Air Force expressed this same opinion.

Medical respondents from the Departments of Medicine and Surgery in the Veterans' Administration and the Navy were nearly equally divided in their opinions.

The five diseases that should be excluded from the list, and mentioned most frequently by the majority in their opinion were: diabetes mellitus, arteriosclerosis, ulcers peptic, brain hemorrhage, brain thrombosis, and arthritis; although there was general agreement among the majority that the entire list should be excluded.

Representative comments of the majority (Presumption for chronic diseases is not based on accepted medical principles)

I would exclude all. It may be said of them all that their basis lies in the preexisting body or personality, that military service is not casually related, only coincidentally, and that the diseases would have occurred if the patient had never been in military service.

* * * * * * *

No. There is no sound basis for presuming that many of the listed diseases are service-connected.

* * * * * * *

Most of these chronic diseases are known to occur naturally irrespective of occupation or military service, i. e., diabetes, pernicious anemia, multiple sclerosis, and a great majority of malignancies.

* * * * * * *

Presumption of service connection for pernicious anemia, Hodgkin's disease, leukemia, and thrombocytopenic purpura depends entirely upon the history in an individual case. For example, Hodgkin's disease, leukemia, and thrombocytopenic purpura may all begin before the onset of symptoms and should not necessarily be presumed to originate 1 year before beginning complaints. Pernicious anemia may have a familial factor.

* * * * * * *

I do not. I would change the whole system to one where there is no presumption in any case, but each case must be consistent with accepted medical knowledge of its life history of a disease (cancer, tuberculosis, etc.).

Not in some cases. I would exclude primary anemia, arthritis, cerebral hemorrhage and thrombosis, calculi, cardiovascular renal disease, diabetes, endocarditis, leukemia, Hodgkin's disease, myasthenia gravis, psychoses, amyotrophic lateral sclerosis, active tuberculosis, malignant tumors of the nervous system, and peptic ulcers. Some of the others on the list are more equivocal.

* * * * * * *

Of the chronic diseases, would certainly exclude arteriosclerosis, arthritis, brain hemorrhage and/or thrombosis, urinary calculi, hypertension, cirrhosis of the liver, diabetes mellitus, endocrinopathies, epilepsy, Hodgkin's disease, myelitis, nephritis, Paget's disease, idiopathic purpura, sarcoid, scleroderma, Burger's disease, and possibly peptic ulcer. Enough is known about the natural history of all the above to make such presumptions unreasonable. In individual cases, service connection may of course be established.

* * * * * * *

This is not so much a question of diseases; rather it is a question of this history of the individual disease and its manifestations and progress in a specific patient. I realize that some practical period seems necessary to be determined, but if the principle applied must be one of time only, then we should at least be consistent and make the determination retroactive as concerns induction. This is only

requesting a fair deal for the taxpayer. Medically, I believe that if one presumes that a soldier with arthritis within 1 year after discharge is service-connected, it is correct to assume that an inductee who is found to have arthritis within 1 year after induction is not service-connected. Specifically, to answer the question directly, I would exclude all diseases that could not be proved by fact to have originated in the service.

* * * * * * *

No. Decisions on tuberculosis and neuropsychiatric disease, particularly, should be based on sound medical principles.

* * * * * * *

I think the whole list should be surveyed, not only the diseases listed on page 11. Some medical panel should go over the whole list of medical diseases and set up criteria to be used at least as guides. I could give any number of examples but pick only 1 or 2. There is no reason to assume that dysentery or malaria, occurring for the first time a year after separation is service-connected, especially in the case of a person living in an endemic area. The same pertains to leishmaniasis. Another example: Supposing a Puerto Rican served 3 years in the Army, always in the northern part of the United States. If he developed the symptoms and signs of schistosomiasis following his discharge, it is reasonable to assume that he acquired the disease when he was living in Puerto Rico. Brain hemorrhage or brain thrombosis, attributable to hypertension or arteriosclerosis, or both, would not necessarily be regarded as service-connected, since they are both likely outcomes of a progressive disease which would have occurred in the individual irrespective of military service.

* * * * * * *

Many of the listed chronic diseases such as cancer, arteriosclerosis, some forms of arthritis, essential hypertension, diabetes mellitus, and multiple sclerosis, are diseases of unknown etiology. It is not possible to be definite in many of these instances, of service connection when the illness manifests itself after separation from service. Since all questionable problems of this type are settled by giving the veterans the benefit of the doubt, it is the latter policy which really underlies the presumption—not a group of proved medical facts. It is likely that more thorough examinations at the time of separation from service would reveal minor changes of many chronic diseases which become evident later.

* * * * * *

Representative comments of the minority (presumption for chronic diseases is based on accepted medical principles)

Yes, if all reasonable doubt is resolved in favor of the veteran.

* * * * * * *

In most instances; yes. It is hard to justify service connection for brain hemorrhage or thrombosis occurring a year after separation. The underlying disease may be incriminated, however, clear-cut medical history of exposure to specific disease or trauma after discharge from service might cause grave doubt on service connection for some of the diseases listed (examples—streptococcic infestion and nephritis, head injury, and epilepsy).

* * * * * *

Yes; with the following exceptions; arteriosclerosis, diabetes mellitus, endocrinopathies.

* * * * * *

In general; yes. However, in the case of psychoses it would appear that all such conditions should be considered individually in accordance with the etiology. In other words, the presumption in each case of psychosis should be largely on a case-by-case basis.

* * * * * *

Yes; in general, and I would delete arteriosclerosis, diabetes mellitus, Hodgkin's disease and leukemia, and sarcoidosis, in which etiology cannot be associated with any particular feature of military service. Each case should be considered upon its own merits.

* * * * * *

This is difficult. I must give a "Yes" answer, since a chronic disease by definition must pre-date the diagnosis by an indefinite period.

* * * * * *

I believe the general presumption that chronic disease occurring within a limited period of time after separation from the service are service-connected, is based on accepted medical principles. However, I feel that it is impossible to develop a list of such diseases which will be inclusive enough to cover all situations. Certainly, the present list appears most inadequate and excludes many diseases which are just as deserving of inclusion as those which are listed.

Summary and conclusions

The presumption of service connection for chronic diseases is not based upon accepted medical principles. The basis for singling out these diseases is not apparent, except that most of them are serious. A majority are of the opinion that the list should be resurveyed and revised, or deleted entirely, as accepted medical principles can determine the onset of a disease or injury, in accordance with the cause, incubation period and residuals of the disease and injury. In questionable cases where it is not possible to be definite as to service connection, and where the disability manifests itself after separation from service, the doctrine of reasonable doubt in favor of the veteran can be applied.

PRESUMPTION OF SERVICE CONNECTION—TUBERCULOSIS

There were two questions on the presumption of service connection for tuberculosis. Both questions are given at this time, and analyzed separately. The background is the same for the two questions.

Coded question D

Have recent developments in methods of diagnosis and treatment for tuberculosis affected the presumptions regarding tuberculosis?

Coded question E

Is the time interval governing presumption of tuberculosis valid under present status of medicine?

Background

As stated in the background to the previous question, the presumption of service connection for chronic diseases, an amendment to the War Risk Insurance Act (Sweet Act) originated the presumption of service connection for pulmonary tuberculosis, in an effort to bring within the law those veterans who were suffering from that disease, who could not produce sufficient evidence to show direct service connection. Pulmonary tuberculosis was to be considered service-connected, if it were shown that the veteran has suffered a 10-percent disability from this disease within 2 years after separation from the service. The presumption was extended to 3 years in a later amendment (Public No. 542, 67th Cong., March 4, 1923). Although the World War Veterans' Act of 1924 repealed the 3-year presumptive period of service connection for tuberculosis section 200 of that act presumed service connection for tuberculosis when an ex-serviceman was shown to have had tuberculous disease prior to January 1, 1925, and was presumed to have been acquired in service between April 6, 1917, and July 2, 1921. This presumptive period remained in the statutes until 1933, when the presumptive period of 1 year for all chronic diseases was promulgated in Veterans Regulation No. 1 (a).

The legislative history on tuberculosis indicates that the word "pulmonary" was not used in the act of March 4, 1923, but stated:

"That an ex-serviceman who is shown to have * * * an active tuberculous disease * * * shall be considered to have acquired his disability in such service * * *".

Following the passage of the World War Veterans' Act of 1924, an administrative presumption was made extending the time interval to 4 years for pulmonary tuberculosis:

Active pulmonary tuberculosis, diagnosticated by approved methods as outlined in regulations, paragraphs 6022 and 6023, will be held to have preexisted the diagnosis 6 months in minimal (incipient) cases; 9 months in moderately advanced cases; and 12 months in far advanced cases (S. Doc. 131, 1932, p. 127).

Public Law 748, 80th Congress, approved June 24, 1948, amended Veterans' Regulations 1 (a) and reestablished statutorily the presumption of service connection for tuberculosis, active, along with other chronic diseases, with disability of 10 percent or more becoming manifest within 1 year after discharge from service. Another amendment to Veterans' Regulations 1 (a) was made in Public Law 573 81st Congress, June 23, 1950, and provided for an extension of the presumptive interval to 3 years for pulmonary tuberculosis only. An additional administrative presumptive interval of 1 year was added by regulations on March 23, 1951:

* * * active pulmonary tuberculosis diagnosticated by approved methods during the fourth year will be held to have pre-existed the diagnosis 6 months in minimal (incipient) cases; 9 months in moderately advanced cases; and 12 months in far advanced cases.

Other types of tuberculosis were limited to the 1 year presumptive period.

The act of August 8, 1953, (67 Stat. 506) amended veterans' regulations and provided for a 3-year presumption for all types of tuberculosis. An explanation of this bill is reported in House Committee Print No. 171, 84th Congress, December 28, 1955, page 50:

* * * This bill was the subject of hearings before the Subcommittee on Compensation and Pension, at which time this question was thoroughly discussed by officials of the Veterans' Administration, as well as the service organizations. The Veterans' Administration points out that it "is not aware of any medical or other basis for a distinction between pulmonary and nonpulmonary forms of tuberculosis." It further states that the enactment of the bill would place all tuberculous diseases on a parity for this purpose. It seems desirable to the committee that the legislation on this subject should apply on an equal basis to all types of this serious disease.

Discussion

Two out of seven respondents did not answer the question; and 1 out of 7 was vague in his reply. Of the remaining, a sizable majority were of the opinion that recent developments in methods of diagnosis and treatment for tuberculosis affected the presumptions regarding tuberculosis. Only 20 percent of the respondents polled were of the opposite opinion.

Five of the nine respondents practicing in the medical specialty of tuberculosis were of the opinion that recent developments in methods of diagnosis and treatment for tuberculosis affected the presumptions regarding tuberculosis. One of these medical specialists felt that there have been no recent developments influencing this very much.

Nine out of thirteen respondents practicing in the medical specialty of internal medicine expressed the opinion that recent developments in methods of diagnosis and treatment for tuberculosis have affected the

presumptions regarding tuberculosis. Two respondents practicing in this specialty did not believe so, while one was vague in his answer, and one did not answer the question.

Twenty-eight respondents out of seventy, classified as non-Governmental medical practitioners, were of the opinion that recent developments in methods of diagnosis and treatment for tuberculosis have affected the presumptions for tuberculosis; and 21 of this group had no opinion. Eight of nineteen medical respondents in the Department of Medicine and Surgery of the Veterans' Administration were of this same opinion, while six did not answer the question. Ten out of twenty respondents from the Department of the Navy; 5 out of 20 respondents from the Army, and 5 out of 20 respondents from the Air Force, also considered that recent developments in methods of diagnosis and treatment for tuberculosis have affected the presumptions regarding tuberculosis. Two of the respondents from the Navy, eight from the Army, and six from the Air Force did not answer the question.

Coded Question D

Table 10. *Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	2	1
Qualified	54	35
No:		
Unqualified	16	11
Qualified	15	10
Indeterminate	23	15
Unanswered	43	28
Grand total	153	

Table 11.—*Distribution of replies, by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8		1	1	1	1	4
Neurology	7	1			1	2	3
Internal and general medicine	13		9		2	1	1
Tuberculosis	9		5	1		2	1
Peripheral vascular diseases	4		3			1	
Cardiovascular diseases	7		4		1	1	1
Allergy	6		2	1		1	2
Gastroenterology	6		2		1	1	2
Tropical diseases	7		1	3			3
Gerontology	6		2	1	1		2
General surgery	11		3	1	2	1	4
Orthopedics	10	1	4	2	1	2	
Neurosurgery	6						6
Plastic surgery	6		1	1		1	3
Audiology and ear, nose, and throat	7		3	1			3
Ophthalmology	6		1	1		2	2
Urology	7		2	1	2	1	1
Rehabilitation and physical medicine	8		3	1	1	1	2
Dermatology	6		2			3	1
Industrial medicine	9		6	1			2
Other	4				2	2	
Total	153	2	54	16	15	23	43

TABLE 12.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	2	3	------	------	------	------	------	------	------	------	------
Qualified	26	37	8	42	10	50	5	25	5	25	------
No:											
Unqualified	5	7	3	16	3	15	2	10	3	15	------
Qualified	9	13	1	5	1	5	------	------	2	10	2
Indeterminate	7	10	1	5	4	20	5	25	4	20	2
Unanswered	21	30	6	32	2	10	8	40	6	30	------
Total	70	------	19	------	20	------	20	------	20	------	4

Representative comments of the majority. (*Recent developments in diagnosis and treatment for tuberculosis have affected the presumptions regarding tuberculosis*)

For some years before World War II, and since then, our better methods of diagnosing tuberculosis make me think that the great majority of cases of tuberculosis not showing symptoms, X-ray or other clinical findings sufficient for diagnosis, have not been developing for from 3 to 4 years. Now, practically all industries, health departments, employment offices, etc., use X-rays for screening their workers and applicants, also more careful histories and screening of contacts often reveal the source of infection.

* * * * * *

Methods of diagnosis, and particularly of therapy, of tuberculosis have drastically changed presumption. If the disease is not manifest by the time of separation, no presumption seems indicated on all inclusive cases.

* * * * * *

I would feel that the whole subject of tuberculosis should be reevaluated.

* * * * * *

Yes; recent improvements in diagnosis and therapy have shown many cases formerly diagnosed as tuberculosis are now toxoplasmosis, as well as other granulomatous infections.

* * * * * *

Recent developments in the diagnosis and treatment of tuberculosis have made case finding much easier, and have facilitated the treatment of the disease considerably. The whole question of tuberculosis is fluid, and no final answer can be given at this time concerning the curability of the disease. Therefore, I would suggest that the subject of compensability for tuberculosis be periodically evaluated by a competent board of experts in the field.

* * * * * *

In the opinion of the undersigned, the same rule of presumption should apply to tuberculosis and psychosis, as is applied to other conditions.

* * * * * *

Under modern theraply, certainly most minimal to moderately advanced tuberculosis victims are rehabilitated, oftentimes with full-life expectancy and earning capacity.

* * * * * *

Since the men have a discharge X-ray, I would consider tuberculosis developing beyond 3 months non-service-connected.

* * * * * *

Tuberculosis is considered a communicable disease, therefore finding the source of infection may give the examiner a clue as to the time of acquiring the infection. Also, chest films at the time of entering and leaving service may be of value in ruling out infection before and during service respectively.

* * * * * *

The use of miniature films in civil life and on induction into and discharge from the service have a potent role. The present chemotherapeutic and surgical methods for the treatment of tuberculosis have greatly modified its prognosis and residual disability.

* * * * * * *

If chest films were taken on admission and discharge and were negative, it would be unlikely that tuberculosis occurring 4 years later could be attributable to military service, unless, perhaps, under unusual circumstances, such as being starved in a prisoner-of-war camp.

* * * * * * *

This is unreasonable with current requirements for annual and discharge radiographic examinations.

* * * * * * *

Representative comments of the minority. (*Recent developments in diagnosis and treatment of tuberculosis have not affected the presumption regarding tuberculosis*)

In my opinion no. One wonders if the tuberculin test could be used on old admissions to the service and all negative reactions to be tested on separation. This would mean that those who changed from negative to positive would require a survey for evidence of active disease. It might prove of limited value to this group.

* * * * * * *

There have not been any recent developments influencing this very much, but the routine application of the tuberculin test and X-ray examination would have a great influence.

* * * * * * *

No. They are false from the start. The presumptions regrding TB have a political basis and are therefore not subject to criticism on clinical grounds.

* * * * * * *

No. Since the men have a discharge X-ray. I would consider tuberculosis developing beyond 3 months non-service-connected.

* * * * * * *

As far as I know the treatment by chemotherapy have no effect on the presumptions described.

* * * * * * *

Recent development in method of diagnosis and treatment for tuberculosis have not affected the presumptions regarding tuberculosis.

Summary and conclusions

The summary and conclusions to this question are combined with those on the next question on tuberculosis.

* * * * * * *

Coded question E

Is the time interval governing presumption of tuberculosis valid under present status of medicine?

Discussion

One out of four respondents did not answer the question; and 1 out of 6 respondents replied vaguely to the question. Of the remainder, a sizable majority were of the opinion that the time interval governing tuberculosis under the present status of medicine is not valid. Only 19 percent of the respondents polled expressed the opposite opinion.

Four of the nine respondents practicing in the medical specialty of tuberculosis were of the opinion that the time interval governing tuberculosis was not valid under present status of medicine; 3 believed the opposite, and 2 gave a vague answer.

Coded Question E

Table 13.—*Distribution of grand total of respondent's replies*

Replies	Number	Percent
Yes:		
Unqualified	20	13
Qualified	9	6
No:		
Unqualified	42	27
Qualified	21	14
Intermediate	24	16
Unanswered	37	24
Grand total	153	

Table 14.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	1		1	1	1	4
Neurology	7	1		1	1	1	3
Internal and general medical	13	1		9	2	1	
Tuberculosis	9	2	1	2	2	2	
Peripheral vascular diseases	4		1	2		1	
Cardiovascular diseases	7			2	2	1	2
Allergy	6	1		1	1	1	2
Gastroenterology	6			2	1	1	2
Tropical diseases	7	1	1	2	2		1
Gerontology	6	1		1	1	1	2
General surgery	11		2	7			2
Orthopedics	10	3		1	2	3	1
Neurosurgery	6						6
Plastic surgery	6					2	4
Audiology and ear, nose, throat	7	1		1	1	1	3
Ophthalmology	6		1	1		3	1
Urology	7	3	1		1	1	1
Rehabilitation and physical medicine	8		1	4		2	1
Dermatology	6	2	1		1	1	1
Industrial medicine	9	1		4	3		1
Other	4	2		1		1	
Total	153	20	9	42	21	24	37

Table 15.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		A-RM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	8	11	1	5	5	25	1	5	3	15	2
Qualified	4	6	2	10	2	10	1	5			
No:											
Unqualified	20	28	6	32	5	25	4	20	6	30	1
Qualified	9	13	3	16	4	20	3	15	2	10	
Indeterminate	11	16	1	5	3	15	4	20	4	20	1
Unanswered	18	26	6	32	1	5	7	35	5	25	
Total	70		19		20		20		20		4

Eleven respondents out of thirteen specializing in internal medicine stated that the time interval governing presumption of tuberculosis was not medically valid; one felt that the presumption was medically valid; and one replied vaguely.

Eighteen respondents out of seventy classified as nongovernmental medical practitioners did not answer the question; eleven were vague in their reply; twenty-nine stated the time interval governing the presumption of tuberculosis was not medically valid; and only twelve considered the presumption as medically valid.

Medical respondents from governmental departments who did not answer the question were: 6 out of 19 in the Veterans' Administration; 1 out of 20 in the Navy; 7 out of 20 in the Army; and 5 out of 20 in the Air Force.

Medical respondents from governmental departments who were of the opinion that the time interval governing the presumption of tuberculosis was not valid under present status of medicine, were: 9 from the Veterans' Administration; 9 from the Navy; 7 from the Army; and 8 from the Air Force. A small minority of the medical respondents in each of these departments felt that the time interval governing the presumption of tuberculosis was medically valid, and still a smaller minority were vague in their replies.

Representative comments of the majority. (*Time interval governing presumption of tuberculosis is not valid under present status of medicine*)

No. However, I would feel that the 3-year presumptive period for tuberculosis is not consistent with other presumptions relating to service connection of disability. I feel that a 1-year period of presumption would be more rational.

Again consideration to the length and type of service of the individual and his civilian occupation during the interim should be of the utmost importance. An individual having had a separation physical, including a negative X-ray of the chest should be presumed to be not service-connected if he develops pulmonary tuberculosis after 1 year.

* * * * * *

The time interval of 3 years is very liberal. Given a negative physical examination, routine urine and chest X-ray, at the time of separation from service, this time interval should be not more than 1, certainly not more than 2 years.

* * * * * *

No, especially since all persons discharged from the service have a chest X-ray study. I would agree with the presumptions of 6 months for minimal cases, etc.; but this should begin with the time of discharge.

* * * * * *

Believe time interval of 1 year would be more realistic. In an interval as long as 3 years, it seems that factors other than service-connection would be relevant.

* * * * * *

However, I would feel that the 3-year presumptive period for tuberculosis is not consistent with other presumptions relating to service-connection of disability. I feel that a 1-year period of presumption would be more rational.

* * * * * *

I believe time interval of 3 to 4 years in case of tuberculosis is unduly long and would be more realistic if 1 to 2 years, particularly if adequate screening on discharge from service. I believe particularly in terms of short-term service, 2 to 4 years; there is serious doubt of line-of-duty or aggravation in any of degenerative and metabolic diseases, diabetes, arteriosclerosis, emphysema, malignant disease, etc.

* * * * * *

I feel that the time interval governing presumption should be 1 year following discharge.

* * * * * *

Representative comments of the minority. (Time interval governing presumption of tuberculosis is valid under present status of medicine)

I think the time interval is valid.

* * * * * * *

Yes, I believe the time interval governing presumption of tuberculosis is valid under the present status of medicine.

* * * * * * *

Yes, although in most instances the disease should be manifest in a shorter interval with the emphasis on, and availability of, tuberculosis detection facilities.

* * * * * * *

Probably yes; with few exceptions.

* * * * * * *

As far as the time of development of chronic tuberculous lesions is concerned the presumption times set are medically reasonable.

* * * * * * *

Summary and conclusion, presumption, service connection—tuberculosis

Modern methods of diagnosis and treatment for tuberculosis have advanced since the enactment of the original presumption of service connection for tuberculosis. The impact of this scientific progress is not reflected in the statutory presumptions, nor the administrative presumption increasing the time interval to 4 years after discharge from service. The consensus of medical opinion was that any type of tuberculosis appearing and becoming manifest after 1 year following discharge from the service should not be presumed to be service connected, and that it is not a valid presumption to assume that any tuberculosis developing 3, or as long as 4, years after separation from the service has a service connection.

PRESUMPTION OF SERVICE CONNECTION—PSYCHOSES

Coded Question F

Should there be presumptions of service connection in the psychoses?
If so, for what time interval after separation?
If not, why?

Background

The legislative history on the presumption of service connection for psychoses parallels that of tuberculosis, except that the presumptive time interval of 1 year has not been changed, for compensation benefits. However, peacetime veterans do not have the advantage of the presumptive service connection for psychoses. They are restricted to direct service connection, or aggravation of a preexisting condition.

Hospitalization and outpatient treatment for veterans of World War II and the Korean conflict, developing an active psychosis within 2 years from the date of separation from active war service, is authorized. The presumption of service connection for psychosis for hospital and outpatient treatment purposes of 2 years is not rebuttable.

Discussion

Two-fifths of the respondents expressed the opinion that there should be presumptions of service connection in the psychoses. This group of respondents recommended a time interval for the presumption of service connection in the psychoses, in numbers of respondents, as follows: The time interval was not stated by three; presumption should be on an individual and reasonable doubt basis—4; interval

of time, no longer than 6 months—7; time interval, 18 months—2; time interval, 2 years—8; time interval, 1 year—31 respondents; extend the 2-year time interval—1 respondent.

Only 23 percent of the respondents polled said there should not be presumptions of service connection for psychoses. Ten percent of the respondents were vague in their replies; and 27 percent of the respondents had no opinion.

Coded Question F

Table 16.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	39	26
Qualified	20	13
No:		
Unqualified	17	11
Qualified	19	12
Indeterminate	16	11
Unanswered	42	27
Grand total	153	

Six of the eight respondents, in psychiatry, said there should be presumptions of service connection for psychoses. One respondent in this group thought the time interval of 2 years for the presumptions should be lengthened; another was afraid that there should be a 2-year maximum time interval; one stated the time interval should be 1 year for the presumptive period; one favored a 6-month time interval; another of the group felt he was not sure and that it should be discussed, and gave 1 year as the time interval for the presumption; and the last one of the group maintained that there should be no presumptions for schizophrenia, and that there should be a presumptive time interval of 1 year for the other physcoses.

Table 17.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	4	2	2			
Neurology	7	4	1	1			1
Internal and general medicine	13	2	3	3		2	3
Tuberculosis	9	2	1	1			5
Peripheral vascular diseases	4	1		1	2		
Cardiovascular diseases	7	2		1	2		2
Allergy	6	3			1	1	1
Gastroenterology	6	2		1	1	1	1
Tropical diseases	7	1	3		1		2
Gerontology	6	1			2	1	2
General surgery	11	1	3	1	1	1	4
Orthopedics	10	1	2	2	2	3	
Neurosurgery	6	1			1		4
Plastic surgery	6		2		1	1	2
Audiology and ear, nose, throat	7	2				1	4
Ophthalmology	6		1	2		1	2
Urology	7	2			1	1	3
Rehabilitation and physical medicine	8	2	1	1	1	2	1
Dermatology	6	2					4
Industrial medicine	9	4	1	1	2		1
Other	4	2			1	1	
Total	153	39	20	17	19	16	42

TABLE 18.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	18	26	8	42	3	15	3	15	5	25	2
Qualified	13	18	1	5	3	15	3	15	------	------	----------
No:											
Unqualified	5	7	2	11	4	20	4	20	2	10	----------
Qualified	7	10	------	------	4	20	3	15	4	20	1
Indeterminate	7	10	------	------	2	10	2	10	4	20	1
Unanswered	20	29	8	42	4	20	5	25	5	25	----------
Total	70	------	19	------	20	------	20	------	20	------	4

Two respondents of the foregoing group of psychiatrists stated, that there should not be presumptions of service connection for psychoses, and that the psychosis be correlated to service connection on an individual basis in accordance with accepted medical principles.

Thirty-one nongovernmental respondents out of 70 believed that there should be presumptions of service connection in the psychoses; 20 more had no opinion; 7 replies were vague; and 12 respondents in this classification were not in favor of presumptions for service connection in the psychoses.

Nine medical respondents, from the Veterans' Administration, felt that there should be presumptions of service connection in the psychoses; 2 believed that there should not be presumptions for psychoses; and 8 had no opinion. Medical respondents, from the Departments of the Navy, Army, and Air Force were nearly equally divided in their opinions.

Representative comments of the majority. (*There should be presumptions for psychoses*)

If the presumption of service connection is to be made in other diseases, it should be made equally in the psychoses, but without special consideration.

* * * * * * *

Yes, if no evidence existed prior to service, though the etiologic relationship of service, at best, doubtful in most instances of aggravation.

* * * * * * *

Yes. This cannot be answered empirically. There are too many preservice and postservice variables.

* * * * * * *

Yes. This would be an individual matter.

* * * * * * *

Only in association with time of war and limited to those in combat. At present time, each case should be judged on its own merits.

* * * * * * *

Yes, if veteran has all reasonable doubt resolved in his favor.

* * * * * * *

Yes. This interval is difficult to set. Two years is probably too long. A better index would probably be whether the onset of symptoms occur before or within 6 months of the time the veteran makes a satisfactory adjustment to civilian life.

* * * * * * *

Probably those within a year. I'm not sure, I think it should be discussed.

* * * * * * *

Yes. All should be presumed inherent, not service connected. It is as certain as anything in psychiatry that the psychoses have their origin in childhood and

their aggravations in youth. Military service may coincide with the manifestations, or uncover the preexisting state, but the relationship is coincidental, not causative.

* * * * * *

Representative comments of the minority. (There should not be presumptions for psychoses)

No this is entirely an individual determination.

* * * * * *

It seems to me, to rule that a psychoses developing 2 years after discharge from the Army is service connected. That may be true. The service connection and its timing in relation to the development of the psychosis are matters for individual psychiatric study and determination. No rule of thumb should be followed.

* * * * * *

It is felt that if a psychosis is service connected it would be precipitated during actual service and not after the person has left the service. If psychosis should become clinically apparent after leaving the service, service connection could be established on accepted medical principles. Thus presumption and time factor would be superfluous.

* * * * * *

Psychoses developing after separation when no related service-connected findings have been recorded should be regarded as nonservice and precipitated by factors unrelated to the service.

Most psychoses are founded on early development (childhood) and become manifest with stress, therefore if they occur after service, the stress is one of civilian life, not military.

In my estimation I would have to answer this as "no" if I took the literal interpretation of the question. In cases of schizophrenia breaking down within a year or two following discharge, it is my opinion that it is the stress of adapting to civilian life again that causes this breakdown. I strongly suspect that many of these would not have broken down had they remained in the service. In other words, it is my opinion that the "total push" of the service was therapeutic for this type and kept these patients from breaking down whether they were in action or not.

The real question, of course, is whether they would have broken down had they not been inducted into the armed services. It is my considered opinion, based upon 25 years of experience as a specialist in psychiatry, and I could be wrong, that most of these cases of schizophrenia would have broken down sooner or later if they had stayed at home. I could not say this about the manic depressive group of psychoses. The average duration of the manic depressive reactions is from 5 to 6 months without treatment. Involuntional melancholia, however, could well be service connected as far back as 2 years.

Psychoses from alcohol or syphilis could easily be service connected as far back as 2 years; also psychosis with cerebral arteriosclerosis or Alzheimer's disease, or general senile brain atrophy.

There is a group of patients that do not fall into the schizophrenic group though frequently put there, and that is those suffering from a paranoid reaction. I believe these cases can date their disturbance back 2 years while in the service. They frequently have latent homosexual conflicts that are lit up in the service, but not caused by service.

Summary and conclusions. Presumptive service connected, psychoses

Thirty-eight percent of the respondents believed that there should be presumptions of service connection in the psychoses. Some of the medical respondents expressing a majority, or a minority, opinion felt that the determination of service connection in psychoses should be determined, without the presumptions, on the merits of the case, and based upon accepted medical principles, with resolution of any doubt made in favor of the veteran.

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PRESUMPTION OF SERVICE CONNECTION—TROPICAL DISEASES

Coded question G

Do you believe the presumption of service connection for tropical diseases is based on accepted medical principles?

For what time interval after separation should the presumption establish service connection?

What revisions, deletions, or additions, if any, should be made to the list of tropical diseases?

Background

Following World War II, the first presumption of service connection for tropical diseases was provided in the act of June 24, 1948, and previously reported in this manuscript under chronic diseases. A list of tropical diseases were spelled out in the act and may be found in appendix C of this section. An innovating feature of this act, and not found in previous legislation, places emphasis on the proviso that tropical diseases, as listed, "and others and the resultant disorders or diseases originating because of therapy, administered in connection with such diseases, or as a preventative thereof, shall be accorded service connection," and as provided in the act, "*or at a time when standard and accepted treatises indicate that the incubation period thereof commenced during active service.*" [Italic supplied.] Peacetime veterans are afforded the protection of this presumption, who are otherwise qualified, and "who served for 6 months or more" in the military or naval service.

Coded Question G

Table 19.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	51	33
Qulified	41	27
No:		
Unqualified	6	4
Qualified	8	5
Indeterminate	11	7
Unanswered	36	24
Grand total	153	

TABLE 20.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	3			1	2	2
Neurology	7	3	1			1	2
Internal and general medicine	13	4	5	2	1		1
Tuberculosis	9	1	4	1	1		2
Peripheral vascular diseases	4	1	2	1			
Cardiovascular diseases	7	1	1	1	1	1	2
Allergy	6	2	1				3
Gastroenterology	6	2	3	1			
Tropical diseases	7		5		2		
Gerontology	6	2	2				2
General surgery	11	4	2		1	1	3
Orthopedics	10	4	2			2	2
Neurosurgery	6	1	1			1	3
Plastic surgery	6	3					3
Audiology and ear, nose, and throat	7	2	2				3
Ophthalmology	6	2	1			1	2
Urology	7	3				1	3
Rehabilitation and physical medicine	8	3	3			1	1
Dermatology	6	2	2		1		1
Industrial medicine	9	4	4				1
Other	4	4					
Total	153	51	41	6	8	11	36

TABLE 21.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	23	33	5	27	5	25	4	20	10	50	4
Qualified	16	23	5	26	9	45	6	30	5	25	
No:											
Unqualified	3	4	1	5			3	15			
Qualified	2	3	1	5	1	5	4	20			
Indeterminate	4	6			4	20	2	10	1	5	
Unanswered	22	31	7	37	1	5	1	5	4	20	
Total	70		19		20		20		20		4

Discussion

A considerable majority of the respondents maintained that the presumption of service-connection for tropical diseases is based on accepted medical principles. A small minority of the respondents sustained the viewpoint that the presumption for tropical diseases was not based on accepted medical principles, 1 out of 4 respondents did not answer the question; and 1 respondent's answer out of 14 was vague.

Nine respondents out of 13 practicing in the medical specialty of internal medicine felt that the presumption of service-connection for tropical diseases is based on accepted medical principles; 3 did not believe so; and 1 did not answer the question.

Five respondents out of seven practicing in the specialized field of tropical medicine, regarded the presumption of service-connection for tropical diseases as being based on accepted medical principles; the remaining two medical specialists, practicing in this medical field, disagreed with the majority.

Eight respondents out of nine practicing in industrial medicine were strongly in favor of the presumption of service-connection for tropical diseases, and considered the presumption as based on accepted medical principles; the remaining one respondent did not answer the question.

There was no great variation from the proportions, as stated above, in the replies from nongovernmental medical practitioners, and governmental medical practitioners. The majority in each classification were of the opinion that the presumption of service-connection for tropical diseases is based on accepted medical principles.

There was clear general agreement that the time interval, after separation from the service, for the presumption of service-connection for tropical diseases, should remain at 1 year, as established by law.

There is a variance of respondents' opinions as to the revision of the list of tropical diseases, or additions. However, the consensus of opinion is that amebiasis, malaria, and dysentery are prevalent not only in the tropics, but are found to be just as prevalent outside of tropical areas. Some respondents are of the opinion that leprosy should also be deleted from the list; others believe that the whole list should be deleted, and that presumptions are unnecessary as accepted medical principles in all cases, as well as approved treatises, establish the incubation period for the disease.

Representative comments of the majority. (Presumption of service connection for tropical diseases is based on accepted medical principles)

Yes, except for amebiasis, which is prevalent in many wide areas.

Yes, excepting cholera and yellow fever on the basis of the short incubation period in these two diseases.

* * * * * * *

I believe a time interval of 1 year after separation will be adequate for all but a few cases. The establishment of service-connection for the occasional case which may develop after 1 year could be handled as an exception where clear and unmistakable evidence demonstrates the disease was contracted in the military service.

* * * * * * *

I should think that, as a general rule, if presumption is legally established, it should be a year for the more acute diseases (e. g. cholera, plague, yellow fever) and longer for others (e. g. kala azar, leprosy, yaws). It is difficult at the best to establish origins, but I think the presumption could be justified for periods considerably in excess of 1 year on the ground of probability in diseases rare in United States of America.

* * * * * * *

The one disease listed which might be questioned is amoebiasis. It is true the incidence of this disease is much greater in some areas but it is also true that this disease is ubiquitous in occurrence. It has also been shown that 85 percent of certain nationalities harbor schistosoma and that malaria and leprosy are more or less endemic in certain areas of the United States. All of these factors must be considered.

* * * * * * *

Yes, provided the veteran has served in an area where the disease is endemic. It is, of course, possible that the disease may be acquired after discharge, particularly amebiasis and malaria. With the stated proviso, however, the presumption seems warranted.

* * * * * * *

Except in a few instances, it seems to be. There are some diseases which are not normally seen in the United States. If one of these develops in a veteran

who has served in an area where such a disease is endemic, I think service-connection should be granted, unless there are extenuating circumstances, such as contacts, subsequent trips to these areas, etc.

* * * * * * *

Omit ambiasis, dysentery, and other diseases with well-known nontropical distribution (as determined by specialists in so-called tropical diseases).

Yes, however, this becomes an individual evaluation and should apply only to tropical diseases unknown to the civilian environment of the veteran since separation.

Representative comments of the minority. (Presumption of service connection for tropical diseases is not based on accepted medical principles)

If place of service, incubation period for the disease, and evidence of reaction or complications of the disease or its treatment are a matter of record, then service-connection in general is based on accepted medical principles.

* * * * * * *

Postwar travel in and out of the Tropics has been common, and so-called tropical diseases are not confined to the Tropics.

* * * * * * *

The whole list should be deleted. Presumptions are unnecessary; accepted medical principles should suffice.

* * * * * * *

I believe it should be limited in all these cases to the time stated in approved treatises as the incubation period.

* * * * * * *

Since some tropical diseases, such as malaria, amebiasis, and dysentery may be contracted in the United States, as well as in tropical countries, one cannot assume that all tropical diseases are a result of military service.

* * * * * * *

Each case can be judged on its merits as they are relatively infrequent in occurrence. Follow standard texts.

* * * * * * *

Separate rules must be set down for each disease.

* * * * * * *

Should be determined in each disease in accordance with incubation period and natural history of the disease, and the time in which residuals and complications may beome apparent or manifest.

* * * * * * *

Not entirely—for instance, amebiasis is endemic in United States, and with increasing world travel many are exposed to other diseases. Each case should be individualized as in other diseases.

* * * * * * *

This will depend entirely upon the incubation period and natural history of each disease. I don't see how one can set a fixed time to cover all.

* * * * * * *

No time, no presumption. Every valid case can be established by accepted medical principles, if a true history is given.

* * * * * * *

Summary and conclusions

The presumption of service connection for tropical diseases is based on accepted medical principles. It is not necessary to list a number of diseases as accepted medical principles and standard accepted treatises are able to determine the incubation period. However, a presumptive time interval of 1 year after separation from the service is generally and medically acceptable for tropical diseases.

PRESUMPTIONS OF TOTAL DISABILITY

There were three questions on the presumptions of total disability propounded to the medical specialists. They are given below, as they have a common background.

Coded question H

Yardsticks for total disability have been established in paragraph 16, page 5, and paragraph 17, page 6, of the 1945 Schedule for Rating Disabilities, as amended by extension 5 [this reference material may be found in appendix I]:

What is the medical validity of these yardsticks?

Coded question I

From your experience, what proportion of people would have a degree of disability 10 percent, or more, at age 65 on the basis of the standards in the schedule?

Coded question J

Is there a set percentage or yardstick by which it can be said that a person with a single disability and rated some percentage (for example, 10 percent, 60 percent, 70 percent) is totally disabled? A combination of disabilities? At a certain age?

Background presumptions total disability

Yardsticks for total disabilities for disabled veterans' compensation purposes have their origin in the various act of the Colonial, Revolutionary War, and pre-General Law period of 1862, establishing veterans' disability benefit payments for total disability and for partial disability, a rate proportioned to, and for the time of, the disability. Implementation of the acts by those responsible for the administration of the various acts; had produced varied standards for these yardsticks.

Under the General Law, July 14, 1862, monetary rates for total disability were: for enlisted persons, maximum of $8 per month; and for officers not to exceed $30 for the grade of lieutenant-colonel and above, per month. During the Civil War "total disability" was considered as a disability "equivalent to anchylosis of a wrist," (fixed, and nonmovable hand at the wrist). As a result, adjudication of disabilities by the Pension Bureau at the time, gradually became confused. (See the Commissioner's annual report for 1864, pp. 656–658.) The confusion was compounded by the employment of and practice of several definitions of "total disability." Because of the vagueness in the law, and contradictory implementation in its administration, a legislative act of July 4, 1864, attempted to establish equitable monetary rates for total disability, by an amendment to the General Law of 1862. The original $8 maximum rate for total disability was retained, as a minimum, and $18 set as a maximum rate, regardless of the effect of the disease or injury, and regardless of the effect of aging upon the veterans' ability and capacity in earning power. Higher monetary rates than the "total disability" rate were paid for certain specific disabilities, by this act, which will be taken up under the statutory awards for specific disabilities. Instead of clarifying the problem, definition and interpretation of "total disability," the various payments caused additional perplexity, bewilderment, and complication in rating disabilities. The criteria for "total disability"

needed standardization, as the Commissioner of Pensions was empowered to fix, in his discretion, rates amounting to some proportion of $18 a month for any degrees of disability not sufficient to warrant the $18 a month rate for which the $8 "total disability" rate did not make provision. Benefit payments in the above were granted for service-connected disabilities only.

Another element in the whole history of criteria for "total disabilities" was introduced in the Civil War Veterans' Act of June 27, 1890. This act provided for nonservice-connected pension benefits to Civil War veterans, only, for disabilities as a result of service and nonservice origin, with monetary payments for "total disability" set at $12 a month and for partial disabilities, rates from $6 to $12, accordingly. A veteran could be employable and in receipt of an income and still be paid the "total disability" maximum of $12 per month. These two laws, acts of 1862 and 1890, gave rise to the system whereby a disabled veteran of the Civil War, if otherwise qualified, could "shop" for the best suited disability award; also gave rise to 2 different systems of rating disabilities, one for disability of service origin, the other for disability regardless of origin.

The act of 1890 introduced a new element and criteria in "total disability" rating. The age of a claimant under the provisions of this act was an important factor in fixing the rate under the act. In his annual report, the Commissioner of Pensions in 1899 stated the application of this rule on the age factor (pp. 33–34):

> Under the established rule of the Bureau of Pensions a claimant who had reached the age of 75 was entitled to the maximum rate for senility alone, * * *. Under decisions of the Department, a claimant who had attained the age of 65 was deemed entitled to at least the minimum rate, unless the evidence disclosed an unusual vigor and ability for the performance of manual labor in one of that age.

On June 30, 1900, the Commissioner of Pensions issued instructions to examining surgeons, for guidance in the examinations of claimants in which he reiterated the foregoing policy on the age factor and added:

> * * * The effect of partial senility should be considered with other infirmities, where there are such, and the aggregate incapacity rated.

In the act of October 6, 1917, (Public 90, 65th Cong.), War Risk Act, as amended, provided that total disability was to be rated at 100 percent and paid accordingly; also, that in addition thereto for certain specified conditions the "totally disabled" veterans was to receive additional monetary awards. Subsequent legislation extended the definition of "total disability" for specified disabilities. Age, per se, was never mentioned as a factor to be taken in consideration in determining total disability. Total disability was 100 percent, or established by law or specified conditions.

The 1925 Veterans' Bureau schedule for Disability Ratings, although based on the California Workmen's Compensation schedule where age is taken into consideration in the percentage rating, did not consider age as a factor in the determination of "total disability" ratings.

The Veterans' Administration Schedule for rating disabilities, originally contained no "age factor" that was to be considered in the determination of "total disability," and as promulgated in Veterans Regulation 1 (a), parts I, II, III, by Executive Order No. 6156, June 6, 1933.

On November 15, 1941, an administrative presumption of total disability was promulgated by extension No. 4 to the schedule for rating disabilities, 1933 edition. The extension provided, that total disabil-

ity was to be determined on the basis of 1 disability rated at 60 percent or more; and that if there were 2 or more disabilities, 1 had to be rated at 40 percent and the combination to equal 70 percent. For pension purposes (award for non-service-connected disabilities) the above requirements were to be reduced by 10 percent on the attainment of age 60; and an additional 10 percent on the attainment of age 65; and that there was to be no percentage requirements for total disability ratings in the cases of unemployable veterans who have reached age 70.

The revised 1945 Schedule for Rating Disabilities incorporated the above "yardsticks" of total disability in paragraphs 15, 16, and 17, pages 5–6. On October 7, 1948, a further administrative presumption of total disability was promulgated in extension No. 5 to the 1945 Schedule for Rating Disabilities. The extension may be found in appendix I.

What is the medical validity of these yardsticks? [*Relating to total disability.*]

Coded Question H

Table 22.—*Grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	7	4
Qualified	29	19
No:		
Unqualified	18	12
Qualified	32	21
Indeterminate	46	30
Unanswered	21	14
Grand total	153	

Table 23.—*Distribution of replies by respondents' medical specialities*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	1	1	3		1	2
Neurology	7	2			1	3	1
Internal and general medicine	13	1	2	6	2	2	
Tuberculosis	9	1	2		1	2	3
Peripheral vascular diseases	4			1	1	2	
Cardiovascular diseases	7		1		3	2	1
Allergy	6	1		1	1	2	1
Gastroenterology	6			1	2	3	
Tropical diseases	7		2		3	2	
Gerontology	6			1	1	2	2
General surgery	11		6	1	2	1	1
Orthopedics	10			1	2	5	2
Neurosurgery	6				3	3	
Plastic surgery	6		2		1	2	1
Audiology and ear, nose, throat	7		2	1	1		3
Ophthalmology	6		1		2	2	1
Urology	7		1		1	4	1
Rehabilitation and physical medicine	8		4	1	2	1	
Dermatology	6		1		1	2	2
Industrial medicine	9		3	1	1	4	
Other	4	1	1		1	1	
Total	153	7	29	18	32	46	21

TABLE 24.—*Presumption of total disability; distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	2	3	------	------	2	10	1	5	1	5	1
Qualified	20	28	4	21	1	5	2	10	1	5	1
No:											
Unqualified	10	14	3	16	------	------	3	15	2	10	----------
Qualified	16	23	3	16	6	30	2	10	4	20	1
Indeterminate	11	16	3	16	11	55	11	55	9	45	1
Unanswered	11	16	6	31	------	------	1	5	3	15	----------
Total	70	------	19	------	20	------	20	------	20	------	4

Discussion

Two respondents out of 7 were vague in their replies to this question, and 1 out of 7 did not answer the question. One out of 4 stated that these yardsticks were medically valid. One of 3 respondents replied that the yardsticks, as contained in the Veterans Administration schedule for rating disabilities, as amended, were not medically valid.

Eight of the 13 respondents, practicing in the medical specialty of internal medicine, felt that the yardsticks, as contained in the Veterans' Administration schedule for rating disabilities, for total disability are not medically valid; 3 expressed the opposition opinion, and 2 were vague in their answer.

Six of the respondents practicing surgery were of the opinion that these yardsticks were medically valid, while 3 were not of this opinion; 1 was vague in his answer and 1 did not answer the question.

Twenty-six of the 70 nongovernmental private practitioners stated that the yardsticks, as contained in the schedule and amendment, were not medically valid; 22 were of the opposite viewpoint; 1 did not answer the question; and 11 were vague in their replies.

The medical respondents in the Department of Medicine and Surgery in the Veterans' Administration, Navy, Army, and Air Force were inclined, as a majority, to feel that the yardsticks as contained in the schedule for rating disabilities, and as amended, were not medically valid.

Representative comments of the majority (yardsticks are not medically valid)

As I understand it, the specified requirements for rating total disability are waived under certain circumstances in the case of unemployability as a result of the existing disability. This is understandable and there is some logic in it if it can be ascertained that the veteran in question is truly unemployable because of the disability. On the other hand, I see no supporting medical basis for specific mathematical provisions permitting such waiver; viz, a disability rated at 60 percent or combination of 2 disabilities adding to 70 percent or more. There is no obvious logic in these particular figures. I think honest unemployability in a partially disabled person is the essential criterion, and I think even this should take into account unemployment compensations from other sources. Most of the actual disabilities named might interfere with employment, although the category "disabilities affecting a single system" seems too vague for intelligent application.

* * * * * * *

There is very little in my opinion. Total disability should be assigned according to the disease or injury.

* * * * * *

It is a matter of judgment in individual cases. It cannot be gaged solely upon an individual's ability to resume some form of gainful work.

* * * * * *

It seems to me that the 60 percent rating for total disability and 70 percent combination rating for total disability are very generous in relation to the overall book ratings which appear to run 10 to 20 percent high. If valid at all, the validity would be more sociological than medical.

* * * * * *

In most instances, these yardsticks in themselves lack medical validity. There is medical validity in the statement in paragraph No. 16 of the rating schedule that total disability rating may be assigned when the requirements of permanence are met without regard for the rating schedule when the individual is unemployable because of his disabilities. The percentage ratings governing this, however, are not valid. If a disabled veteran is really unemployable, his rating should be made 100 percent after reclassification. Total disability with a 60 or 70 percent rating is illogical. This applies also in the percentage reductions given in special consideration of age (par. 17).

* * * * * *

Determination of total disability under paragraph 16 (p. 5 of schedule) and extension No. 5 are made without regard to the specific provisions of the rating schedule provided certain percentages, and permanence is met. It seems to me that while there is medical validity in determining there is a permanent condition ratable at some percent of total, the final determination is made on the basis of nonmedical evaluation, i. e., "unable to secure or follow a substantially gainful occupation * * *." The medical area is that the veteran either has or does not have the physical or mental capacity to engage in some occupation. Whether, having the capacity, he is able to "secure or follow a substantially gainful occupation" involves a host of other factors outside of medicine. Therefore, it seems to me that while there is a basic area having medical validity, the total process goes beyond medicine and dilutes the medical validity by becoming a medical-legal or medical-social determination.

* * * * * *

These yardsticks appear to measure 48 rather than 36 inches.

* * * * * *

The yardsticks are arbitrary rather than strictly medical, but are workable based on employability experience. Few industries would utilize a man with 60-percent disability, yet from a strictly medical point of view, some utilization under special conditions could be made of the rated subject.

* * * * * *

There is none. The big factor in most of these situations is motivation to do effective work and compensation possibilities. These are not, strictly speaking, medical.

* * * * * *

None in some cases. The loss of 1 hand or 1 foot is not a permanent total disability.

* * * * * *

The yardsticks referred to are presumably set up for the use of nonmedically trained personnel. If such is the case they are valid; if to be used by medical personnel they are invalid because each case must be considered individually. Actually, the problem is one of social and economic rehabilitation and should be considered by workers trained in those fields alone, in which case the yardsticks should provide only a starting point for such consideration.

* * * * * *

The yardsticks for total disability as referred to are considered impracticable. The extension No. 5, amending 1945 schedule by superimposing a further sliding scale for the disability and by adding three interpretative guides for employability simply created more confusion.

* * * * * *

Representative comments of the minority (yardsticks are medically valid)

I feel these yardsticks are valid, if not carelessly applied. Here we are dealing with totally unemployable individuals which usually have to have someone look after them. Of course the amounts each are paid is another question. The loss of earning power of a doctor as a result of his diabilities is not comparable with that of a common laborer, yet he receives no more but has lost considerably more.

* * * * * * *

I believe in general that they are valid. However, paragraph 16, page 5, in which total disability rating is granted for the amputation or the loss of the use of either hand, of either lower extremity above the knee, is subject to question. With the new prostheses available, gainful employment is definitely possible. Likewise, relative to extension No. 5, paragraph (a), marginal employment, it is certainly inconsistent that an individual is completely disabled and should be so rated when he is able to carry out on a farm or in his own business at less than half the usual hours of work or less than half the usual remuneration. Such men from a medical standpoint cannot be considered as completely disabled and it is my impression that this is the opinion of the industrial commissions.

* * * * * * *

These yardsticks seem to be medically valid, but every precaution should be taken to prevent individuals from claiming unemployability as a basis for total disability, especially as they get older. This is something that will have to be handled on an individual basis in each case as is provided.

* * * * * * *

The yardsticks for total disability are valid, in my opinion, only when the veteran cannot, in fact, secure or follow a substantially gainful occupation. Many veterans when adequately treated and occupationally rehabilitated can and do follow a substantially gainful occupation.

* * * * * * *

These ratings seem fair to the patient. In the light of improved prosthetics and rehabilitation some changes could be considered. The statement of "unable to secure or follow a substantially gainful occupation is important and there may be need for great encouragement and guidance in a patient having to change his occupation, but there is universal agreement that the patient is better doing something than nothing.

* * * * * * *

These yardsticks are generally valid today. An exception may be assessment of degree of disability in patients whose major lesion has been successfully excised by the surgeon. Employment of pulmonary function studies may be of value on these and other arrested and inactive cases, in addition to other diagnostic tools.

* * * * * * *

Medically, reasonably valid; administratively, confusing, bulky, and difficult to apply with fairness to all.

* * * * * * *

They are valid only in general terms of approximately. The value of these yardsticks and of the "schedule" as a whole lies in their administrability, not their clinical validity.

* * * * * * *

As a whole I feel that they are about right and are certainly fair, except for the recent trend of unwillingness to employ workers in the older age group.

* * * * * * *

If properly applied perhaps as valid or more so than percentage. In many instances percentage disability actually erroneously grade ability to work.

Summary and conclusions

The summary and conclusion to this question are incorporated in the summary of the following two questions.

Coded question I

From your experience, what proportion of people would have a degree of disability 10 percent or more at age 65 on the basis of the standards in the schedule?

Background

The background to this question is contained in the above introduction to the problem of presumptions of total disability.

Discussion

The worded question did not specify how the "proportion" was to be stated, that is, in percentages, adjectivally, or in fractions. As a result, the replies were reclassified:

(*a*) Those respondents who answered the question by using adjectives, such as: high, most, nearly all, majority, etc.

(*b*) Those respondents who included percentages in their replies.

The following shows the percent of distribution of the replies by the new reclassification:

(*a*) Twenty-one percent of the respondents used adjective in describing the proportion of people who would have a 10 percent or more disability at age 65.

(*b*) Fifty-nine percent of the respondents used percentages to indicate the proportion of people who would have a 10 percent or more disability at age 65. These were assembled into groups of percentages as follows:

Of the 59 percent of respondents' replies in (*b*) above, the following shows, in percentages, the proportion of people believed to have a disability of 10 percent or more at age 65:

Percent of people having disability 10 percent or more at age 65

Percent of respondents' replies:	
26 percent said	90 to 100 percent.
4 percent said	80 to 90 percent.
10 percent said	60 to 80 percent.
11 percent said	40 to 60 percent.
4 percent said	20 to 40 percent.
4 percent said	0 to 20 percent.
59 percent total.	

Fourteen percent of the respondents did not reply to the question, and less than 1 percent were vague in their replies.

Coded Question I

Table 25.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	123	80
Qualified	6	4
No:		
Unqualified	----------	----------
Qualified	----------	----------
Indeterminate	2	1
Unanswered	22	15
Grand total	153	----------

TABLE 26.—*Presumption of total disability; distribution of replies, by respondents' medical specialty*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	6					2
Neurology	7	6					1
Internal and general medicine	13	11	1				1
Tuberculosis	9	7					2
Peripheral vascular disease	4	4					
Cardiovascular disease	7	6					1
Allergy	6	5				1	
Gastroenterology	6	5					1
Tropical diseases	7	3	1				3
Gerontology	6	5					1
General surgery	11	8	2				1
Orthopedics	10	8	1				1
Neurosurgery	6	5					1
Plastic surgery	6	3				1	2
Audiology and ear, nose, and throat	7	7					
Opthalmology	6	5					1
Urology	7	6					1
Rehabilitation and physical medicine	8	6					2
Dermatology	6	5					1
Industrial medicine	9	9					
Other	4	3	1				
Total	153	123	6			2	22

TABLE 27.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	49	70	14	74	20	100	18	90	19	95	3
Qualified	4	6					1	5			1
No:											
Unqualified											
Qualified											
Indeterminate	2	3									
Unanswered	15	21	5	26			1	5	1	5	
Total	70		19		20		20		20		4

Representative comments of respondents expressing percentages

I have no figures available but in estimating I would say that it would closely approach 100 percent.

* * * * * *

I believe if a thorough search is made of each individual over age 65 years we could approach, almost 100 percent could have a disability rating of 10 percent or more. Occult carcinoma of the prostate is one example where the Government gains and the individual loses.

* * * * * *

Certainly 100 percent of population at age of 65 would show symptoms listed under psuchosis namely: "slight impairment of social and industrial adaptability." Under psychoneurosis the term "moderate"—10 percent; in the footnote this is modified to "mild (symptoms) when findings actually interfere with employability." I would say that most people at 65 could have these symptons and have some of them.

* * * * * *

I would say between 90 and 100 percent of all people at age 65 would have at least 10 percent disability according to this schedule.

* * * * * * *

At least 80 percent of people would be found to have generalized arteriosclerosis "with slight weakening of bodily vigor," and is rated 20 percent.

* * * * * * *

About 75 to 80 percent—higher if diagnosis of generalized arteriosclerosis is casually made.

* * * * * * *

Possibly 75 percent. Depends entirely on type of employment, profession, source of livelihood, etc. Labor laws reretirement, social security, etc., enter into this problem.

* * * * * * *

Twenty-five percent at least.

* * * * * * *

Representative comments of respondent expressing proportions with adjectives

It would be difficult to estimate this percentagewise, but my impression is that a very large proportion of persons would have a disability rating of 10 percent for one reason or other at age 65.

* * * * * * *

A large proportion of people at age of 65, have 10 percent or more disability.

* * * * * * *

Most people age 65 could be rated as 10 percent disability on the basis of arteriosclerosis if nothing else, perhaps asymptomatic arthritis of the spine demonstrable by X-ray or some similar degenerative change due to age. In my experience a great many men who retired from professional, administrative or industrial jobs at the age of 65 because of local ground rules are quite dissatisfied at being retired. They are still capable of excellent performance.

* * * * * * *

Most people on the ground that by the age of 65 practically everybody has some lessening of optimum function that might be interpreted as a disability affecting a single body system (e. g., digestive, cardio-vascular-renal, neuropsychiatric).

* * * * * * *

A very high percentage, in fact, I personally know of no one aged 65 who could not rate a 10 percent disability under these schedules.

* * * * * * *

I believe practically everyone over the age of 55 would have a disability of 10 percent or more, but do not believe this would be significant from a functional standpoint.

* * * * * * *

Summary and conclusions

The summary and conclusions are incorporated below with all summaries and conclusions of the several questions on the presumptions of total disability.

Coded question J

Is there a set percentage or yardstick by which it can be said that a person with a single disability and rated some percentage (e. g., 10, 60, or 70 percent), is totally disabled? A combination of disabilities? At a certain age?

Is there a set percentage or yardstick by which it can be said that a person with a combination of disabilities and rated some percentage is totally disabled?

Background

The background to this question is contained in the above introduction to the problem of presumptions of total disability.

Discussion

Over two-thirds of the respondents clearly expressed the viewpoint that there is no set percentage or yardstick by which it can be said that a person with a single disability and rated some percentage is totally disabled. One out of 50 respondents stated the opposite viewpoint; 14 of the total number of the respondents were vague in their replies; and 13 of the total number of respondents did not answer the question.

The reply distribution, by number, and the respondents' medical specialty showed that in all of the medical specialties there was virtually unanimous opinion that there is no set percentage by which it can be said that a person with a single disability and rated some percentage, is totally disabled. This same unanimous opinion was expressed by both nongovernmental and governmental medical practitioners.

Coded Question J

Table 28.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	0	----------
Qualified	3	2
No:		
Unqualified	91	59
Qualified	32	21
Indeterminate	14	9
Unanswered	13	9
Grand total	153	----------

Table 29.—*Presumption of total disability: Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	----------	----------	4	1	1	2
Neurology	7	----------	1	2	----------	2	2
Internal and general medicine	13	----------	----------	9	4	----------	----------
Tuberculosis	9	----------	----------	5	3	----------	1
Peripheral vascular diseases	4	----------	----------	3	1	----------	----------
Cardiovascular diseases	7	----------	----------	6	----------	1	----------
Allergy	6	----------	----------	4	1	----------	1
Gastroenterology	6	----------	----------	5	----------	1	----------
Tropical diseases	7	----------	----------	5	----------	1	1
Gerontology	6	----------	----------	4	----------	1	1
General surgery	11	----------	----------	8	2	----------	1
Orthopedics	10	----------	2	4	2	2	----------
Neurosurgery	6	----------	----------	4	1	1	----------
Plastic surgery	6	----------	----------	2	2	1	1
Audiology and ear, nose, and throat	7	----------	----------	4	3	----------	----------
Ophthalmology	6	----------	----------	4	1	1	----------
Urology	7	----------	----------	3	2	1	1
Rehabilitation and physical medicine	8	----------	----------	3	4	----------	1
Dermatology	6	----------	----------	2	2	1	1
Industrial medicine	9	----------	----------	6	3	----------	----------
Other	4	----------	----------	4	----------	----------	----------
Total	153	----------	3	91	32	14	13

TABLE 30.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										Others
	PP		VA		NAV		ARM		AF		
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	------	------	------	------	------	------	------	------	------	------	----------
Qualified	2	3	------	------	------	------	------	------	1	5	----------
No:											
Unqualified	39	56	10	53	15	75	12	60	11	55	4
Qualified	17	24	4	21	4	20	3	15	4	20	----------
Indeterminate	5	7	------	------	1	5	5	25	3	15	----------
Unanswered	7	10	5	26	------	------	------	------	1	5	----------
Total	70	------	19	------	20	------	20	------	20	------	4

Analysis of replies

Eighteen of the 153 medical respondents replied that a combination of 2 or more disabilities, and rated some percentage should be considered totally disabled. Nine of the 18 respondents who were of this opinion, did not state what the set percentage should be in the make-up of this yardstick; the remaining 9 respondents with the viewpoint further qualified their replies by a recommended set percentages as the yardstick:

(*a*) Three respondents stated that by definition total disability should be 100 percent.

(*b*) One respondent said, "Disabilities of 80 or 90 percent should be considered 100 percent."

(*c*) Two respondents recommended combined disabilities of 70–80 percent, as a yardstick for total disability.

(*d*) One said, "Two disabilities each rating 50 percent or more, or in any combination adding up to over 100 percent should constituted total disability."

(*e*) One believed that total disability should be granted when a combination of disabilities averaged 40 percent or more.

(*f*) The remaining respondent had a unique recommendation: "If the percentage is 100 or greater by adding to the greatest disability the percentages for half the lesser."

Multiple disabilities as a factor in total disability

Sixteen of the total 153 medical respondents did not answer the second part of question J; and 5 respondents of 153 total were vague in their replies. One hundred thirteen respondents, of the grand total of 153, were of the opinion that there is no set percentage or yardstick by which it can be said that a person with a combination of disabilities and rated some percentage, is totally disabled. Representative comments of this group are:

No, not that I can define or foresee. The only equitable method that occurs to me is the appraisal in the individual case, in reference to the training, skill, and ability, and job versatility, and the nature of the disease or injury, its complications and residuals, and the impairment in these skills and abilities by the disease or injury. Perhaps this is an impractical approach on such a large number of disability claims.

* * * * * * *

Here again, any figure used appears to be arbitrary. The claimant's type of work and his motivation for self-support will all be factors which will reduce

individual variations from a definite percentage. This applies to a single disability, a combination of disabilities, and to the case factor.

* * * * * *

It is possible that certain combinations of disabilities may totally incapacitate an individual for specific occupation or profession. On the other hand, other combinations of single disabilities might total to a much higher percentage and may interfere with the patient's occupation to only a minimal degree.

* * * * * *

There is no set percentage for any one disability, combination of disabilities, or a given age which will necessarily result in total disability. People differ very widely in their reaction to their disability. The type of a person's occupation, his motivation, interest, etc., also affect his ability to earn a livelihood in the face of his physical or mental handicap.

Individual judgment. That's no accurate way of measuring them.

* * * * * *

I don't believe that any 1 set percentage or yardstick, or a combination of the 2 can adequately apply to any 1 patient. Each veteran must be evaluated from his own mental, physical, social, and economic standpoint.

* * * * * *

This should be determined by a special rating board, medical, social, and economic.

* * * * * *

Each case must be individualized and the recommendation of the examining board who actually see the veteran be carefully considered.

Analysis of the third part of the question—Age as a factor and yardstick in total disability ratings

A third part to the question on total disability and the yardsticks for this determination was the age factor:

Is there a set percentage or yardstick by which it can be said that a person with a single disability and rated some percentage, *at a certain age*, is totally disabled?

Twenty-four respondents from the grand total of 153 expressed the opinion that age as a factor and a yardstick should be taken into consideration in total disability ratings; 10 of the respondents believed that the yardstick should start at age 65 years; 2 respondents believed starting at age 60 years as a yardstick; 4 respondents set the age factor from 45 to 60 years; and the remainder of the 24 respondents in this group did not commit themselves to any age period. Representative comments of this group analyzed are:

Probably after age 75 (years).

* * * * * *

For purposes of common manual labor, job acceptance, and lasting gainful employment, age 65, or at least 70, is a point where the vast majority of individuals may be said to be totally disabled.

* * * * * *

None other than prevailing economic conditions, mandatory retirement at age 65 and labor market of supply and demand.

* * * * * *

Although I agree that a lower percentage of disability as the veterans becomes older and, particularly, after the age of 55; but again I don't see how one could outline a set percentage or yardstick which will apply in all cases. It seems to me that each case must be individualized and considered on its own merits.

* * * * * *

The obviously totally disabled veteran is no problem to adjudicate. The border line, ne'er-do-well, is the problem. Younger individuals can learn new

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skills, trades, or professions. Older veterans cannot or will not and are thus less employable. Fifty years of age might be the dividing line.

* * * * * *

Age is definitely a frequent factor, and as such, the percent increases with age.

* * * * * *

A disability in a young person may not totally disable him whereas the same disability in an older person, combined with the infirmities of age, would render him totally disabled.

* * * * * *

Yes; at the unemployable age in this economic era.

* * * * * *

Age should be considered only when it per se affects employability on the open labor market, that is, age plus disability, plus general condition.

* * * * * *

Twenty-three respondents out of the grand total of one hundred and fifty-three did not answer the third part of the question on total disability yardsticks, and the age factor. Six respondents of the grand total of one hundred and fifty-three were vague in their reply to the question on total disability yardsticks, and the age factor.

Two-thirds of the grand total of 153 respondents stated that there was no set percentage or yardstick by which it can be said a person with a single disability and rated some percentage, at a certain age, is totally disabled. Some typical comments from this group are given:

No; age is not entirely a variable matter with respect to disability.

* * * * * *

No; some elderly people are very capable of earning a living; others are not. Difficult to measure by age alone.

* * * * * *

It would not be possible to specify a certain age for all people. Many retired from their regular job at 65, do well financially in other forms of employment.

* * * * * *

No; I recently saw an 83-year-old man who was active in civil defense in his community and was in excellent health.

* * * * * *

No; there are many people who at 75 or over are alert, robust, and active and by the same token many younger people who have deteriorated much earlier in life.

* * * * * *

No; however, it must be borne in mind that veterans age 65 or more find it impossible to find work.

* * * * * *

None that I know of, because there is such a difference in patients.

* * * * * *

No; because chronological age in some individuals means nothing. Physiological age is all important in disease and pathology.

* * * * * *

Since almost every citizen is covered by old-age pension or social security, or both, I do not see how the age factor can logically be brought into the veterans' compensation rates.

* * * * * *

When "age" looms large as a factor, one gets too close to an "old-age" program rather than a disability pension one.

Other typical comments to this question on total disability, and yardsticks

I believe this represents an honest attempt to arrive at the conclusion that the claimant is totally disabled. The matter of exaggeration of disability is of great importance and a careful study of the veteran's civilian work record is also important. There are said to be about 3 million civilians unemployable at all times. Some of these are bound to be veterans.

* * * * * *

Permanent disability is the sum total of malordered physical, psychic, and social factors. The disabled person can overcome one major (60 or over) physical disability and may be further assisted to overcome a combination of physical and psychic disabilities but his fellowman may not accept him as employable or acceptable with his known handicap. Multiple physical disabilities (40, 20, 12—75 percent) can produce losses of strength, agility, stamina, coordination, perception and social acceptance, which in combination may make the disabled person unemployable.

* * * * * * *

Those yardsticks seem to represent a fair appraisal of physical disability and the consequent loss of earning power. Much of the latter may be based on the inability of older persons to obtain employment through employer reluctance.

* * * * * * *

I do not understand the use of language which designate one and the same disability as "60 percent of total" in one breath and "total disability" in another. I suspect that the intent of lawyers rather than the judgment of physicians and rehabilitation experts is responsible for the definitions of total disability and employability.

* * * * * * *

What is the medical validity of these yardsticks? I tend to agree that in many cases total disability ratings are justifiable when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantial gainful occupation as result of his disabilities, providing 1 of his disabilities is rated at 60 percent or above and that, if there are 2 or more disabilities, there should be at least 1 disability rated at 40 percent or above, and sufficient additional disabilities to bring the combined rating to 70 percent or above. I do not agree that total disability ratings should always be granted for persons with deafness and with the amputation or loss of use of one hand or of one lower extremity above the knee. It is realized that there is a qualifying statement which reads "when followed by unemployability"; however, it does not seem logical to assume that unemployability will always be the case in all of these persons. My comments regarding the amendment in extension No. 5, are as follows: I agree that age should be a factor and that the percentage of disability should be lower, and probably 60 percent rating at age 55 and 50 percent at age 60 are reasonably valid. However, I do not agree that there are medical reasons for granting total disability rating at age 65 when the percentage requirement is only 10 percent.

* * * * * * *

Summary and conclusions

The yardsticks for total disability, as established in the schedule for rating disabilities, in current use, and as amended by extension No. 5 are not entirely medically valid. Each case has to be judged on its own merits. Age and combinations of disabilities may or may not cause unemployability, depending upon many other factors not considered in the yardsticks. There is no medical validity to establish a yardstick of 10-percent disability at age 65 with unemployability as indicative of total disability.

These criteria for the establishment of total disability would seem reasonable insofar as the provision of inability to secure or follow a gainful occupation is concerned. Establishing yardsticks on a per centile basis is much more difficult and there the dangers involved in any sweeping generalization become apparent. Certainly, many individuals aged 55 to 60 with 50 to 60 percent rated disabilities are capable of gainful occupation; conversely, some individuals in this age group with a lesser degree of disability rating are in fact prevented from engaging in substantially gainful occupations because of age, and not because of less seriously considered infirmities.

In general, it would seem reasonable to upgrade these yeardsticks, or to place less emphasis on percentagewise criteria and more on the essential problem of gainful employability.

SUMMARY TABLE ON PRESUMPTIONS

A summary table on the presumptions relating to service connection of disability, percent of grand total of all questions and replies is included in the following page. Details required for explanation of any coded question may be found by reference to that question in this chapter. A summary, and conclusions on all of the respondents' replies is contained in the last chapter of this report.

TABLE 31.—*Summary on presumptions relating to service-connection of disability: Distribution of grand total, all questions and replies*

Presumptions	Question code letter	Classified replies											
		Yes				No				Indeterminate		Unanswered	
		Unqualified		Qualified		Unqualified		Qualified					
		Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Sound condition	A	50	33	16	11	29	19	48	31	8	5	2	1
Service connection	B	56	37	19	12	29	19	29	19	13	8	7	5
	C	22	14	23	15	18	12	58	38	24	16	8	5
	D	2	1	54	35	16	11	15	10	23	15	43	28
	E	20	13	9	6	42	27	21	14	24	16	37	24
	F	39	26	20	13	17	11	19	12	16	11	42	27
	G	51	33	41	27	6	4	8	5	11	7	36	24
Total disability	H	7	4	29	19	18	12	32	21	46	30	21	14
	I	123	81	6	4	------	------	------	------	2	1	22	14
	J	------	------	3	2	91	60	32	21	14	9	13	8

NOTE.—Grand total, 153.

CHAPTER III. VETERANS' ADMINISTRATION SCHEDULE FOR RATING DISABILITIES, BASIC PERCENTAGE AWARDS, AND REEXAMINATIONS. MEDICAL STRUCTURE AND SCOPE OF THE SCHEDULE FOR RATING DISABILITIES

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INTRODUCTION

The basic concern in the Veterans' Administration compensation and pension program is the adjudication of claims, that is, determination and entitlement, or nonentitlement to, and the rate of compensation or pension for disability or death by the veterans of various wars and of the Regular Establishment, and their surviving dependents. The purpose of adjudicating claims is to provide monetary benefits as compensation for impaired, or lost earning capacity as a result of disability, or death due to disease or injury incurred in or aggravated by military service, or presumptively connected therewith, as indicated in chapter II of this section.

During the process of adjudicating an authorized claim, the case is presented to a rating board in one of the various regional offices of the Veterans' Administration where it is the function of the board to determine service connection and to evaluate the veterans' disabilities in accordance with the schedule for rating disabilities. After an award is made, several situations may arise: (1) If the disability is not static, reexamination is scheduled in accordance with Veterans' Administration regulations; (2) the veteran may claim an increase in the severity of his condition in which event he is reexamined and the results of the examination reevaluated by the rating board.

Prior to 1917 awards for service-connected disabilities were based upon a table of monetary rates for total and partial disabilities. The present schedule for rating disabilities was started in 1917. The War Risk Insurance Act, created a new system of evaluation of disability claims and awards. A veteran's disabilities were processed and evaluated by a new principle, based upon social insurance and workmen's compensation practices in the various States at that time. The new system called for an adoption of a schedule of ratings of reductions in earning capacity resulting from specific injuries or combinations of injuries. The ratings were to be based upon the average impairments in earning capacity resulting from such injuries in civil occupations and not upon the impairment in earning capacity in each individual case. Further, the law established the requirement that the schedule of ratings was to be readjusted from time to time in accordance with actual experience. The rating schedule was originated and designed hopefully on a scientific basis; and was to be revised and readjusted in accordance with actual experience. This "experience" has materialized, and the schedule of ratings has undergone several revisions, but the question or questions still remain—Whose actual experience? What kind of actual experience? When should this actual experience dictate a revision? Who was to designate the time of revision, after actual experience dictated? Or, does actual experience dictate any revision of the veterans schedule for rating disabilities? It is now 11 years since the last revision of the schedule for rating disabilities, and we have passed through another national emergency, with only 9 amendments by extensions to the schedule for rating disabilities. What are the criticisms of the current schedule? Is it outmoded? Is it in accord with the accepted medical principles and standard medical nomenclature? Are the ratings for the various disabilities equitable?

The following list of questions were submitted to the medical specialists. Their replies have been analyzed separately under each question in the following pages.

QUESTION

Code letter of question

K Are the disability ratings in accord with present-day accepted medical principles?

L Is the disease nomenclature in accord with present-day medical standards?

M Do the medical criteria reflect accurately the residuals of the injury or disease for different percentage ratings?

N Is it medically feasible to assign graduations within an accuracy of 10 percent, when determining the percentage of bodily and mental impairment? If not, what scale of graduations do you regard as feasible?

O In your opinion, do the ratings fairly represent the average impairment of earning capacity resulting from the various degrees of severity of physical impairment?

P Do the disabilities at 10 percent and 20 percent constitute a material impairment of earning capacity?

Q Do you know of any medical data which can be used to set percentage ratings to represent the average impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations?

IS DISABILITY RATING IN ACCORD WITH PRESENT-DAY MEDICAL PRINCIPLES?

Coded question K

Are the disability ratings in accord with present-day medical principles?

Background

When the system of disability ratings, by percentages, was introduced and developed nearly 40 years ago, it was based on the anatomical concept of medicine. This was known as the dismemberment schedule. Ability and disability, and competence, were measured in terms of loss of part of the body. The degree to which a man was considered disabled was determined on the body as a whole. There was some justification for this concept at that time, since many of the jobs were manual in nature and did not require the specialized skill they do at present. The concept that an individual was fit or unfit, and that he could do the whole job or none of it, had some degree of medical and economic validity. The disability was visible and obvious, and rated accordingly.

Today, disability ratings are made upon the obvious disability—and that which is not so obvious. Too, the role of medical rehabilitation has greatly altered the ability to work; and the earning power of the disabled veteran. Consequently, with present day medical treatment, followed by proper rehabilitation, many veterans who previously would have been unemployable now have an earning capacity equal to or greater than that prior to service. There have been other changes in compensation medicine too, since the Veterans' Administration Schedule for Rating Disabilities was originally prepared when there were comparatively few compensation laws in existence, and almost no data on injuries or disease on which to base a scientific analysis from factual field studies. That the schedule was considered tentative and far from a finished product appears over and over again. Medical principles have changed also. Military-medical practice and treatment is another great change.

Accepted medical principles are fundamental deductions, consistent with medical facts, and based upon observation of a large number of cases. The large number of cases upon which to base fundamental deductions consistent with medical facts are available.

Discussion

The discussion is contained in the summary and conclusion to this question.

Coded Question K

Table 32.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	37	24
Qualified	60	39
No:		
Unqualified	32	21
Qualified	15	10
Indeterminate	8	5
Unanswered	1	1
Grand total	153	

Table 33.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	3	2	2	1		
Neurology	7	5			2		
Internal and general medicine	13	1	6	5	1		
Tuberculosis	9		5	3	1		
Peripheral vascular diseases	4	1	2	1			
Cardiovascular diseases	7	1	4	1		1	
Allergy	6	1	4	1			
Gastroenterology	6	1	3	2			
Tropical diseases	7	2	3	1	1		
Gerontology	6	1	2	2	1		
General surgery	11	1	7	2	1		
Orthodepics	10	3	3	1	1	2	
Neurosurgery	6	1	3		1	1	
Plastic surgery	6	2	2		2		
Audiology and ear, nose, throat	7	1	4	2			
Opthalmology	6	3	1	1		1	
Urology	7	3	3		1		
Rehabilitation and physical medicine	8	2	1	2		2	1
Dermatology	6			4	2		
Industrial medicine	9	4	3	2			
Other	4	1	2			1	
Total	153	37	60	32	15	8	1

Table 34.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	17	24	7	37	5	25	3	15	4	20	1
Qualified	25	36	6	32	11	55	10	50	6	30	2
No:											
Unqualified	20	29	1	5	2	10	3	15	6	30	
Qualified	4	6	5	26			2	10	4	20	
Indeterminate	4	6			1	5	2	10			1
Unanswered					1	5					
Total	70		19		20		20		20		4

Representative comments of the majority (disability ratings are in accord with present-day medical principles)

Yes. In general, but accepted medical principles call for the application of all available approved methods of treatment and rehabilitation. Hence, disability ratings ought to be assigned only concurrently with or after such treatment and/or rehabilitation.

* * * * * * *

Yes. In general, I believe the disability ratings of veterans are in accord with present-day accepted principles. Judging from the disability ratings in a few instances by the industrial commission of one State of which I have knowledge, it is my impression the Veterans' Administration is more liberal in its decisions.

* * * * * * *

Generally, yes. However, there are a number of conditions which are overrated. For example, surgery should be done for disease improved by operation instead of allowing continued disability. Examples include hemorrhoids, 20 percent, hernias, postoperative, from 10 to 40 percent; resection of the small intestine, up to 40 percent; and chronic cholecystitis, 10 to 30 percent.

* * * * * * *

In general, yes. However, the rating of 40 percent for a subtotal gastric resection per se seems excessive. Present-day statistics on results of subtotal gastric resection for ulcer indicate a very high percentage (55–85 percent) of patients have no untoward symptoms following resection, eat 3 meals a day, smoke, drink, etc., and have no impairment of earning capacity.

* * * * * * *

In general, yes. But, numerous individual items need revision in the light of changes in modern therapy.

* * * * * * *

Generally, yes. There should be ratings for the organic psychoses. Psychoses with mental deficiency or "psychopathic personality" are disabling, should rate better than zero.

* * * * * * *

In general, these standards are acceptable, however, in extension 8–A, the use of bone-conduction testing is not acceptable because bone-conduction has never been standardized.

* * * * * * *

The disability ratings for the most part are in accord with present-day accepted medical principles. However, some of the ratings are obsolete because of advances in therapy. This is particularly true in the field of tuberculosis, wherein rapid advances have been made both in chemotherapy and in surgical treatment. To a certain extent it is true in vascular lesions, such as traumatic arteriovenous aneurysms where, in certain cases, surgery offers hopes of a cure.

* * * * * * *

In most instances, yes. It would appear desirable to modify disability ratings for many diseases on the basis of whether they are amenable to surgical correction and whether such treatment has been made available, attempted, or refused. This has been done to some extent on hernias.

* * * * * * *

Yes, with the following exceptions: Arteriosclerosis, generalized, is ambiguous and ratings for disability incident to arteriosclerosis should be based on incapacities produced by impaired function of a specific organ, namely the brain, kidney, extremities, coronary arteries, etc. "Slight weakening of bodily vigor" may be due to a dysfunction of one of the endocrine glands, anemia, inactivity, hysteria, and dozens of other causes. I believe this category should be eliminated in favor of specific visceral impairment due to arteriosclerosis.

* * * * * * *

Yes, reasonably, although the subjective element of the examiner is very obvious in this evaluation.

* * * * * * *

Yes, the system of ratings is satisfactory. The figures given are not always in line with accepted values.

* * * * * * *

Representative comments of the minority (disability ratings are not in accord with present day medical principles)

The term "accepted medical principles" is, of course, open to controversy because of its breadth and lack of precise definition. Using the term to mean "my impression of the consensus of opinion of the leaders in the field of physical medicine," the answer to this question is "yes," in some instances and "no" in others.

* * * * * * *

Not entirely. Certain conditions which were once quite incapacitating, now, under modern treatments, plus more and practical rehabilitation, there is little or no residual incapacity as to making a living, provided, of course, that the veteran will cooperate sincerely and do his part.

* * * * * * *

No. A large number of the disability ratings do not properly take into account recent advances in medical rehabilitation, improved prostheses, reconstructive orthopedic procedures, and improved plastic surgery procedures.

* * * * * * *

Believe they require extensive review mainly from the aspect of impairment of function and progression.

* * * * * * *

It is generally accepted that the severity of an impairment can be rated or graded on the basis of medical findings. Whether or not a physical or mental impairment of a given degree of severity can be translated into an average loss of earning capacity is open to question.

* * * * * * *

No, although the announced policy of disability awards is based on degrees of disability preventing the individual from performing work, in most instances it appears that the ratings are based primarily upon diagnosis and anatomical findings rather than upon functional loss resulting in inability to perform work.

* * * * * * *

Not exactly as outlined. Frequently, it is difficult for the rating officer to secure an accurate concept as to the extent of the condition described by the medical examiner, thus the rating officer may make an error in percentage rating.

* * * * * * *

Not in entirety. For example, there is no necessary correlation between extent of a third degree burn scar and the functional impairment. A small scar interfering with the closure of the eyelids may be far more disabling than a large one of the back. Also, ulcerations of the soles of the feet are far more disabling than similar ulcerations of the legs.

* * * * * * *

In my opinion, no. This seems true, particularly, in the case of diseases of the cardiovascular system, gastrointestinal, and hematological systems.

* * * * * * *

Not in all cases. Frequently, the neurologic case are not supplied with definite, concise criteria for which basis an award for disability can be reasonably made. Instead, so-called minimum ratings are listed which are meaningless in the evaluation of the disabled individual and are subject to too much individual variability in interpretation.

* * * * * * *

Find it hard to reconcile compensation for such disorders as multiple sclerosis, amyotrophic lateral sclerosis, progressive muscular atrophy, Huntington's Chorea (always hereditary). At the same time myopathies or dystrophies are admitted.

* * * * * * *

In many cases the rating schedule allows payment of compensation following an operation regardless of the postoperative status of the patient. As exemplified by the compensation for duodenal ulcer, this often results in an increase in compensation despite the fact that the patient's symptoms and general health are improved by surgery. Under present-day medical standards surgery is performed only when it is anticipated that the operation will improve symptoms and save life, or aid in the rehabilitation of the patient and therefore one would anticipate that the disability rating would stay the same or would decrease following surgery rather than be increased.

* * * * * * *

No. In the present schedule for the skin, the criteria for designation of specific percentage disability ratings are included for eczema and scars. There is an additional statement to the effect that skin diseases, other than those mentioned, are to be rated as for eczema, dependent upon location, extent, and repugnant, or otherwise disabling character of manifestations. The criteria which are outlined under eczema for assignment of specific percentage disability are vague and inadequate. Eczematized cutaneous eruptions vary in their severity from week to week; it is not possible to estimate the percentage of disability on the basis of such criteria as the degree of crusting and ucleration, which are present at a given time. The occupation or profession of the affected veteran is a most important deciding factor in estimating disability due to chronic recurrent dermatitis. For example, a dentist who has a chronic eczematized eruption on only a few fingers of his hands may be completely incapacitated, whereas a much more extensive eruption involving his legs, for example, would be annoying but probably not incapacitating to any degree. On the other hand, a clerk who has a chronic eczematous eruption of the hands, of similar degree of severity, may not be incapacitated significantly. No attempt is made to outline criteria for estimating the percentage of disability in veterans with psoriasis and lupus erythematosus. The severity of involvement in lupus erythematosus may vary from 1 to 2 relatively inconspicuous scars on the face to severe systemic involvement, with a fatal prognosis. It seems to me that the instructions which are outlined for rating cutaneous diseases are particularly inadequate.

* * * * * *

No cardiovascular ratings too rigid for long periods without reevaluation. 30 percent ratings unnecessary. 10 percent for mild general arteriosclerosis, absurd. AV aneurysms amenable to correction.

* * * * * *

Allergy is not mentioned in 1945 schedule.

* * * * * *

I would say that, in general, the disability ratings are higher than we would interpret them here on a basis of workmen's compensation.

* * * * * *

Compared to industrial ratios in California, they range from the same to twice as much.

* * * * * *

I am not sure that I know the answer. The life and accident insurance people should be asked this one. I am sure disability ratings are necessary. I doubt that the ratings now employed are in accord with present-day medical knowledge and practice, since they have had no revision for 10 years. Many important changes have occurred in medicine during the past 10 years.

Summary and conclusions

In round figures, it would appear as if there was a predominance of opinion that the disability ratings were in accord with medical principles. A closer analysis of the replies from the respondents showed that the majority believed that the disability ratings in the Veterans Administration Schedule for Rating Disabilities are in general and in most instances, in accord with present-day accepted medical principles.

Representative comments of the majority (disease nomenclature in schedule is in accord with present day medical standards)

On the whole, yes. There is no such thing as acute, chronic, or incipient pernicious anemia, with rating on basis of disability due to the disease. Pyelitis is an obsolete term. Sinus tachyardia (rapid heart) is not a disease.

* * * * * *

Yes, with exceptions. The heading "Cholecystitis, chronic" is unsatisfactory as is the phrase "Gall bladder dyspepsia". Chronic cholecystitis per se is not a cause of symptoms and should not be compensable. The same is true of gall bladder colic which suggests the presence of stones. The same is true of gall bladder dyspepsia, which usually is due to aerophagia or some other functional disturbance. The phrase confirmed by "X-ray technique" is indefinite because it leaves room for erroneous roentgenologic diagnoses based on delayed emptying of the gall bladder and unusually large gall bladders, neither of which are significant. The significant roentgenologic signs are the demonstration of stones as

positive or negative shadows or nonvisualization of the gall bladder. A better heading, it would seem to me, would be cholelithiasis with recurring acute cholecystitis.

* * * * * * *

In general, yes. However, in case of distomiasis, the preferred term is paragonimiasis for lung flukes and clonorchiosis for liver flukes.

* * * * * * *

In general, yes. Notable exceptions are in the fields of cardiovascular, gastrointestinal, hematological, and neurological diseases.

* * * * * * *

In general, yes. There are some that require revision to meet with modern knowledge on these subjects.

* * * * * * *

In the main, it is. Although exceptions can be pointed out. For instance, there is no proper rating for regional enteritis, subacute or chronic, with the disabling symptoms it may produce. Certainly, it deserves a higher rating in its more severe forms than that of enteritis chronic 0–10 percent.

Still, a considerable number of respondents, who were of the majority opinion, agreed with the minority that numerous disability ratings and items in the schedule need revision in the light of changes in modern treatment, both surgical and medical, as disability ratings are changed when residuals of injuries and diseases are improved by operations, prostheses, and other mechanical aids, and particularly in the light of the new drug and surgical treatment of pulmonary tuberculosis. A large number of disability ratings do not properly take into account recent advances in medical rehabilitation, improved prostheses, reconstructive orthopedic surgery, and improved plastic surgery procedures.

IS DISEASE NOMENCLATURE IN ACCORD WITH PRESENT DAY MEDICAL STANDARDS?

Coded question L

Is the disease nomenclature in accord with present-day medical standards?

Background

This question is a corollary to the previous question. The background material contained in the previous question applies as well to this question. The development of a uniform system of medical nomenclature for diseases in the United States is comparatively recent. During the twenties each medical teaching center had its own classification for its own immediate needs. These systems were spread throughout the country by individuals trained in a particular center. There resulted a polyglot of diagnostic labels and systems. Modifications in the transplanted nomenclatures became necessary. In the late twenties a movement toward a nationally accepted standard nomenclature was started by the New York Academy of Medicine, and the first national conference on Nomenclature of Disease met at the academy in March 1928. The conference was composed of representatives of interested governmental agencies and of the national societies representing the medical specialties. The first official Standards Classified Nomenclature of Disease was published in 1933. Two revisions have been made, the last revision in 1942. Other standards of nomenclature have been published and universally adopted, such as: The Fourth Edition of the Standard Nomenclature of Diseases and Operations (Blakiston Co., 1952). This edition comprises a complete revision of the nomenclature, incorporating the most recent diagnostic terms and classifications approved by the respective specialty groups, such as: The National Tuberculosis Association,

American Cancer Association, and the American Psychiatric Association. This standard is used in the Department of Medicine and Surgery, Veterans' Administration.

However, prior to the 1952 Standard Nomenclature of Diseases and Operations, considerable confusion reigned in the field of psychiatric nomenclature. At the beginning of World War II, American psychiatry, civilian and military, was utilizing a system naming mental diseases developed primarily for the needs of public mental hospitals. As a result military psychiatrists, induction station psychiatrists, and Veterans' Administration psychiatrists found themselves operating within the limits of a nomenclature specifically for the large number of cases to be handled. For example, relatively minor personality disturbances, which became of importance only in the military setting, were classified "psychopathic personality"; and the "psychoneurotic" label had to applied to men reacting briefly to a situational maladjustment—individuals who were not ordinarily psychoneurotic in the usual meaning of the term.

During the progress of World War II, terms had to be invented for diagnosing phychological reactions to the stress of combat, with the result of additional confusion. During this period the Veterans' Administration Schedule for Rating Disabilities contained a mental disease nomenclature in the neuropsychiatric disability section, based upon neuropsychiatric terminology used in1933.

In 1946, in what is now the Department of Medicine and Surgery of the Veterans' Administration, a psychiatric nomenclature was adopted based upon the Armed Forces nomenclature. The 1945 revised edition of the Schedule for Rating Disabilities did not incorporate this psychiatric nomenclature, but retained the psychiatric nomenclature of the 1933 schedule. By 1948 utter confusion resulted similar to that which had existed throughout medical nomenclature of the twenties. Within these governmental agencies there were at least three psychiatric nomenclatures in use, and none of them accurately in line with the International Statistical Classification. Within the Veterans' Administration one nomenclature of psychiatric diseases is used by the Department of Medicine and Surgery, one for the International Statistical Classification, and another different psychiatric nomenclature is used for disability rating within the Department of Veterans' Benefits and the Schedule for Rating Disabilities.

Discussion

The discussion is contained in the summary and conclusion to this question.

Coded Question L

Table 35.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	52	34
Qualified	44	29
No:		
Unqualified	39	26
Qualified	14	9
Indeterminate	2	1
Unanswered	2	1
Grand total	153	

TABLE 36.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8			8			
Neurology	7		3	3	1		
Internal and general medicine	13	2	6	3	2		
Tuberculosis	9	3		6			
Peripheral vascular diseases	4	1	2	1			
Cardiovascular diseases	7		5	2			
Allergy	6	3	1	1	1		
Gastroenterology	6	3	2	1			
Tropical diseases	7	3	2	1	1		
Gerontology	6	4	1	1			
General surgery	11	7	3	1			
Orthopedics	10	4	5		1		
Neurosurgery	6	1	2	1	2		
Plastic surgery	6	4	1		1		
Audiology and ear, nose, throat	7	1	4	1	1		
Opthalmology	6	4	1	1			
Urology	7	4	3				
Rehabilitation and physical medicine	8	3	1	1		1	2
Dermatology	6			3	3		
Industrial medicine	9	4		3	1	1	
Others	4	1	2	1			
Total	153	52	44	39	14	2	2

TABLE 37.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	26	38	6	32	7	35	5	25	7	35	1
Qualified	21	30	5	26	4	20	7	35	5	25	2
No:											
Unqualified	18	26	4	21	5	25	5	25	6	30	1
Qualified	3	4	4	21	3	15	2	10	2	10	
Indeterminate	1	1					1	5			
Unanswered	1	1			1	5					
Total	70		19		20		20		20		4

Representative comments of majority. (Disease nomenclature is in accord with present-day medical standards.)

Yes, for the most part. However, terminology for all systems should be identical to standard diagnoses.

* * * * * * *

Yes, in most cases. Otitis interna should be eliminated. The conversational voice in feet, determination, has no value.

* * * * * * *

Yes. However, fistula of the intestine should not be used, but should be diagnosed as a complication of the underlying condition, e. g., regional enterocolitis, visceral actinomycosis, etc. Also, the diagnosis of peritoneal adhesions with the various rate for these items should be listed as complications of an underlying disease process, and given a properly higher rating than the condition itself without complications. In addition, remedial conditions such as hernia, cholelithiasis, and at time rectal stricture, should not be given disability rating until efforts at surgical correction have failed.

* * * * * * *

Yes. However, there is a discrepancy of range-of-motion measurements as shown on pages 26 and 27 of the schedule. The schedule describes measurements of flexion, abduction and adduction of upper and lower extremities which start at 180° from the anatomical position up toward zero. Whereas in the joint, girth, and length measurement, the reverse is true Standard Form No. 527. That is, the anatomical position of the extremities starts at zero and goes upward towards 180°. This could lead to a great deal of confusion.

* * * * * * *

Yes. The Department of Medicine and Surgery, VA, with few exceptions follows the Standard Nomenclature of Diseases and Operations, fourth edition. It is essential that the medical profession, health, and allied organizations have a standard uniform nomenclature and coding system. All Federal agencies should cooperate to the fullest extent in establishing and supporting such standardization.

* * * * * * *

Yes. The terminology is simple and direct. While it does not conform to the Standard Classified Nomenclature of Disease, it nevertheless has virtue in its simplicity.

* * * * * * *

Yes, to some extent. However, it is noted that ratings for disability arising out of industrial or wartime poisonings, intoxications, etc., can only be coded diagnostically under psychoses. Some poisons, for example, carbon tetrachloride, basically produce a hepatorenal syndrome; acute nitrogen oxide poisoning basically produces pulmonary edema.

* * * * * * *

Yes, with few exceptions as noted, in the cardiovascular system with rating based on the underlying lung disease.

Representative comments of the minority. (Disease Nomenclature in Schedule is not in accord with present-day medical standards.)

No, for psychiatry. Should be revised in accordance with the American Psychiatric Association Standards.

* * * * * * *

Possibly there is need for change in some sections—particularly psychiatry—and the hemic and lymphatic systems, to reflect more recent terminology, concepts, and classifications.

* * * * * * *

Decidedly not. The neurologic section is very incomplete. In the section on psychiatry the terminology is completely outmoded and not in accordance with either the terminology used by the services or that recommended in the Standard. Separate schedules should be established for impairment of function due to spasticity, ataxia, and rigidity, contrasted with peripheral nerve deficit.

* * * * * * *

Not altogether. The Standard Nomenclature of Diseases would be more serviceable. From the allergist's point of view the diagnosis of vasomotor or allergic rhinitis should be instituted. This would help clarify ENT ratings on sinusitis.

* * * * * * *

No. Nomenclature is too restricted. Since there are so many dermatological diseases it is not necessarily desirable to greatly expand this field, but many more common diseases then leishmaniasis, for example, are considered every day, and the rare diseases should be eliminated rather than entered as separate entities. Nomenclature should be made to conform with Standard Nomenclature.

* * * * * * *

This should be carefully checked with the Standard Nomenclature of Disease, and the Standard Nomenclature of Diseases of the Heart and Blood Vessels of the American Heart Association. They are the most complete and up-to-date lists presently available and are in common use in civilian hospitals. Using identical standards would be helpful.

* * * * * * *

No. The physicians who examine and treat tuberculosis patients have been instructed to follow in toto the Diagnostic Standards and Clinical Classification

of Tuberculosis (1950), and I am told the Adjudication Division has not been so directed. I am sure this is also true in other conditions, especially in neuropsychiatry.

* * * * * * *

In my opinion, the nomenclature used in Standard Nomenclature of Disease should be used wherever possible. The term "rheumatoid arthritis" is preferable to "atrophic arthritis." "Degenerative joint disease" connotes more accurately the patholgoy of this type of joint disease than does the term "hypertrophic arthritis." Gout should be termed "the arthritis of gout." Furthermore, disability ratings for patients with arthirits of gout should be made on the basis of the presence of active arthritis, the extent of permanent joint incapacity and the presence or the absence of complicating visceral diseases, such as arteriosclerosis, coronary artery disease, renal disease, etc.

* * * * * * *

No. There should be additions and changes. A new section of collagen diseases should be added. Hemolytic anemias should be further delineated. Cor pulmonale should be given separate mention. In light of present knowledge, it might be advisable to revise much of the classification under the endocrine system—particularly in reference to pituitary and adrenal gland dyscriasias. For example, Cushing's syndrome is usually described under hyperfunctions of the adrenal cortex. Addison's disease is but one of the syndromes due to adrenal cortical insufficiency, and probably in less than 50 percent of the cases is due to tuberculosis. Diabetes insipidus might well be described as a separate entity.

* * * * * * *

It is different from the International Code, and the one used by military medical facilities. Thus, the usual accepted diagnostic name and number found in military medical facilities is not always available in the 1945 schedule.

* * * * * * *

In certain instances only—e. g., arteriosclerosis obliterans, thromboangitis obliterans, varicose veins. Phlebitis is ambiguous. The symptoms and signs listed under phlebitis are those we usually associate with chronic venous insufficiency.

* * * * * * *

This area could stand considerable revision in order to bring nomenclature into line with modern advances in medicine and its terminology.

* * * * * * *

Summary and conclusions

It would appear from the statistical data that two-thirds of the respondents believed that the disease nomenclature is in accord with present-day medical standards. However, on a closer inspection of these replies it was found that the majority opinion was not clearcut, as many comments were added in the replies taking exception to specific portions of the schedule as not being in accord with present-day medical standards. This opinion was expressed, as well, by all of the minority. For example, some of the majority took exception to the outmoded terminology in the psychiatric section of the schedule. This viewpoint was taken by all of the respondents practicing psychiatry. Standard nomenclature of diseases should be required for the physical disability processing and evaluation of the serviceman while in the service and after he becomes a veteran beneficiary. There is confusion of disease nomenclature between the agencies which have to use the schedule for rating disabilities in their physical disability processing and evaluation, and medical examiners of the Department of Medicine and Surgery who have to be able to speak in two languages during this disability processing—one for translation from the standard nomenclature used by the Department of Medicine and Surgery, and the other for translation into a pen picture of the disease and disability for the Department of Veterans' Benefits. There is no common denominator in this physical disability processing.

DO MEDICAL CRITERIA IN PERCENTAGE RATINGS REFLECT RESIDUALS OF DISEASE AND INJURY?

Coded question M

Do the medical criteria reflect accurately the residuals of the injury or disease for different percentage ratings?

Background

Medical criteria should be in accord with accepted medical principles. These criteria may be used for various medical purposes. They are used in the Veterans' Administration schedule for rating disabilities. The percentage gradations of 10 percent to 100 percent are arbitrary percentages established by legislation for the schedule. When medical criteria (one or more) are fitted to a desired arbitrary percentage, as in the schedule, we establish an instrumental guide for the measurement and evaluation of a disability. This arbitrary percentage of disability is then translated into a percentage loss of earning power of the veteran. We then say, that this percentage of rating "represents as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations."

An arbitrary scale (or schedule) as an instrument has to be improvised, as nearly scientifically as possible, by means of medical criteria; and, as in the schedule, state that this given percentage represents percentage of disability. The medical criteria reflect the residuals of the injury or disease for different percentage ratings.

Coded Question M

Table 38.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	36	24
Qualified	48	31
No:		
Unqualified	39	25
Qualified	19	12
Indeterminate	7	5
Unanswered	4	3
Grand total	153	

TABLE 39.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	3	1	4			
Neurology	7	2	3			1	1
Internal and general medicine	13		5	4	2	2	
Tuberculosis	9		3	5	1		
Peripheral vascular diseases	4	1	1	1	1		
Cardiovascular diseases	7	1	3	3			
Allergy	6	1	2	1	2		
Gastroenterology	6		3	2	1		
Tropical diseases	7	3		1	1	2	
Gerontology	6	2	3	1			
General surgery	11	2	5	3	1		
Orthopedics	10	3	4	1	1		1
Neurosurgery	6	2	1	1	2		
Plastic surgery	6	1	4		1		
Audiology and ear, nose, throat	7	1	3		2	1	
Ophthalmology	6	3		2	1		
Urology	7	2	3	2			
Rehabilitation and physical medicine	8	2	1	3			2
Dermatology	6			2	3	1	
Industrial medicine	9	3	3	3			
Others	4	4					
Total	153	36	48	39	19	7	4

TABLE 40.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	12	17	7	37	6	30	3	15	5	25	3
Qualified	25	36	3	16	4	20	9	45	6	30	1
No:											
Unqualified	22	31	2	11	6	30	4	20	5	25	
Qualified	5	7	5	26	3	15	3	15	3	15	
Indeterminate	4	6	1	5			1	5	1	5	
Unanswered	2	3	1	5	1	5					
Total	70		19		20		20		20		4

Discussion

The discussion is contained in the summary and conclusion to this question.

Representative comments of the majority (medical criteria, percentage ratings do reflect residuals of disease and injury)

In general, yes. In relation to the psychoneuroses, no.

* * * * * * *

In general, yes. Please note specific exceptions as listed on the comment sheet.

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Generally speaking, this is true. The acceptance of poor vision or even blindness is widely variable.

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Generally, yes. However, the proper rating for most of the diseases would require special knowledge in a given branch of medicine. The rating boards

which now exist (consisting of 1 disinterested physician and 2 laymen) may be inefficient and incapable of interpreting the schedule for rating correctly.

* * * * * *

In general, they appear to do so. Notable exceptions would seem: In malignant diseases (cancer) of various systems it would seem indicated, in the light of clinical experience, to continue the 100-percent disability rating for a period of 5 years, even in the face of lack of clinical evidence of metastases (spread) or recurrence. The medical criteria for ratings of various cardiovascular diseases, notably rheumatic heart disease, hypertensive heart disease, hypertensive vascular disease and the various arrhythmias, do not reflect accurately the residuals of the disease process. Similarly, this would seem to be the case in instances of diabetes, peptic ulcer, ulcerative colitis, nephritis, pernicious anemia, purpura hemorrhagica, Hodgkin's disease, leukemia, "splenectomy," and hyperthyrodism, as well as hypothyrodism.

* * * * * *

Surprisingly well, on the whole. There are some exceptions and omissions. I am puzzled because the ratings, as listed, would indicate a person, once having a disease, remains permanently in that state. Modern advances, such as pulmonary resection for tuberculosis and chemotherapy for the same, completely invalidate some of the ratings for this disease. So it is in many other instances. There are some outmoded criteria such as reliance on the basal metabolic rate for sole estimation of thyroid function, and the use of the insulin dose as a measure of the degree of incapacity of a diabetic. Migraine occurring once per month does not really justify any rating, let alone 30 percent.

* * * * * *

In most instances they do. However, the categories of malignant and benign new growths of brain and spinal cord is not a useful differentiation for the purposes of considering tumors involving the nervous system. The concept of benignity versus malignancy as a measurement of invasiveness, spread, etc., is not as useful in the nervous system because the disability is more often a reflection of the area involved (regardless of the nature of the tumor) and the amount of space occupied. Under cerebral arteriosclerosis the differentiation between pronounced, severe, and moderate do not adequately reflect the disability caused by this disease, i. e., the patient may be severely disabled in one sphere of his life and quite capable in another. Paranyoclonus multiplex, although a rare disease, should be rated in the same manner that epilepsies are. The categories of epilepsy do not reflect current concepts of the disease. Psychomotor epilepsy is not even listed. This section should be completely rewritten in keeping with modern concepts of etiology and treatment of epilepsy.

* * * * * *

In most cases it would seem that the ratings for various residuals are too high. Example: Asymptomatic postgastric resection.

* * * * * *

Yes. In majority, I think the medical criteria present an accurate disability picture with a minimum of discrepancy. However, the term "residuals" is often used loosely, lending itself to misinterpretation, and should be prohibited. The exact nature of the disability should be properly described, diagnosed, and recognized as a clinical entity. The initial disease, if it still exists, should be properly categorized; but I am opposed to combining two. In my experience "residuals" too often lack exactness and may perpetuate confusion.

* * * * * *

Yes, with the exceptions enumerated on the attached sheets. In general, the milder forms tend to be rated too high.

* * * * * *

Yes, except that the criteria for the 10 percent rating should be increased in some instances.

* * * * * *

Yes, until such time as they are remedied surgically or by proper rehabilitation. When remedied, should be re-rated.

* * * * * *

Yes, but there are exceptions, and the criteria should be critically reviewed and probably extended in the light of current knowledge.

* * * * * *

Representative comments of the minority (medical criteria—percentage ratings do not reflect residuals of disease and injury)

Not entirely. There are many inadequacies in criteria, some of which I have tried to indicate as follows: Signs and symptoms attributed to phlebitis are those of chronic venous sufficiency; arteriosclerosis obliterans should be rated on the basis of objective signs indicating the degree of severity, etc.

* * * * * * *

In some instances, the wording as to residuals, noted in the schedule, is incomplete if it is to offer guidance to the rating board. I will cite one example: Arteriosclerotic heart disease in the schedule. The 80, 60, and 30 percent ratings do not define the criteria by means of which the board can assign the percentage ratings following a coronary occlusion. No mention is made of the number and severity of occlusive episodes, the presence or absence of diurnal or nocturnal dyspnea, presence or absence of murmurs, arrhythmias, cyanosis edema, ECG and X-ray findings, frequency of anginol attacks, etc.

* * * * * * *

No. In most instances the percentage ratings are based on the degree or extent of residuals, not on the physical capacity or work capacity remaining to the veteran. In the cardiovascular system, function, not form, determines the individual's physical capacity for work. Hence the rating schedule was devised to ascertain the average impairment of earning capacity, and since this depends, so far as the heart is concerned, on functional derangement, any attempt to make ratings on the basis of anatomical changes and their extent must, of necessity, be entirely inadequate and inaccurate. In this regard, paragraph 10 of the schedule states the physiological approach well, but the ratings themselves and the criteria are, for the most part, not on this basis.

* * * * * * *

In many instances, no. This is particularly true in respect to the flat, unqualified ratings for certain surgical procedures. Fixed rates for pulmonary pneumonectomy and lobectomy, resection of the stomach, otherwise, etc., without regard for attendant dysfunction is most unrealistic. Diaphragm, rupture of, parts of the stomach or colon in the thoracic cavity, is subject to some criticism.

* * * * * * *

Percentage ratings vary considerably in some instances—the most notable being tuberculosis. A very large percentage of patients with minimal to moderate tuberculosis are permanently arrested or cured and should not receive a lifetime statutory rating or disability.

* * * * * * *

Not always. In my field, tuberculosis, there are probably 4 divisions, such as: (1) No residual impairment; (2) minimal residuals; (3) moderate residuals, and (4) severe residuals. These might serve better to give a true picture and could, if desired, be translated into percentages by adjudication division. For conditions other than tuberculosis I would rather not express an opinion.

* * * * * * *

No. Under the National Tuberculosis Association 1950 classification of tuberculosis, only three Clinical Status Classifications are recognized: (1) Active; (2) arrested; and (3) inactive. The terms "apparently arrested" and "apparently cured" and "quiescent" are no longer used.

No. While in general there are not many serious shortcomings, those which exist are conspicuous. For example, criteria for pneumonoconiosis are incomprehensible to me. In Code 6704, tuberculosis, the criterion of 16 hours a day hospitalization or bed-rest should be reviewed and revised in the light of modern therapy. Consideration also has to be given to unprecedented situations, such as the open pulmonary tuberculous cavity with a negative sputum during chemotherapy. Better criteria should be used for describing the residuals of lung abscess and the functional impairments due to diseases of the bronchi and the pulmonary parenchyma.

* * * * * * *

No. Residual disability can often now be measured by pulmonary function studies, virtually unknown in 1945.

* * * * * * *

No. For example, a veteran who has fully recovered from a functional psychosis, if he was hospitalized for more than 6 months, is eligible for 10 percent

compensation for the remainder of his life. Another example is the veteran who sustained a cerebral concussion. He is rated the minimum of 30 percent, if he complains of even an occasional headache.

* * * * * * *

No. Specifically, the psychoses at the lower levels. It is considered that 30 percent should be the lower limit for the functional psychoses, regardless of the degree of incapacitation or the amount of dependence and reward this might create. Further, medical considerations preclude the accurate determination of pronounced against severe. Severe should be the term, and awarded 100 percent disability. Also, the mild category seems superfluous. One either has a mental illness, or they do not.

* * * * * * *

In the schedule for rating disabilities under "Skin", all diseases other than scars are rated as analogous to eczema. This I feel is incomplete and leaves too much to the discretion of the Rating Board.

* * * * * * *

The criteria frequently do not contain sufficient data as to the extent (area involved, area covered, extent of impairment), or repugnance of the lesion and the psychological effect upon the patient. Unfortunately, black and white photos are not the complete answer. Thirty-five milimeter color transparancies are much better.

* * * * * * *

I am not sure I understand this question, but I do not think the residuals of the disease for rating purposes can be reflected by the medical criteria alone. Rating should be evaluated by actual earning capacity and earning opportunities in individual cases.

* * * * * * *

No. Present-day advances in physical medicine and rehabilitation procedures have greatly reduced residuals of injury or disease formerly encountered. Percentage ratings should be consequently revised.

* * * * * * *

No. Present-day advances in physical medicine and rehabilitation procedures have greatly reduced residuals of injury or disease formerly encountered. Percentage ratings should be consequently revised.

* * * * * * *

No. Criteria for the disagnosis of residuals of diseases should be revised to meet accepted medical principles. Example: Diabetes, when controlled as it can be in most cases, should not impair the earning capacity at all. The 10 percent disability allowed for mild degrees of certain diseases, such as bronchitis, sinusitis and infrequent attacks of asthma, probably represent in many instances payment to individuals having no impairment of earning capacity.

* * * * * * *

No. This idealistic goal can never be achieved. "Residuals," as I understand the term as it is used here, consist of the total of the objective findings and the subjective symptoms of a patient. It must be remembered that identical objective findings and/or identical subjective symptoms cannot be expected to produce identical disability. This is true because a great part of any disability consists of the patient's reaction to his misfortune. No two people react the same to the same disability. Any attempt to so enumerate and assign weight to findings and symptoms in evaluating an individual against a theoretical group standard results, as past experience has already shown, in absurdities in some cases and inequities in many instances.

* * * * * * *

No. Such considerations as discomfort, effect on nutrition, involvement of critical areas such as hands, feet, or face, are not considered.

* * * * * * *

They do not. Residuals of injury are clinical, anatomic, pathologic, physiologic, economic, social, and psychological. One of the basic errors in the construction of all these tables is the absence of any concern with (1) the emotional component present in all illness and injury, (2) the safety factor—the reintegration of all the body's functional activities to deliver a unified performance in the face of even serious disability, and (3) the theory of critical limits—ordinary arithmetic and geometric concepts are inconsistent with the biologic effects of

injury. The body adjusts itself in a biological way to disease and injury up until the point of no return, the critical limit. This is not arithmetic or geometric. It has a different dimension. It is biologic—compared critical limits in physics, water freezing at 32°, water changing again in qualitative character at 220°.

* * * * * * *

No. This is the weakness of the system. It takes an individual experienced in both the business of rating and in a specialty to do justice both to the individual and the Government. Generally the doctor rendering the final diagnosis for rating has not been trained in the provisions of this schedule. He may present a very accurate clinical record and final diagnosis. The case must be carefully studied to bring out the residuals of the disability resulting. A very careful written final diagnosis does not alone bring out the disability existing.

* * * * * * *

Summary and conclusions

As in the two previous questions, it appears that the majority opinions are that medical criteria accurately reflect the residuals of the injury or disease for different percentage ratings. The majority state this to be so, generally, with exceptions as noted in some of the representative comments of the majority. The minority opinion maintained, on the other hand, that the criteria did not reflect accurately the residuals of the injury or disease for different percentages. The majority and minority opinion did agree that a revision of the criteria was required and that the medical criteria should be modernized and more clearly correlated to percentages, disability, and average impairment in earning capacity. The criteria for tuberculosis were singled out, as an example, as requiring revision.

MEDICAL BASIS FOR PERCENTAGE EVALUATION OF BODILY AND MENTAL IMPAIRMENT

Coded question N

(Note.—This question was in 2 parts of one question in the questionnaire; since the second part was closely related to the first, the 2 were combined into 1 and the replies analyzed from the answers of the second part.)

Is it medically feasible to assign gradations within an accuracy of 10 percent when determining the percentage of bodily and mental impairment?

If not, what scale of gradations do you regard as feasible?

Background

The Veterans' Administration Schedule for Rating Disabilities defines functional impairment and the basis of disability evaluation as:

> the ability of the body, as a whole, or of the psyche, or of a system or organ of the body, according to the general or localized effects of disease or injury, to function under the circumstances of ordinary activity, that is, in daily life, including employment. Thus, whether the upper or lower extremities, the back or abdominal wall, the eyes or ears, or the cardiovascular, digestive, or other system, or the mind, are affected, evaluations are based upon the usefulness, or lack of usefulness, of these parts or systems, especially in self-support.

One Department of Defense definition of physical disability is:

> Any manifest or latent impairment of function due to disease or injury regardless of the degree of impairment. The presence of physical disability does not necessarily require a finding of unfitness for duty. The term "physical disability" includes mental diseases other than such inherent defects as behavior disorders, personality disorders, and primary mental deficiency.

"Impairment of function" is defined as:

> Any lessening of weakening of the capacity of the body, or any of its parts, to perform that which is considered by accepted medical principles to be the normal activity in bodily economy.

"Manifest impairment" is that impairment which is accompanied by signs and/or symptoms (any objective evidence of a disease or injury, accompanied by any changes in the patients' condition).

"Latent impairment" is that impairment which is not accompanied by signs and/or symptoms but which is of such a nature that there is reasonable and moral certainty, according to accepted medical principles, that signs and/or symptoms will appear within a reasonable period of time.

Discussion

Fifty-three percent of the respondents polled, stated that it was not medically feasible to assign gradations with an accuracy of 10 percent when determining the percentage of bodily and mental impairment. This group made various recommendations for gradations, as shown in table 41 (a). Eighty-four of the respondents making these recommended gradations were of several different opinions as to how these gradations should be made: 20 of the respondents recommended a scale of gradations in 5 steps of 20 percent each; 26 of the 84 respondents recommended a scale of 4 steps; 16 respondents recommended 25–50–75–100 percent; 3 respondents recommended the gradations start at 30 percent with 3 higher gradations; 4 respondents recommended a rate in gradations of thirds—0–33–66–100 percent; 3 respondents recommended that the terms of mild, moderate, severe, and total, be used to designate gradations; 1 respondent recommended gradations of 5 percent; 37 respondents recommended miscellaneous scales of gradations each different from the rest.

Coded Question N

Table 41.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	67	44
Qualified	2	1
No:		
Unqualified	74	48
Qualified	7	5
Indeterminate	1	1
Unanswered	2	1
Grand total	153	

Table 41 (a).—*Number of recommendations for a specified scale*

Percentage gradations, specified scale	Number of recommendations
Scale of 5 steps, gradations 20 percent	20
Scale of 4 steps:	
25–50–75–100 percent	16
Start at 30 percent with 3 higher gradations	3
Rate in thirds; 0–33–66–100 percent	4
Use terms of: mild, moderate, severe, and total	3
Gradations of 5 percent	1
Miscellaneous gradations	37
Total	84

Note.—The total of 84 recommendations were the combined negative classified replies to the request put by the question for a recommended scale of gradations.

TABLE 42.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	4	----------	3	1	----------	----------
Neurology	7	5	----------	1	----------	----------	1
Internal and general medicine	13	4	----------	9	----------	----------	----------
Tuberculosis	9	----------	----------	8	1	----------	----------
Peripheral vascular diseases	4	----------	----------	4	----------	----------	----------
Cardiovascular diseases	7	4	----------	3	----------	----------	----------
Allergy	6	3	----------	3	----------	----------	----------
Gastroenterology	6	3	----------	2	1	----------	----------
Tropical diseases	7	2	----------	5	----------	----------	----------
Gerontology	6	3	----------	3	----------	----------	----------
General surgery	11	3	1	6	1	----------	----------
Orthopedics	10	4	----------	4	1	1	----------
Neurosurgery	6	1	----------	4	----------	----------	1
Plastic surgery	6	5	----------	1	----------	----------	----------
Audiology and ear, nose, throat	7	4	----------	3	----------	----------	----------
Ophthalmology	6	5	----------	1	----------	----------	----------
Urology	7	4	----------	3	----------	----------	----------
Rehabilitation and physical medicine	8	4	1	2	1	----------	----------
Dermatology	6	3	----------	2	1	----------	----------
Industrial medicine	9	5	----------	4	----------	----------	----------
Others	4	1	----------	3	----------	----------	----------
Total	153	67	2	74	7	1	2

TABLE 43.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	20	29	12	63	12	60	11	55	11	55	1
Qualified	2	3	------	------	------	------	------	------	------	------	----------
No:											
Unqualified	42	60	6	32	6	30	8	40	9	45	3
Qualified	5	7	------	------	1	5	1	5	------	------	----------
Indeterminate	1	1	------	------	------	------	------	------	------	------	----------
Unanswered	------	------	1	5	1	5	------	------	------	------	----------
Total	70	------	19	------	20	------	20	------	20	------	4

A sizable minority of two-fifths believed that it is medically feasible to assign gradations with an accuracy of 10 percent when determining the percentage of bodily and mental impairment.

Table 42 shows the reply distribution, by number, and respondents' medical specialty. The respondents were nearly equally divided in their opinions as to whether it is, or is not, medically feasible to assign gradations within an accuracy of 10 percent when determining the percentage of bodily and mental impairment, except all the respondents practicing in the medical specialty of tuberculosis, and all the respondents specializing in peripheral-vascular diseases, believed that it was not medically feasible to assign gradations within an accuracy of 10 percent when determining the percentage of bodily and mental impairment.

Representative comments of the majority (it is not medically feasible to assign gradations within an accuracy of 10 percent)

Absolutely not. This is a highly presumptive assumption, but has no basis in any scientific fact. To estimate or to rate is really to measure. To measure is to compare. To make comparisons there must be standards. No standards exist by means of which we can compare qualitatively or quantitatively the functional capacities of individuals. Until these standards have been established, all our tables in compensation and veterans' pensions are pure fiction.

* * * * * * *

No; but there seems to be no better alternative. Too much subjectivity goes into decisions unless there are strict objective criteria such as degrees of limitation of motion, etc., especially limitation of essential motion. Extremes of motion of joints which are not strictly essential for employment (varies with job) should be considered in evaluating the case at hand and disability ratings for such limitation of unnecessary mobility be given very low percentage rating.

* * * * * * *

No; cannot say what scale of gradations should be used. Often the willingness or desire of the individual will make a big difference as well as the occupation.

* * * * * * *

No. Perhaps probable number of hours lost from earning capacity per month.

* * * * * * *

No; not in most instances. A scale of gradation could only be medically approximated on the basis of actual performance of each individual. On the other hand, this would not be any too accurate as, for example, the man with antina pectoris might attempt to do more than he is capable of doing. Here, too, the element of motivation is an important one. I don't know the answer.

* * * * * * *

With respect to tuberculosis and certain other chronic pulmonary diseases, this is not feasible in such narrow gradations. It might be more sensible to think in terms of fewer categories, such as slight, moderate, severe, and total disability.

* * * * * * *

Gradations within an accuracy of 10 percent degree of disability for chronic pulmonary tuberculosis is not medically feasible.

* * * * * * *

Not in the vast majority of disabilities. To determine the degree of functional impairment even in such objective instances as limitations of joint motions which bears little relation to actual "work impairment" is actually very arbitrary and subjective. Admittedly, some compromise must be made. I would suggest a scale of 33⅓ percent, 66⅔ percent, and 100 percent.

* * * * * * *

This is difficult. A more practical scale is 25 percent mild, 50 percent moderate, 75 percent severe, 100 percent total disability. Rating would certainly be simplified and expedited by a reduction in gradations.

* * * * * * *

No. I do not think that minor conditions now rated below 30 percent are disabling. I believe that above this degree, division into thirds is as close as can be fairly judged.

* * * * * * *

No. Disabilities regarded under 30 percent are in my opinion compatible with full duty. Gradations above 30 percent could possibly be limited to three (3) higher percentage ratings.

* * * * * * *

25 percent or 33 percent for psychiatric cases.

* * * * * * *

I do not believe so. 20 percent would probably be the greatest degree of real accuracy.

* * * * * * *

Right now I wouldn't feel comfortable with gradations smaller than 20 percent but I am sure that with experience gradation in 10 percent increments can be made with reasonable accuracy.

* * * * * * *

Probably not. A disability rating of 20 percent or less is probably based almost entirely on subjective findings in many instances. Certainly a gradation of less than 10 percent is impossible.

* * * * * *

This is a "when did you stop beating your wife" type of question. A "yes" answer implies that those now graded as 10 percent are actually 10 percent disabled which I do not believe. A "no" answer implies that gradations of 10 percent cannot be accurately made, which I do not believe. I believe that 10 percent disabilities do not exist and such claims are not worth rating. Over 10 percent, a system of rating can be devised within an accuracy of 5 percent.

* * * * * *

An accuracy of 10 percent is not always feasible. I believe it would be of great value to have a 5 percent rating (or "less than 10 percent") for very minor injuries which the examiner believes cannot be completely discounted and which are now assigned 10 percent automatically. If there were ranges of percentage (or classification according to minor, moderate, severe, maximum) with pay fixed for each group, I believe there would be less tendency to overestimate disabilities.

* * * * * *

Ten percent is all right, but if you want something simpler, try 10 percent, 25 percent, 50 percent, 100 percent.

* * * * * *

I believe the gradations are too fine. Total disability is a fairly definite and measurable condition but partial impairment of earning capacity depends upon many factors. I would favor a reappraisal on a gradient rising from 10 percent or less, to 30 percent, 30 to 60 percent, and more than 60 percent but less than 100 percent.

* * * * * *

No. Possibly 10, 10–30, 30–60, 60–100 would be more accurate and still fit fairly well into the present accepted values. This way you would be closer to a logarithmic scale, with less change of error.

* * * * * *

No. Must have an arbitrary scale.

Representative comments of the minority (It is medically feasibly to assign gradations within an accuracy of 10 percent)

There were not many comments by the minority to this question. In this instance, the replies to the question were preponderantly a straight "yes."

It is feasible to assign gradations within an accuracy of 10 percent if the individual patient's problem is considered in terms of total disease activity.

* * * * * *

It is feasible to assign gradations within an accuracy of 10 percent if the individual patient's problem is considered in terms of total disease activity.

* * * * * *

From a practical standpoint it is feasible. When used with the combined rating table the adjustment should be satisfactory.

* * * * * *

I believe it is and I believe 10 percent is an excellent way of computing, i. e., 10 degrees of disability ranging from 10 to 100 percent. Besides being feasible it lends itself to simplicity and ease of computation, etc.

* * * * * *

I think the 10 percent gradation is the most practical system especially in the higher percentages of disability.

* * * * * *

I can see no better way unless disease and injury or static and nonstatic conditions were to be treated differently.

* * * * * *

I believe that 10 percent gradations are as accurate as one could get. Lesser gradations of 1 to 5 percent would be extremely difficult to justify and would lead to numerous appeals and litigations.

* * * * * *

I believe the gradations should be within an accuracy of 10 percent. It is noted that many conditions carry gradations of 30–60–100 percent, and it would appear

to me that these gradations should be within a 10 percent deviation rather than 30 and 40 difference.

* * * * * * *

In general, I believe 10 percent gradations are satisfactory as a basis. It is noted that the 1945 schedule divides many conditions into 4 groups with gradations of 100 to 60 to 30 or 40 percent to 10 percent. For descriptive groupings I believe this is proper except, and particularly from the viewpoint of the armed services, an 80 percent class as mentioned in paragraph 1a is desirable.

* * * * * * *

Any scale of gradation must be arbitrary. Grades of 10 percent usually can be assigned with reasonable accuracy. Several minimal ratings of 10 percent probably should be zero.

Summary of conclusions

Although there was a slight majority of the respondents who believed that it is not medically feasible to assign gradations within an accuracy of 10 percent when determining the percentage of bodily and mental impairment, this majority were divided in their recommendations as to what scale of gradations they regarded as feasible. Still, a sizable minority were definite and clear in their opinion, that it is medically feasible to assign gradations within an accuracy of 10 percent when determining the percentage of bodily and mental impairment. Both the majority and the minority recognized the fact that any scale adopted was an arbitrary scale. It is not medically feasible to assign gradations within an accuracy of 10 percent when determining the percentage of bodily and mental impairment in any patient with tuberculosis—according to the 8 medical respondents practicing this medical specialty. One tuberculosis specialist suggested the scale of "slight, moderate, severe, and total disability."

AVERAGE IMPAIRMENT IN EARNING CAPACITY—ARE DISABILITY RATINGS FAIRLY REPRESENTATIVE

Coded question O

In your opinion, do the ratings fairly represent the average impairment in earning capacity resulting from the various degrees of severity of physical impairment?

Background

Historically, disability has been correlated to earning capacity of the individual. Service-connected disabilities of the Revolutionary War veteran had been granted an award on the basis of total disability, and a proportionate amount of total for partial disability correlated with "earning a livelihood," and later through the 19th century veterans of other wars including the Civil War, disability was correlated to "inability to perform manual labor," "procuring subsistance by manual labor," "capacity for manual labor." Some of this history is given in the first section of this manuscript.

It was the act of October 6, 1917, War Risk Insurance Act, as amended, which introduced a new concept in veterans' compensation benefits, that also introduced a correlation of permanent disability and reduction in earning capacity in a disabled veteran. Percentage ratings in this act were to be "based as far as practicable, upon the average impairments of earning capacity resulting from such injuries in civil occupations."

At the time of the adoption of this new principle of awarding disability benefits, there was in practice and operation in California undee the State's workmen's compensation law, an original method unlikr other workmen's compensation methods, of fixing benefits under the

workmen's law. This method was based on several assumptions by the inventor of the plan; one important assumption being "that a worker who is less than 60 percent disabled will be largely capable of rehabilitation". Another assumption was, that the period of time during which financial aid would be required for rehabilitation varied directly with the degree of disability—loss of earning power (Trans. Act. Soc. Am., Discussion: Schedules in Workmen's Compensation, vol. 51; 166–170).

In most workmen's compensation schedules at that time, the loss of earning power was made to depend upon the physical injury alone and considered "altogether crude" as it put the matter of convenience in settling claims ahead of "actual needs as determined by the facts of wage earnings before and after injury." The California method, unlike other methods, was constructed on additional assumptions of physical injury, age, and occupation, and that an injury which occasions a permanent disability, for example, of 20 percent for a man of 75 will occasion a similar disability of 15 percent for a man of 39—the reason for this assumption was; that a younger individual had more recuperative and readjustive powers to injury and disease. "The term disability seems to be a misnomer in many cases of slight permanent injury," as one critic of the system stated at that time.

It was considered, at that time, that the method outlined, above, for obtaining the proper benefit which should apply to a certain degree of loss of earning power, was equitable. On the other hand, critics felt that the schedule in which the percentage loss of earning power was expressed as a function of the physical injury, the age, and occupation, did not take into account all factors in arriving at a percentage of disability determination.

In 1924, under the World War Veterans' Act, to the concept of "average impairments of earning capacity" was added another qualifying phrase requirement: "resulting from such injuries in civil occupations *similar to the occupation of the injured man at the time of enlistment,* and not upon the impairment in earning capacity in each individual case" (italics supplied). With this innovation of compensation awards to veterans, the newly formed Veterans' Bureau constructed a new rating schedule, based upon the experience of foreign governments, insurance companies, the various State compensation laws, in particular, the principal factor contained in the California workmen's compensation law—individual occupational variants. The ratings under the variants were considered to be the "average" for each variant, and occupation. The percentage of disability under each variant was considered to be the "average impairments of earning capacity resulting from such injuries in civil occupations similar to the occupation of the injured man at the time of enlistment," as required by the World War Veterans Act.

The disability rating schedule of 1925, was discontinued on the enactment of Public No. 2, 73d Congress, March 20, 1933, and because of administrative difficulties encountered in the application of the 1925 schedule, the act of March 20, 1933, authorized the President to prescribe by regulation minimum degrees of disability, for veterans, by regulation and such higher degrees of disability. This act did not specify "average impairments in earning capacity." It did however, authorize the President to "prescribe the degrees of disability" only, and that any regulations promulgated by the President establishing a schedule for disability ratings was to become law automatically, after 2 years following approval of the act.

Coded Question O

Table 44.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	46	30
Qualified	18	12
No:		
Unqualified	41	27
Qualified	17	11
Indeterminate	25	16
Unanswered	6	4
Grand total	153	

Table 45.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	4		1		2	1
Neurology	7	2	1	3			1
Internal and general medical	13	2	2	2	3	3	1
Tuberculosis	9	2	1	4	1	1	
Peripheral vascular diseases	4	2		1		1	
Cardiovascular diseases	7	4	1	1		1	
Allergy	6	1	2	1	1	1	
Gastroenterology	6	1	1	4			
Tropical diseases	7	2	2	3			
Gerontology	6	3		1		2	
General surgery	11	2	1	2	1	3	2
Orthopedics	10	2	1	4	2	1	
Neurosurgery	6	3	1	1		1	
Plastic surgery	6	2	1		1	2	
Audiology and ear, nose, and throat	7	3	1	1	1	1	
Ophthalmology	6	2	1	1	1	1	
Urology	7	3		1	1	1	1
Rehabilitation and physical medicine	8	2	1	2	1	2	
Dermatology	6	1		2	3		
Industrial medicine	9	2	1	4	1	1	
Others	4	1		2		1	
Total	153	46	18	41	17	25	6

Table 46.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	18	26	5	26	8	40	6	30	8	40	1
Qualified	9	13	3	16	1	5	3	15	2	10	
No:											
Unqualified	17	24	5	26	8	40	5	25	4	20	2
Qualified	14	20					2	10	1	5	
Indeterminate	10	14	5	27	1	5	4	20	4	20	1
Unanswered	2	3	1	5	2	10			1	5	
Total	70		19		20		20		20		4

Discussion

Two-fifths of the respondents believe that the ratings fairly represent the average impairment of earning capacity resulting from the various degrees of severity of physical impairment. Also, two-fifths of the respondents believed that the ratings do not fairly represent the average impairment of earning capacity resulting from the various degrees of severity of physical impairment. One-fifth of the respondents either did not answer the question, or their replies to the question were vague.

Representative comments of the respondents who believed the ratings in the schedule fairly represented average impairment in earning capacity

Fairly well on the whole, some excessive; some inadequate.

* * * * * * *

Disability ratings below 30 percent are in many instances not disabilities and do not represent impaired earning capacity.

* * * * * * *

Except in lower brackets, yes.

* * * * * * *

Yes with certain exceptions; e. g., it would appear that a man with chronic bronchitis, severe, with dyspnea at rest or on slight exertion would be 100 percent disabled as far as earning capacity is concerned. On the other hand, an arrested case of tuberculosis might in some instances be perfectly capable of performing the duties of a full-time job with no impairment of earning capacity.

* * * * * * *

In general the ratings do represent average impairment of earning capacity although considered too high.

* * * * * * *

In my opinion the ratings do represent the average impairment in earning capacity. This is true in the higher ratings, but in some instances may not apply to some of the lower ratings.

* * * * * * *

For the upper percentage degrees of disability, I would agree with the exceptions that I have previously mentioned. Most of the lower degrees of disability do not have sufficient disability to impair earning capacity except for a short period of time after the onset of the disease or injury.

* * * * * * *

In general, they do fairly represent average impairment of earning capacity but there are numerous exceptions such as a minor injury to the little finger of a laborer would be of no significance whereas it could be a tragedy in the case of a professional violinist.

* * * * * * *

Ratings of 80–100 percent represent the average impairment of earning capacity. In general, conditions with lower ratings do not cause impairment of earning capacity although there are exceptions to this.

* * * * * * *

Yes, with the exception of 10 percent.

* * * * * * *

Yes, except in the lower ratings such as 10 percent.

* * * * * * *

Yes, except in the lower 10- to 20-percent ratings which would appear to have little or no real meaning in terms of impairment of earning capacity.

* * * * * * *

Yes, for the severe conditions. Usually, no for rating of 30 percent and under.

* * * * * * *

Yes, for severe conditions; usually, no on less than 30 percent.

Representative comments of respondents who did not believe the ratings in the schedule fairly represented average impairment in earning capacity

No. In the range of 10- and 20-percent disability there is likely to be no actual impairment of earning capacity.

* * * * * * *

No. There are too many high ratings given for conditions particularly in the orthopedic field, that interfere little with average earnings.

* * * * * * *

It does not. In many cases, there are glaucoma patients who maintain fields and proper intraocular tension for long periods of years under proper medical treatment, and there is no impairment to their earning capacity.

* * * * * * *

No. I don't think there is such a thing as an average impairment due to tuberculosis. Much depends on the education of the individual and his motivation. I believe this applies to other diseases too. Many instances could be cited in which tuberculosis increased earning capacity by directing a person's efforts into new lines.

* * * * * * *

Not always. For example, removal of a kidney, loss of testicle or partial loss of a penis may not impair earning capacity at all. In most instances the ratings are related to earning capacity at high levels.

No. An individual with one-half of the penis amputated has no impairment of earning capacity. Neither is a man with one kidney removed, assuming the remaining kidney is normal. The occupation, skill, or trade of an individual must be considered in connection with impairment of earning capacity.

No; the assumption that "average impairment was taken to be that in manual labor" bears little relation to the earning capacity of an employee whose duties for example, require no physical labor, i. e., an accountant whose loss of a toe or even a leg would not permanently cause any loss of earning capacity.

No. In my work with veterans, I find that even those with fairly high ratings do not necessarily have impairment of earning capacity.

No. In view of remarkable earning capacity of rehabilitated individuals, the ratings do not fairly represent the average impairment of earning capacity.

Generally speaking, no. With good motivation and benefits of a real rehabilitation program, many, including disabilities rated in the higher percentages, do not suffer any impairment of earning capacity and, as a matter of fact, improve their earning capacity because their injuries have given them a better insight in their own problems and civic responsibilities.

Summary and conclusions

Some respondents believe, and others do not, that the ratings do or do not represent the average impairment of earning capacity resulting from the various degrees of severity of physical impairment. Lower ratings do not fairly represent the average impairment in earning capacity resulting from the various degrees of severity of physical impairment, particularly those ratings below 30 percent.

AVERAGE IMPAIRMENT IN EARNING CAPACITY—DISABILITY RATINGS 10 AND 20 PERCENT

Coded question P

Do the disabilities rated at 10 percent and 20 percent constitute a material impairment of earning capacity?

Background

Much of the background to this question has been given in preceding questions.

The Veterans' Administration Schedule for Rating Disabilities (1945) lists over 1,500 disease and injury entities and conditions. About 300 of these have no assigned percentage rating; some 500 are

assigned a percentage rating of 10 and 20 percent; and the remainder of 700 are assigned a percentage rating of 30 percent, and above, to 100 percent. Discounting those conditions that are not assigned a percentage rating, 41 percent of the disease and injury entities and conditions are assigned a percentage rating of 10 percent and 20 percent in the schedule for rating disabilities. As of March 31, 1955, there were 1,185,000 veterans, out of 2,071,000, drawing compensation for disabilities rated at 20 percent and 10 percent. The annual value for these 20 percent and 10 percent disabilities was $326 million.

Discussion

Two-thirds of the respondents believed that the rating of 10 and 20 percent did not constitute a material impairment of earning capacity; 1 of 5 respondents expressed the opinion that the 10 percent and 20 percent ratings did constitute a material impairment in earning capacity.

Coded Question P

Table 47.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	21	14
Qualified	4	2
No:		
Unqualified	90	59
Qualified	5	3
Intermediate	32	21
Unanswered	1	1
Grand total	153	

Table 48.—*Distribution of replies by respondents' Medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	1	1	5		1	
Neurology	7	2		3		2	
Internal and general medicine	13			9		4	
Tuberculosis	9	1		6	1	1	
Peripheral vascular diseases	4			3		1	
Cardiovascular diseases	7		1	4		2	
Allergy	6	1		5			
Gastroenterology	6			4	1	1	
Tropical diseases	7	1		5	1		
Gerontology	6			5		1	
General surgery	11	1		9		1	
Orthopedics	10			5		4	1
Neurosurgery	6	2	1	3			
Plastic surgery	6		1	1		4	
Audiology and ear, nose, and throat	7	2		4		1	
Ophthalmology	6	3		1	1	1	
Urology	7	2		4	1		
Rehabilitation and physical medicine	8	1		6		1	
Dermatology	6	2				4	
Industrial medicine	9	2		5		2	
Others	4			3		1	
Total	153	21	4	90	5	32	1

TABLE 49.—*Distribution of replies by employment of resopndents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	5	8	5	27	2	10	4	20	5	25	----
Qualified	2	3	1	5	1	5	----	----	----	----	----
No:											
Unqualified	47	67	8	42	10	50	13	65	9	45	3
Qualified	1	1	1	5	2	10	----	----	1	5	----
Indeterminate	14	20	4	21	5	25	3	15	5	25	1
Unanswered	1	1	----	----	----	----	----	----	----	----	----
Total	70	----	19	----	20	----	20	----	20	----	4

Representative comments of the majority (disabilities rated 10 and 20 percent do not constitute a material impairment of earning capacity)

In my opinion, the disabilities rated at 10 percent rarely constitute an actual impairment in earning capacity. Those rated at 20 percent infrequently do until they progress to a degree of severity which would warrant a higher rating.

* * * * * * *

Disabilities rated at 10 percent do not seem to me to result in actual impairment of earning capacity. Some rated at 20 percent may impair earnings in some occupations, but not all. Even jobs classed broadly as "common labor" are not equal in their demands.

* * * * * * *

In general, a 10 percent disability rating does not constitute an actual impairment of earning capacity. There may be exceptions observed in finger injuries; for example, in the case of a typist. The rating of 20 percent in most cases represents some impairment of earning capacity; although there are many individuals and many occupations where a 20 percent disability would not constitute an actual impairment of earning capacity.

* * * * * * *

In many instances, no. This depends upon type of work performed prior to induction. Toe, other than great toe, for example, does not represent a loss of earning capacity in a laborer.

* * * * * * *

I believe some of the disabilities rated as 10 and 20 percent do not constitute an actual impairment in earning capacity. For example, removal of one testicle, disability rating 10 percent—this individual's earning capacity is not impaired; stricture of the urethra requiring dilation every 2 or 3 months, rated at 10 percent—earning capacity is not impaired; penis removal of glands, rated 20 percent—earning capacity not impaired, except possibly may cause an emotional conflict; atrophy of the testes rated as 20 percent—no impairment of earning capacity.

* * * * * * *

Usually not, though eczema, when moderate area involvement might be real handicap physically. Mild diabetes, no impairment of ability to work.

* * * * * * *

Disabilities of 10 and 20 percent when considered individually have very little effect on earning capacity. Exceptions, of course, are present and dependent on the type of work the individual is qualified for. For example, the individual rated 10 percent under valvular heart disease would be advised to avoid work where he would endure undue exposure. The 10 or 20 percent diabetic might escape from control with injuries or infections.

* * * * * * *

Frequently they do not, i. e., mild bronchitis, asthma, sinusitis, adhesions.

* * * * * * *

No. Under the existing regulations disabilities rated 10 and 20 percent represent minor physical handicaps. By and large, they constitute no impairment of

earning capacity. I seriously doubt if such disabilities have been basically responsible for altering occupational assignments.

* * * * * *

The undersigned does not believe that a percentage of disability can be developed objectively to such fine gradations as 10 or 20 percent, nor does the undersigned believe that disability ratings at 10 or 20 percent constitute an actual impairment of earning capacities, particularly for disabled veterans who have available to them both medicine and vocational rehabilitation.

* * * * * *

As a general rule, no. They take no account of other factors than tuberculosis itself; e. g., rehabilitation, education, intelligence, willpower, etc.

* * * * * *

No. These ratings seem to be for discomfort or mental trauma.

* * * * * *

Largely no. Many of these appear to be granted automatically on basis of mere diagnostic label without consideration of whether disability exists or not.

* * * * * *

For the most part, no. Tax abatements, job priorities, and service organizations serve to increase the number of such ratings and are always in competition with the competent and honest appraisal of the physician. In many cases, corrections, such as arch supports, and treatment or control, as in diabetes, restore earning capacity.

* * * * * *

Probably not. Recommend continuing the 10- and 20-percent ratings but paying a pension only when the disability reaches 30 percent.

* * * * * *

No. Generally, I don't believe a rating under 30 percent does, but such ratings must remain in order to give equity in cases where they are combined with other disabilities.

* * * * * *

These do not actually constitute impairment of earning capacity. They appear to be used more for the establishment of "service connection" to qualify for any eventuality in the future and/or other benefits.

* * * * * *

No. They should be recorded for future reference but payments should be eliminated.

* * * * * *

I believe not. Could a plan be made for future use to pay one-time awards for small residuals, so that something would be given beyond that paid to veterans with no residuals?

* * * * * *

Do the disabilities rated 10 and 20 percent constitute an actual impairment of earning capacity? Absolutely not. No one has ever made such a study.

Representative comments of the minority (disabilities rated 10 and 20 percent do constitute a material impairment of earning capacity)

Disabilities in my specialty rated at 10 and 20 percent are for burns and other scars and minor dental deformities. In some instances a scar or pigmentation disfigurement which is visible might jeopardize the earning capacity of the individual to the extent of the rating, whether or not accompanied by psychic disturbance. With the exception of scars on the lower extremities with poor nourishment the rating for the majortiy of lesions in my category is on the basis of either cosmetic deformity or functional impairment of mastication.

* * * * * *

Yes; but in some instances the dollar increases the disability, and in some cases it actually decreases it.

* * * * * *

In many cases, yes. Some cases with no percent disability have impairment of earning capacity. My experience is that industry shies away from hiring men who have compensable disabilities.

* * * * * *

77289—56——13

Yes, except for the above factor and difficulties in obtaining vocational or occupational employment opportunity, such as in the case of the epileptic who is practically ostracized by his application, or the moderate or severe tic sufferer and psychomotor epilepsy individual and the paralysis agitans case.

* * * * * *

Ten or twenty percent disability as mentioned above has to be considered in view of the occupation. If an individual developed post-traumatic epilepsy and was rated 10 percent because of the infrequency of his seizures, he would be severely impaired if his usual occupation was that of a truck driver, but only slightly impaired for clerical work.

* * * * * *

Sometimes they do. A moderate peroneal palsy (foot drop) rates some 20 percent yet does constitute a handicap to earning capacity.

* * * * * *

In some instances, no; in others, yes. The decision would rest primarily on the degree of functional impairment and the nature of the individual's occupation.

* * * * * *

For many types of manual work they do at the 20 percent level.

* * * * * *

Some 10 and 20 percent disability ratings represent diseases which cause actual impairment of earning capacity; e. g., sinusitis, cystitis, prostatitis, hemorrhoids, auricular fibrillation, etc. If a number of these disabilities, so rated, coexist in the same person, the impairment of earning capacity may be considerable.

* * * * * *

These would seem to reflect more potential than actual impairment. However, even with these considerations 10–20 percent ratings seem very fair.

* * * * * *

Yes, there is an intermittent loss of earning capacity occasioned by necessary visits to the physician or to the hospital.

Summary and conclusions

Most of the medical specialists who responded to the question, two-thirds, said that the disabilities rated 10 and 20 percent did not constitute a material impairment of earning capacity.

AVERAGE IMPAIRMENT IN EARNING CAPACITY—KNOWN MEDICAL DATA

Coded question Q

Do you know of any medical data which can be used to set percentage ratings to represent the average impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations?

Background

In the study of the compensation program, the President's Commission on Veterans' Pensions was faced, early in the project on the schedule for rating disability, with a corollary problem of rules and precedents for measuring loss of earning power. Study of this problem revealed that: (1) The act of 1917, War Risk Insurance Act, as amended, that provided for disabilities to be rated in percent of total disabilities also provided for the basis of the ratings—that is, "upon the average impairments of earning capacity resulting from such injuries in civil occupations and not upon the impairment in earning capacity in each individual case"; and further provided that the Bureau of War Risk Insurance was to readjust the schedule of ratings from time to time in accordance with experience. (2) The architects of the 1919 schedule had no guide, nor any generally accepted type of table or other form of measurement by which the

factors to be used in adjusting disability ratings to "average impairments of earning capacity". (3) At the time of this activity (1917) there was no State in the United States with workmen's compensation law that had sufficient experience upon which a schedule could be built for rating disabilities in terms of total disability—the California Workmen's Compensation law provided for a similar schedule, but that State, too, had insufficient experience. (4) Subsequent to 1917, veterans compensation acts were searching for remediable measures that would suit the particular situations—frequently interjecting statutory awards for specific disabilities which circumvented the prohibition of the basic concept of the law for percentage disability ratings based on "average impairments of earning capacity". (5) No substantial modification in the basic concept "average impairments of earning capacity" was made during the intervening years—schedules were changed in 1925, but not the basic concept, and changed back again in 1933 and revised in 1945 with no change in the basic concept. (6) The framers of the original United States veterans compensation law in 1917 did not expect their framework to remain unchanged during the next four decades. They regarded much of it as experimental, and hoped experience would lead to subsequent improvements, but it was found that little basic change has occurred, and that many of the early objectives have become obscured. The same situation exists in the States' workmen's compensation field, as one authority expressed it:

> If, in the field of our mechanical contrivances, the same adherence to old models had prevailed as that which is found in respect to social arrangements, we should now be driving around in oxcarts.

Coded Question Q

Table 50.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	4	3
Qualified	26	17
No:		
Unqualified	73	48
Qualified	32	21
Indetermine	13	8
Unanswered	5	3
Grand total	153	----------

TABLE 51.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8			4	3	1	
Neurology	7		2	3	1		1
Internal and general medical	13			4	6	2	1
Tuberculosis	9		2	5	1	1	
Peripheral vascular diseases	4		1	2	1		
Cardiovascular diseases	7	1	1	3	1		1
Allergy	6			5		1	
Gastroenterology	6			4	1		1
Tropical diseases	7		2	5			
Gerontology	6			4	2		
General surgery	11	1	1	5	4		
Orthopedics	10		4	3	1	2	
Neurosurgery	6		3	2	1		
Plastic surgery	6		1	4	1		
Audiology and ear, nose, and throat	7			4	2	1	
Ophthalmology	6		2	2		2	
Urology	7		3	2	2		
Rehabilitation and physical medication	8	1	2	4	1		
Dermatology	6		1	2	1	2	
Industrial medicines	9		1	5	2	1	
Others	4	1		1	1		1
Total	153	4	26	73	32	13	5

Discussion

Seven-tenths of the respondents stated that they knew of no medical data which could be used to set percentage ratings to represent the average impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations. Two-tenths of the respondents stated that they knew of some medical data which could be used to set percentage ratings to represent the everage impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations. The remaining respondents either replied vaguely to the question or did not answer the question.

TABLE 52.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	1	1	1	5					1	5	1
Qualified	16	23	3	16	1	5	1	5	5	25	
No:											
Unqualified	27	39	8	42	12	60	14	70	11	55	1
Qualified	18	26	3	16	6	30	3	15	1	5	1
Indeterminate	5	7	3	16			2	10	2	10	1
Unanswered	3	4	1	5	1	5					
Total	70		19		20		20		20		4

Representative comments of the majority. (Do not know of any medical data to set percentage ratings)

No. However, the larger industrial organizations should have data accumulated that could prove valuable in this respect.

* * * * * *

No, unless data is available from some of the better insurance carriers, particularly those writing general health and accident insurance. Some information might be obtained from compensation insurance carriers. As high as these awards usually are, I do not believe they equal the awards in the schedule.

* * * * * *

No, unless you could procure this material from the insurance companies.

* * * * * *

None except those used by industrial commissions in various States.

* * * * * *

No, though I should think certain of the insurance companies must have data of this type.

* * * * * *

No. I do not believe we have any set of medical data that can be used as a general yardstick of measurement. I believe each case must be considered individually on its own merit.

* * * * * *

No. Each case has to be evaluated fairly and impartially, commensurate with pathology found.

* * * * * *

There is no such thing as average impairment. Each case should be judged on the basis of diagnosis, severity, and type of employment.

* * * * * *

So far as I know there is no such accurate data. Civil occupations vary so greatly in physical and mental requirements that I do not believe such accurate data could be compiled. For instance, loss of fingers, which would completely incapacitate a watchmaker, would not be disabling for a businessman or lawyer, in regard to their respective abilities to make an adequate living. The same comparison could be made between, say, a surgeon and an internist.

* * * * * *

As previously discussed, the undersigned knows of no medical or other data available at this time which can be used to set percentage ratings to represent the average impairment in earning capacities resulting from various diseases and injuries. Such a rating, in the opinion of the undersigned, must be based on the clinical judgment and experience of the individual making the rating.

* * * * * *

No, and there probably will never be any. Sound medical judgment of the disease and/or injury together with periodic reevaluation offers the most sensible means. The individual's occupation must receive consideration also.

* * * * * *

No, because there will always be the difference of opinion of the examiner and a difference of interpretation of any prescribed data.

* * * * * *

I know of no closely comparable data for percentage ratings for disability from chronic pulmonary tuberculosis in civilian occupations.

* * * * * *

Particularly difficult in psychiatric conditions.

* * * * * *

No, except in certain fields. For instance, the amount of disability and loss of working capacity after such operations as gastric resection, colostomy, and the like is well known from studies on nonveteran populations.

* * * * * *

No, but such is possible with the aid of medical specialists and experts from other fields.

* * * * * *

No. Along this line, it would be most interesting to survey the present earning capacity of present-day persons being paid disability payments.

* * * * * *

No, as a career Armed Forces physician, I am not acquainted with such medical data for civil occupation.

* * * * * * *

No. It would appear to me that the Veterans' Administration is in an excellent position to obtain such data by actually studying the earnings of veterans in the various categories of disability and comparing them to the earnings of nondisabled veterans. Certainly, the information obtained would be more valuable than a composite of opinions or clinical impressions obtained in answer to the above sections of this question.

* * * * * * *

Average impairment in earning capacity would represent economic rather than medical data. Medical disability and industrial disability are distinct and separate findings.

* * * * * * *

The data depends upon actual examination of the payroll of the employer before disease or injury and of the payroll of the employer after the residual phase has set in and the claimant is reemployed. The problem is primarily an economic question and only secondarily medical.

* * * * * * *

No. I think this is more an industrial and social than a medical problem.

* * * * * * *

No, but it might be possible to set up a group of criteria after careful study.

Representative comments of respondents who know of medical data to set percentage of ratings to represent "Average impairment in earning capacity, etc."

Six of the respondents of the twenty-six who said they knew of medical data, in answer to this question, made references to certain medical publications.

Eleven of the twenty-six respondents, who said they knew of medical data, in answer to this question, made references to: commercial insurance companies; the various State compensation laws for industrial diseases and accidents; and State industrial commissions.

The remaining nine respondents in this group stated in their replies:

We are working on a scheme.

* * * * * * *

Yes, but they cannot be so exact as to arrive at lower multiples than 0, 33.3, 66.6, and 100 percent.

* * * * * * *

Those for epilepsy have been estimated and there are good statistical studies on results of thereapy for the psychomotor epilepsy group.

* * * * * * *

Arthritis percentage ratings should be adapted to the classification of the American Rheumatism Association in regard to severity and functional impairment.

* * * * * * *

Such data may eventually be available from followup statistics on placement and employability, now being collected by work classification units, e. g., American Heart Association work-classification unit and rehabilitation teams supported by various social agencies.

* * * * * * *

I believe the diagnostic classifications of the nomenclature and criteria for the diagnosis of diseases of the heart are the most serviceable and should be adopted and adapted to percentage interpretation.

* * * * * * *

Yes. There is a vast amount of information available as a result of post World War II rehabilitation and training programs.

* * * * * * *

Yes. Medical data with allied information collected by another discipline have been applied by the rating agency of the VA which I believe has been fairly satisfactory. It is presumed that insurance companies have adhered to a recog-

nized system of collecting medical data for determing compensation for disease or injuries.

* * * * * * *

In peripheral nerve injuries, the average functional as compared to anatomical regeneration is available in the forthcoming VA study. I know of no other data.

Summary and conclusions

Two-thirds of the respondents commented that they did not know of any medical data which could be used to set percentage ratings to represent the average impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations. The comments varied.

Of the group of respondents who stated they knew of medical data that could be used for the purposes, as requested in the question, some made references to certain medical publications; some made references to commercial insurance companies; State industrial commissions; and other State compensation commissions; other respondents in this group referred to miscellaneous sources.

REEXAMINATIONS

Coded question R

As regards disabilities within your specialized field of medicine, how frequent should the reexamination be scheduled?

Background

Legislative history indicates that veterans drawing disability compensation were required to undergo a physical examination at various intervals of time, to determine the continuance of monetary awards for their disability. For example, the act of March 3, 1819 (3 Stat. L. 514), required the affidavits of two surgeons or physicians certified by a magistrate and required attesting to the rate of the disability at the time of physical examination, and at the end of 2 years thereafter. The act also provided that, in a case of a—

continued disability it shall be stated at a rate below that for which pension [compensation] was originally granted, the applicant shall only be paid at the rate in the affidavit: *Provided*, That where the pension [compensation] shall have been originally granted for a total disability, in consequence of a loss of limb, or other cause which cannot, either in whole or in part, be removed, the above affidavit shall not be necessary to entitle the applicant to payment.

This act was entirely repealed by an act of July 14, 1832 (4 Stat. L. 599.)

Biennial physical examinations of veterans with service-connected disabilities was reinstituted by the act of March 3, 1859, and again repealed by the act of June 21, 1879.

In his Report of the Commissioner of Pensions, 1900, page 31, the Commissioner stated:

The only law bearing upon this subject provides that the Commissioner of Pensions shall have power to order special examinations in his judgment, the same may be necessary, and to increase or reduce the pension [compensation] according to right and justice. The necessity of annual or biennial examinations in cases of soldiers and sailors pensioned [compensation] for disabilities recently contracted has become apparent, and under the authority conferred upon the Commissioner by the act of June 21, 1879, I have directed that in cases where pension [compensation] is granted on account of disabilities which are likely to vary in degree annual or biennial examinations shall be required. It is believed, however, that the law providing for biennial examinations of these pensioners [service-connected disabilities] would prove more efficient and that it should be reenacted.

The War Risk Insurance Act of October 6, 1917, as amended, contained a provision for physical reexaminations at such times, and as frequently and at such places, as was reasonably required. The veteran was, in the discretion of Director of the Bureau, paid his reasonable traveling and other expenses and loss of wages incurred in order to submit to such examination. If he refused to submit himself for, or in any way obstructed, any examination, his right to claim compensation under the act was suspended until such refusal or obstruction was removed. Similar provisions were enacted in the act of August 9, 1921, and World War Veterans Act of 1924. On July 2, 1926, the provision for reimbursement of loss of wages was eliminated and superseded by a provision for payment of per diem for the period of travel and observation. Under the World War Veterans Act, claimants carrying a total permanent disability award for active tuberculosis, pulmonary or otherwise, were reexamined at intervals of 5 years, and the award continued or reduced in accordance with the findings at such reexamination.

Also, under the World War Veterans Act, awards were reviewed, in accordance with the provisions of the law, and the administration was authorized to end, diminish, or increase the compensation previously awarded.

Today, similar provisions are provided in Veterans' Administration Regulations, Claims 1185. The regulations require an initial examination of convalescent cases in 6 months; that is after the serviceman has been released from the Armed Forces otherwise within 1 year. After the initial examination, reexaminations are scheduled on the combined nonstatic disabilities, except as otherwise provided in the schedule for rating disabilities, such as tuberculosis over a 11-year period. At the present time the practice is to review the records, and the person may or may not have to present himself for a physical examination. Reexaminations in nonstatic cases are scheduled upon the degree of disability as shown in the record on a percentage basis [Italics supplied.]:

Where the percentage of disability is *10, 20, and 30 percent*, after examination of the record, the person may or may not be given a physical examination, *in 5 years.*

Disability rating is *40, 50, 60, 70 percent*, the person may or may not be given a physical examination, *in 3 years.*

Disability rating is *80, 90, 100 percent*, the person may or may not be given a physical examination, *in 2 years.*

Other provisions for reexaminations are made:

If there is *an increase* of 10 percent in the disability rating, reexamination is scheduled in accordance with the above schedule.

If there is *a decrease* in 10 percent disability rating, reexamination is scheduled, regardless of rating, *in 2 years.*

"If the disability is unchanged [over what period is not specified] so as to warrant continuation of the same percentage rating, 5 years after the date of initial examination or 5 years after the date of the first examination disclosing current percentage of disability."

"In running award tuberculosis cases which do not qualify for rating without future scheduled examination by reason of absence of improvement established by examinations at least 5 years apart, examination will be scheduled at 6 month intervals for the first year, thereafter at yearly intervals.

"* * * Where the rating board determines that improvement earlier than the periods above can be expected, appropriate future examination date should be assigned and explanatory statement set forth on the rating decision justifying the action."

Reexaminations are *not* made in service-connected cases under the following conditions:

(*a*) When the disability is established as static.

(*b*) When the rating is *a prescribed minimum* rating in the schedule for rating disabilities. [Over 500 conditions in the schedule are 10 to 20 percent.]

(*c*) In cases of veterans of World War I, and other veterans over 55 years.

(*d*) When the lesions and symptoms are shown by examinations scheduled as above, or other examinations and hospital reports to have persisted without material improvement for a period of 5 years or more.

(*e*) Where the disability from disease is permanent in character and of such nature that there is no likelihood of improvement.

(*f*) Where a combined disability evaluation would not be affected if the future examination should result in reduced evaluation for one or more conditions.

Reexaminations are made for non-service-connected pension disabilities, where a permanent total disability is in effect on nonstatic conditions, within 30 months of the initial rating.

Reexaminations for non-service-connected pension disabilities are *not* made on veterans of World War I, and other veterans over 55 years of age.

Reexaminations are not made on veterans where total disability is *confirmed by history* of the case.

Tuberculosis.—Public No. 339, section 2, 81st Congress, provides a penalty for failure to follow prescribed treatment or to submit to examination, in the case of an ex-service person who has reached a condition of complete arrest, and within a 2-year period following establishment of complete arrest. The total disability award for 2 years following establishment of complete arrest is reduced to 50 percent for failure to submit to an examination as prescribed above. Veterans' Administration Regulations 1135 (A) provides that where there is other classification than active pulmonary tuberculosis, and complete arrest is not established, examinations are scheduled 6 months after date of examination or hospital report, and thereafter at intervals of 6 months.

Statistical data and discussion

The frequency of scheduled physical reexaminations for nonstatic disabilities is shown in the following tabulation of the recommendations made by the respondent medical specialist, as requested by the question. The respondents' recommendations are grouped and accumulated under headings pertinent to the group making similar recommendations. The number of respondents making a specified type of recommendation are shown under "number." Where "physical" is used in this discussion, it includes mental also.

The recommendations made in response to this question are given in the following tabulation:

TABULATION: FREQUENCY OF PHYSICAL REEXAMINATIONS

NONSTATIC DISABILITIES

Frequency of reexaminations and number of recommendations for each frequency

	Number
I. Continuous, recurring, periodic physical reexaminations—time interval between reexaminations—as specified and shown—termination date, and duration not specified—duration unlimited.	
(*a*) Begin 2 to 3 months after initial rating:	
(1) All cases:	
Every 2 months	1
Every 3 months 1st year, then every 6 months	1
Every 3 months for 6 months; then 6 months; then 12 months; then every 2 years; then every 3 years; then every 5 years	1
(2) Tuberculosis cases:	
Every 3 months after discharge from hospital, for 1 year; then 6 months up to 2 years; then every 1 year	1
The same as the previous recommendation, except that examinations be made every 2 years after the first 2-year period in the above	1
Every 6 months for active cases and every 1 (annual) year for inactive	1
Every 6 months for 3 years; then every 1 (annual) year thereafter	1
Every 6 months for 3 years, then every 2 to 3 years thereafter	1
(*b*) Every 6 months after initial rating	15
(*c*) Every 12 months after initial rating (annual)	44
(*d*) Every 18 months after initial rating	11
(*e*) Every 2 years (biennial)	18
(*f*) Six months after initial rating, then every 2 years	3
(*g*) Every 3 years	5
(*h*) According to percentage of disability:	
Disabilities 50 percent or more every 6 months	1
Disabilities 10 to 30 percent every 3 months; 30 to 60 percent every 6 months; 80 to 100 percent every 12 months (annual)	1
10 to 40 percent every 12 months (annual), others every 2 years	1
40 to 100 percent every 2 years; 10 to 30 percent every 3 years	1
(*i*) According to present Veterans' Administration policy	7
(*j*) Miscellaneous	3
II. Continuous recurring physical reexaminations as specified:	
(*a*) As specified by medical specialist	3
(*b*) According to disability, and disease and injury	12
III. Physical reexaminations more frequent—periodicity not specified	5
IV. Physical reexaminations should not be performed	1
V. Periodic physical reexaminations, then discontinued after specified number of years:	
Every 6 months for 18 months, then none	1
Every 6 months until condition is stabilized for 3 successive examinations	1
Every 6 months, deafness every year, for 3 years	1
Every 6 months for 5 years, then none	1
Every year for 3 years, then none	1
Every 18 months for 5 years, then none	1
Reexamination 1 year after initial rating, then 3 years after initial rating, then 5 years after initial rating	1
VI. No recommendations	7
Grand total	153

Representative comments of respondents who favor annual physical reexaminations in nonstatic disabilities

I believe that most psychiatric cases should be reexamined each year, and if they do not show some proof they have tried to seek medical or other rehabilitative treatments, like failure to appear for examination, they should be notified that their pensions will be dropped or reduced until they do show such proof. This would give the positive health emphasis so much needed in NP work more probably than in any other field. The Government is already emphasizing self-improvement through education for GI's and more recently rehabilitation. The pension system needs to be shot through with this emphasis.

* * * * * * *

Those veterans who have conditions which are permanent in nature and static as to progression or regression and properly evaluated on an individual basis probably do not require further examination. From time to time they may require hospital treatment without change in disability rating.

For the others, so many factors enter in that to set a definite interval for reexamination is most difficult. A disability once granted, even though moderate or minimal, becomes a crutch to all but the most stalwart of individuals. Thus, to remove this crutch from certain medical conditions acts to increase unwarranted invalidism. Particularly is this true in conditions wherein the psyche plays such an important role, such as peptic ulcers, colitis, dysentery, arthritis, etc.

However, inasmuch as I am in favor of the annual physical examination for all, I believe an annual report should be made on that part of the physical deficiency for which the individual has been rated.

* * * * * * *

The frequency of examinations depends entirely upon the individual case and the diagnosis. Certain fixed conditions such as loss of limb, loss of organ, etc., would require infrequent examinations. On the other hand, diseases such as peptic ulcer would need reexamination not less than annually until the disability was rated zero.

* * * * * * *

Again, I individualize. I set an estimated time after an operation when I believe the patient will be able to resume his work. This done on a generous basis from the standpoint of time. Annual reexaminations are advised unless more frequent examinations are indicated. As an example: After gastric resection for a nonmalignant condition, annual examinations advised. For a malignant condition, when resection of stomach or colon has been carried out, I advise reexamination after 6 months, after another 6-month period, and annually thereafter unless conditions indicate more frequent examinations.

* * * * * * *

In cardiovascular diseases there are three groups of patients.

1. Those showing progressive downhill courses—they should be reevaluated at least once a year.
2. Those in a stationary status who could go two years unless some new development occurred.
3. Those showing improvement (a smaller group except for frostbite cases) which should be rechecked annually.

* * * * * * *

At least once a year. The time element in the treatment of tuberculosis has been radically shortened since 1945. In posttreatment cases we recommend an examination every three months for the first year, and at least annually thereafter.

* * * * * * *

Amputations do not need to be reexamined. Diseases, i. e., arthritis, tuberculosis of bones, myositis, etc. should be examined at least yearly.

Orthopedic disabilities should not be reexamined until 12 months have elapsed from date of discharge from active medical care, which includes all rehabilitative efforts for optimal physical restoration. Other rehabilitative efforts should occur concurrently to be effective.

* * * * * * *

Obviously this is influenced by the pathologic lesion. Chronic nephritis—believe the groups classified as moderate and mild should be reexamined at yearly intervals to justify an increase or decrease in the disability rating.

* * * * * * *

In functional and nonstatic conditions, regardless of percentage ratings, reexaminations should be scheduled on an annual basis until structural changes set in which have definite relation to earning capacity or if a fair degree of perma-

nency has been established. These intervals, however, in certain cases may be increased before such periods at the discretion and recommendation of the examiner who would be more familiar with the fluctuations and progress of the disease.

* * * * * * *

Patient without static disability should be reexamined annually for the following reasons:

Some disabilities improve spontaneously with passage of time, e. g., residual of cold injury; simple arterial thrombosis.

Some diseases are surgically correctible, e. g., varicose veins, arteriovenous aneurysm, occlusion of the bifurcation of the aorta, aneurysm of the aorta.

Some are amenable to significant improvement by newly developed drugs, e. g., chemotherapy of hypertension, Raynaud's phenomenon, idiopathic, acrocyanosis.

Development of collateral vessels in patients with arterial occlusion may materially decrease their incapacity.

* * * * * * *

Annually or more seldom. The tropical diseases as a group are strikingly amenable to therapy. With proper therapeutics, residuals are few, inconsequential, or nondisabling. As soon as possible these cases should be properly treated, evaluated as convalescents, and permanently disposed of.

* * * * * * *

In the field of neuromuscular diseases which is of special interest to those of us in physical medicine, progressive and regressive patients should be reexamined every year, during which time rehabilitation techniques should be vigorously applied in those cases where it is indicated. Static conditions should not be reevaluated.

* * * * * * *

At least once annually. The reason for this is that many individuals who have achieved remarkable rehabilitation can often advantageously enter an entirely new occupation in which their disability is no handicap at all as far as their earning power is concerned.

Representative comments of respondents who favor biennial (every 2 years) physical reexaminations

Probably every 2 years. This would principally be for the purpose of uprating the veteran as his disease grows worse, as is the usual situation in acquired heart disease. The reverse procedure would be less common but conceivable after surgical correction of cardiac or peripheral vascular disease.

* * * * * * *

For major burns (third degree involving 20 percent or more of the body surface) I believe that patients should be given 100 percent disability for 18 months following injury, then reevaluated. For lesser burns, scars, and skin grafts evaluation should be on the basis of location of lesion severity (functional impairment), and amount of disfigurement first following healing and next at the end of an 18-month period. Reexamination should be scheduled at 2-year intervals. Major dental and oral lesions which require prosthetic appliances should be checked at 6-month intervals until the condition becomes static.

* * * * * * *

For diseases of the ear, nose, and throat every 2 years. For hearing impairment, examination every 2 years for 3 examinations and then once every 5 years.

* * * * * * *

Nonstatic disabilities like peptic ulcer, chronic ulcerative colitis, hepatitis, chronic enteritis should be examined every 2 years, especially those with higher rating.

* * * * * * *

Every 18 to 24 months. This should give time to note change progress, deterioration, or improvement in most neurological disorders.

* * * * * * *

Somewhere between 12 and 24 months. If reexamination must be uniform, then every 18 months. In the lymphomas and most malignancies no injustice would be done if the rating were kept at 100 percent until a 5-year evaluation.

* * * * * * *

This is extremely variable, with as frequent as every 3 months in malignancies to as infrequent as never in such situations as the loss of a tongue which is perma-

nent. As an average in most gastrointestinal situations, however, every 2 years should give you an accurate appraisal as to the degree of disability.

* * * * * *

The conditions which I have been designated to review are all nonstatic in nature. In my opinion, all nonstatic conditions regardless of the percentage of disability should be reevaluated at least once every 2 years. Present treatment methods may, in many instances, produce a decided change for the better and even effect cure in many instances in a year or two, and to delay reevaluation for as long as 3 to 5 years permits many individuals to continue to receive pensions far beyond the time when the disability ceases to exist at least to the degree which it was originally present.

* * * * * *

At yearly intervals and at maximum every 2 years. Disability resulting from scars and many other fibrous contractures decreases with the age of the scar, especially in the young military individual. These scars soften and become more pliable with age. Skin grafts and pedicle tissues soften, smooth out, and become more stabilized from a vascular and neurogenic standpoint with the increase in age. Many patients adapt to loss of parts, such as parts of jaws or teeth, etc., and become adjusted to their environment so that their earning capacity is increased merely by virtue of their finding the right slot and attitude toward their conditions.

* * * * * *

In pulmonary tuberculosis cases, reexamination should be made at the inactive (1 year) and inactive (2-year) stage. Following this, if the disease shows stability, rating should be dropped for tuberculosis. Further, disability rating would then be for degree of functional impairment only. This, of course, should not preclude reinstating of disability rating for tuberculosis in the event of reactivations.

* * * * * *

Twelve to twenty-four months. For infectious diseases as tuberculosis, evaluation should be within 24 months until inactivity present for 5 years. For degenerative diseases as emphysema, fibrosis, etc., evaluations after the initial one might be less frequent.

Summary and conclusions

One-half of the medical specialist respondents favor annual physical reexaminations up to a maximum of 2 years after the initial disability rating has been given in nonstatic disabilities. One-eighth of the respondents favor biennial physical reexaminations after the initial rating has been given. The remaining respondents made diversified recommendations. Five of the 153 respondents particularly singled out tuberculosis in their recommendations; and 2 of this group of 5 recommended annual physical reexaminations with other qualifications. A majority of the respondents favored annual examinations.

SUMMARY TABLE

Summary table 53 tabulates the statistical data of the replies to questions on the Veterans' Administration schedule for rating disabilities and percentage awards, and shows the percent of grand total of replies to the coded questions from K to Q, inclusive.

TABLE 53.—*Summary on Veterans' Administration schedule for rating disabilities and percentage awards: Distribution of answers to questions*

	Classified replies											
	Yes				No				Indeterminate		Unanswered	
	Unqualified		Qualified		Unqualified		Qualified					
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
K	37	24	60	39	32	21	15	10	8	5	1	1
L	52	34	44	29	39	26	14	9	2	1	2	1
M	36	24	48	31	39	25	19	12	7	5	4	3
N	67	44	2	1	74	48	7	5	1	1	2	1
O	46	30	18	12	41	27	17	11	25	16	6	4
P	21	14	4	2	90	59	5	3	32	21	1	1
Q	4	3	26	17	73	48	32	21	13	8	5	3

NOTE.—Grand total, 153.

CHAPTER IV. STATUTORY AWARDS

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INTRODUCTION

Background

Statutory awards for service-connected disabilities are monetary rates granted, by legislation, for specified disabilities, and payable in addition to or in lieu of the percentage benefits. The Veterans' Administration schedule for rating disabilities only provides the percentage for the proportionate monetary amounts of (100 percent) total disability.

Today, monetary awards for total disability (100 percent) and amounts for partial disabilities are set by law corresponding to the percentage of disability in gradations of 10 percent. For example, where the disabilities are rated in gradations of 10 to 100 percent the corresponding amount is established by law:

Percent:		Percent—Continued	
10	$17	60	$109
20	33	70	127
30	50	80	145
40	66	90	163
50	91	100	181

Statutory awards for specific disabilities began when the Civil War was within a year of its termination. The General Law of 1862 established monetary payments for total disabilities for enlisted persons as $8 per month, and for officers the awards were set according to rank, not to exceed $30 per month, for a lieutenant-colonel. Proportionate amounts for partial disabilities were to be provided. The act of July 4, 1864, raised the monetary awards for certain specified disabilities $20 and $25, such as: Loss of sight of both eyes; loss of

both hands; loss of both feet. This monetary raise benefited principally enlisted persons who had these disabilities. In addition, this innovated concept established two different systems of payments for disabilities considered as total—one system with a maximum payment for total disability of $8 per month, which was prorated in accordance with the degree of disability less than total; and the other, which was fixed, could not be prorated and was over double the total disability rate. By subsequent enactments to this first act for extra payment for specified disabilities, additional specified disabilities were added to the list, and increased monetary amounts provided. A table of rates, provided by law, for permanent specified disabilities prior to 1917, and up to 1929 is contained in Federal Laws Relating to Veterans of Wars of the United States, 72d Congress, 1st session, Senate Document No. 131, page 65. (This is also reproduced in Staff Report No. I, page 166.)

The War Risk Insurance Act of October 6, 1917, as amended, provided for two schedules of disability monetary awards. One monetary award was based upon the concept of "average impairments in earning capacity" and correlated to permanent disability and reduction in earning capacity of the disabled veteran, with percentages of total (100 percent) disability paid a corresponding monetary value set at $30 per month for a single man. The other schedule (a dismemberment schedule) shied away from the basic concept of "average impairment in earning capacity," and paid extra monetary benefits (above total disability). For example, for the loss of both feet, or both hands, or both eyes, or for becoming totally blind, $100 per month. The act of October 6, 1917, also provided $100 per month to a disabled veteran helplessly and permanently bedridden; $20 per month, in addition to total disability, where the veteran was helpless and in constant need of a nurse or attendant.

A long series of laws subsequently increased the statutory awards and list of specific disabilities. Appendix H, of this report, shows the series of laws and increased list of specific disabilities, with the applicable statutory award, since 1917 up to the act of August 28, 1954. Today, for example, statutory awards for specific disabilities are granted in addition to the basic percentage rate; $47 per month for loss, or loss of use of, 1 foot, 1 hand, creative organ, or blindness in 1 eye. Statutory awards are granted in lieu of the basic percentage awards and exceed the $181 total disability (100 percent) award under the basic percentage rates from $279 per month for specified disabilities, as shown in the table in appendix H, to a maximum of $420, with intermediate rates that are not fixed by law set by the Administrator of Veterans' Affairs. Tuberculosis, all forms, are paid a minimum amount of $67 per month for life, when completely arrested; also statutory graduated percentages are granted over an 11-year period for pulmonary tuberculosis.

The peacetime disabled veteran is not granted the full monetary awards, quoted above, for specific disabilities and the basic percentage awards. He receives 80 percent of the above rates, except as provided in the law for hazardous duty, etc.

The following list of questions was asked of the medical specialists in this survey. Each is analyzed separately in the following pages:

Code letter of question	QUESTION
S.	Are the statutory awards in your specialized field medically sound in comparison with other rated disabilities for which no such awards are provided? Do statutory awards provide equal compensation for equal physical impairments?
T.	Under the schedule, a permanent and total disability is paid a rate of $181 monthly. Under the statutory awards, alternative higher rates are paid ranging up to $420 monthly for certain disabilities. In your judgment, is there medical validity for different monetary rates for disabilities which are all rated 100 percent?
U.	Have there been any medical developments in chemotherapy, surgery, diagnosis, treatment, prosthesis, etc., in the past 10 years within your medical specialty, to affect the conditions in the statutory awards?

STATUTORY AWARDS—MEDICAL SOUNDNESS

Coded question S

Are the statutory awards in your specialized field medically sound in comparison with other rated disabilities for which no such awards are provided?

Do statutory awards provide equal compensation for equal physical impairments?

Background

The background at the beginning of this chapter is applicable to this question.

Statutory awards are principally given for "loss of, or loss of use of." Excepting the awards for the helplessly, permanently bedridden; and for aid and attendance, statutory awards are not given for the residuals of diseases that are included in all specialized fields of medicine. For example, there are no statutory awards for skin conditions and tropical diseases, except for loss of vision from some of these diseases such as leprosy, loss of use of limbs from filariasis or leprosy, or paralysis of muscle groups from encephalitis, or other infectious conditions; cardiovascular conditions, etc.

Specific drug therapy of relatively recent development has revolutionized and changed the picture of tuberculosis. The statutory award for the payment of loss of creative organ, or function, is in some respects questionable, such as, there is no comparison between the loss of one, or both, testicles, and the anatomical loss of the penis or other ancillary structure. The specified disabilities for which statutory awards are provided are those recognized by most insurance companies as producing total permanent disability.

The question of equal compensation for equal physical impairment leaves room for argument. For example, the individual with a facial injury, resulting in grotesque and unsightly facial deformity, receives no statutory awards.

Discussion

Forty-three percent of the respondents say the statutory awards are not medically sound in comparison with other rated disabilities for which no such awards are provided. Twenty-five percent of the

respondents maintain that the statutory awards are medically sound in comparison with other rated disabilities for which no such awards are provided. Four percent of the respondents answered the question vaguely, and 27 percent expressed no opinion.

Seven respondents of ten practicing the medical speciality of orthopedics (the specialized field of medicine in which a greater majority of the statutory awards are made) said that the statutory awards are not medically sound, in comparison with other rated disabilities for which no such awards are provided; two of this group of medical specialists disagreed with these seven and stated the opposite was true—that the wards are medically sound; and one respondent in this group was vague in his reply.

Coded Question S

Table 54.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	34	22
Qualified	5	3
No:		
Unqualified	60	39
Qualified	6	4
Indeterminate	6	4
Unanswered	42	28
Grand total	153	

Respondents practicing in the specialized field of rehabilitation and physical medicine were equally divided in their opinions, that is, out of 8 respondents, 4 said the statutory awards were medically sound; and 4 said the statutory awards were not medically sound.

There was no wide diversity of expressed opinions between the non-Governmental medical specialist respondents and the governmental medical specialist respondents.

The second part of this question "Do the statutory awards provide equal compensation for equal physical impairments?" was not answered by all the respondents. There were only 7 respondents, of 153 total number, who believed that the statutory awards provided equal compensation for equal physical impairments; and 22 respondents of 153 disagreed and stated that the statutory awards did not provide equal compensation for equal physical impairments. This left 80 percent of the respondents who did not express an opinion to the question, as given here.

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TABLE 55.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8			2			6
Neurology	7	4		2			1
Internal and general medicine	13		1	6	4	1	1
Tuberculosis	9	1		4	1	2	1
Perpheral vascular diseases	4	1		3			
Cardiovascular diseases	7	1		4			2
Allergy	6	1		1			4
Gastroenterology	6			4			2
Tropical diseases	7	1		1			5
Geronotology	6			4			2
General surgery	11	3	2	3			3
Orthopedics	10	2		7		1	
Neurosurgery	6	3		1	1		1
Plastic surgery	6	2					4
Audiology and ear, nose, throat	7	2		1			4
Ophthalmology	6	2		2		1	1
Urology	7	2		5			
Rehabilitation and physical medicine	8	3	1	4			
Dermatology	6			2			4
Industrial medicine	9	3	1	3		1	1
Others	4	3		1			
Total	153	34	5	60	6	6	42

TABLE 56.—*Distribution of replies by employment of Respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	15	21	5	26	3	15	2	10	6	30	3
Qualified	5	7									
No:											
Unqualified	19	27	6	32	12	60	12	60	10	50	1
Qualified	6	9									
Indeterminate	6	9									
Unanswered	19	27	8	42	5	25	6	30	4	20	
Total	70		19		20		20		20		4

Twenty-six percent of the respondents expressed a specific opinion, and were not opposed in their opinion, that the statutory award for tuberculosis and creative organ was not medically sound. Representative comments of this group are given below under tuberculosis.

Representative comments of the majority (statutory awards are not medically sound)

The statutory awards are limited to anatomical loss, or loss of use, of body parts. Those paid in lieu of the basic percentage awards are admittedly severe and dramatic losses. It is not clear whether, for this group, the award is based on the philosophy of compensation for loss of earning capacity or not. If it is based on loss of earning capacity it seems to be that many veterans who receive statutory awards in lieu of the basic percentage awards, have more physical capacity for work than many of the 100 percent award cases, for example: nephritis chronic, pronounced; or hypertensive heart disease, with congestive failure.

Further, the statutory award conditions are not the threat to life that is true for many of the percentage award conditions.

* * * * * * *

No. They appear to be partly based on presumption of mental anguish and partly on physical impairments obviously calling for aid and attendance. Little relation to earning capacity.

* * * * * * *

No. The awards for anatomical or functional loss of one hand or one foot running from 40 to 90 percent plus the $47 may be awarded to individuals whose earning capacity is high. These cases should be studied.

* * * * * * *

As I read the statutory award under schedule b, a patient with hemiplegia (from injury to the nondominant cerebral hemisphere) would collect the same maximum award as the helpless and the blind veteran. This is obviously unfair because such a hemiplegic can earn a good livelihood at any number of occupations in spite of his handicap.

* * * * * * *

No. A person permanently disabled from multiple, severe trauma, or ankylosing arthritis and unemployable has a greater handicap than amputees. This also holds true for malignant bone tumors, severe osteomyelitis, metastatic bone disease, fractured vertebrae with cord involvement, and severe polio residuals. There are many battle casualties far worse off from disability and employability standpoint.

* * * * * * *

In my opinion the statutory awards are not medically sound, e. g., a person with vision of 20/50 or 20/40 in the good eye and blind in the other is not disabled to the point of needing extra compensation over the basic rating. Perhaps some slight adjustments might be necessary with individual cases considering past training and occupation.

* * * * * * *

No. From the medical standpoint there is no sound reason for statutory awards. Many patriotic individuals who do not qualify for statutory awards have as much or more disability.

* * * * * * *

None are given in my field (unless TB is included). No. A person who develops a disabling rheumatic heart disease and cannot work is just as crippled as someone who lost his limbs.

* * * * * * *

I believe that the statutory awards are in some instances greater than the degree of disabilities rated. I do not believe that the statutory awards provide equal compensation for equal physical impairments since some with less disabling inpairments are benefited by these statutory awards.

* * * * * * *

The statutory awards for orthopedic disabilities are made, of course, for rather severe disabilities, principally amputations of one or more extremities. It appears that, in comparison with other disabilities not drawing statutory awards, they have been awarded on the basis of sympathy rather than for real relative increased disability.

* * * * * * *

In view of present day rehabilitation practices, it is my opinion that statutory awards should be completely abolished. I do not believe that statutory awards are, at the present time, medically sound."

* * * * * * *

No. In my opinion statutory awards are discriminative and should be eliminated. Permanent 100-percent disability ratings should be awarded only on the basis of total unemployability taking into account in any disease its eventual outcome and opportunities for rehabilitation.

* * * * * * *

The whole question of statutory awards is open to considerable controversy. It is believed that they are generally out of line and a better rating would be percentage of disability using added awards if attendant and/or special equipment is necessary in order to maintain life or comfort.

Representative comments of the minority (statutory awards are medically sound)

I am in complete agreement with the principle of statutory awards. These awards are consistent with the long-established principle that certain categories of injury, paraplegia, blindness, double arm, double leg, or arm and leg amputations, come under the heading of absolute or irrevocable anatomic change or loss; that the general economic and social adjustment to these injuries creates such a hardship that they should be considered as justifying a fixed award.

Statutory awards, however, do not provide equal compensation for equal physical impairments because of our inability to equate them.

* * * * * * *

Yes, with a few exceptions, i. e., loss of both hands is a far greater disability than loss of both feet. (There are only a few Charlie McGonagle's.)"

* * * * * * *

Yes, there have been many advances in the treatment, surgical care, and the application of prostheses, but in most of the statutory awards as enumerated in the schedule for rating disabilities in our field, the handicap as to earning capacity is more or less permanent.

* * * * * * *

These appear to be medically sound in comparison with other rated disabilities for which no such awards are made. In general, they provide equal compensation for equal physical impairments. In neuropsychiatric disabilities the awards should be probably conditioned on the need for care and treatment.

* * * * * * *

The statutory awards are medically sound in comparison with other rated disabilities. Statutory awards do not provide equal compensation for equal physical impairmen.

* * * * * * *

I believe this is probably O. K. It is too bad it necessitates such a regional evaluation, rather than a measure of whole-patient effectiveness.

Representative comment on tuberculosis and creative organ

Representative comments of the respondents, who commented on tuberculosis and creative organ, and who believed that the statutory awards were not medically sound:

I believe that 100-percent disability should be given for exceptionally repulsive disfigurement of the head and neck just as for the statutory disabilities outlined. This is certainly as much of an economic handicap as tuberculosis, which has no cosmetic impairment as a rule.

* * * * * * *

The arrested tuberculosis awards are in excess nowadays, with the new drugs and ambulatory therapy practiced and especially in those cases which have been operated on and for all practical purposes, cured.

* * * * * * *

In my opinion, statutory awards do not provide equal compensation for equal impairment. For example, a patient with arrested thromboangiitis with arterial occlusion and minimal symptoms may be awarded $33 monthly, whereas in fact, he is in far greater danger, has a far greater degree of incapacity and is subject to more rigid privations and restrictions, than an individual with arrested tuberculosis, who would receive $67 monthly. If reactivation of thromboangiitis obliterans occurs, no specific therapy is available to halt the process. On the other hand, chemotherapy of pulmonary TB has been remarkably successful in controlling reactivation of this disease. Many patients with arrested TB are employed in arduous tasks (1, I know, is a practicing surgeon, 2 are medical residents who put in at least an 80-hour week.)

* * * * * * *

I disagree with the statutory award of $67 to arrested tuberculosis, all forms. This is unrealistic and pernicious. Healed minimal tuberculosis deserves no award. Many forms of arrested tuberculosis can be treated by resection and would need no award. No doubt, in spite of the Veterans' Administration's best efforts, this clause is abused.

* * * * * * *

I believe that statutory awards for tuberculosis, all forms, are no longer based on good medical judgment. This condition should have percentage rating only

based on extent of involvement, activity, and residual of the disease or its therapy when arrested or cured.

* * * * * *

There are no statutory awards in the cardiovascular field. The statutory awards in other fields do no always provide equal compensation for equal physical impairments. Especially is this so in cases of arrested pulmonary tuberculosis who receive a statutory award of $67 monthly, for life, often without any residual disability.

* * * * * *

No. Arrested tuberculosis does not deserve a statutory award, in my opinion. Compensation should be given for functional impairment, not for mere arrested forms which in themselves are not disabling.

* * * * * *

Yes, except for tuberculosis. I do not see the rationale of providing a statutory award of 67 percent for a veteran whose pulmonary TB has been in arrest or inactive for more than 5 years and is regarded healed.

* * * * * *

Tuberculosis. It would seem that the permanent $67 rate for completely arrested tuberculosis should be subject to review from year to year, and when cure is obvious after 5 years, might be considered for nonpermanent rating.

* * * * * *

No. Continuous payment for life of $67 monthly for wholly arrested tuberculosis equivalent to permanent partial disability for a minimal scar from a boil. Absurd.

* * * * * *

None of the statutory awards refers specifically to the field of gastroenterology However, the awards for those severely disabled seem in order. The award for tuberculosis paid at a minimum monthly rate for life is entirely out of order. Specific drug therapy of relatively recent development changes completely the picture of tuberculous infection, and it is believed that this statutory award should be deleted.

* * * * * *

No. I believe that statutory awards are frequently excessive and arbitrary. For instance, a patient with an arrested tuberculosis will receive $67 per month for the rest of his life and yet he, in all probability, will never have a reactivation of his TB and to all intents and purposes, is a normal healthy individual and is capable of full employment.

Statutory awards should also take into consideration the ability of the physician to restore function by rehabilitation procedures. I believe that the loss of both feet is far less handicapping than the loss of both hands, and yet they are given equal compensation.

* * * * * *

No. Tuberculosis is not as hopeless as some other conditions.

* * * * * *

The statutory awards do not provide equal compensation for equal physical impairments.

* * * * * *

Tuberculosis program should be reevaluated.

* * * * * *

No. Loss of one creative organ does not justify statutory award of $47 a month in addition to the basic percentage rating. Again, I question the equity of awarding $67 a month for life to a patient with arrested TB. It could be justified on the basis of dietary needs to maintain health. In the case of diabetes, no award is made for the purchase of special diet and insulin.

* * * * * *

No. I do not believe the statutory award of $47 a month for the loss of a creative organ (testicle), payable in addition to the basic percentage rates for the same disability, is justified. There is no impairment of earning capacity due to the loss of a testicle. I do not believe that the statutory awards provide equal compensation for equal physical impairments; certainly an individual with a loss of a testicle can be engaged in manual labor with less difficulty than a person having chronic cystitis with coexisting incontinence, requiring the constant wearing of an appliance.

* * * * * *

In answer to the first part of the question, it is desired to state that the phrase "anatomical loss, or loss of use of a creative organ" is too broad. I believe elsewhere the phrase "the loss of procreative power" is employed. This also is too broad as it does not necessarily imply total loss. As an example, the loss of a testicle represents the loss of a creative organ and also of procreative power but does not necessarily make an individual sterile. This I believe should be made more specific as I believe some raters have given the statutory award on partial loss while others required evidence of total loss. It's hard to accept in answer to the second part of the question, that the awarding of equal compensation for the loss of a creative organ is equitable to the loss of a foot, hand, or an eye when we consider it in the light of earning power.

* * * * * * *

I believe the answer to the first part of the question is "No." In regard to the second part of the question the answer is "No." Some of these conditions should be qualified depending upon the level of the amputation and which creative organ is involved.

Representative comments of the respondents, who commented on tuberculosis and creative organ, and who believed that the statutory awards, were medically sound, except for tuberculosis and creative organ

As a whole, yes, however, it seems to me that the statutory award of monetary payments to veterans for the rest of their lives, whose only residual is a positive tuberculin reaction, is somewhat out of line.

* * * * * * *

Yes. Tuberculosis may be rated too long and too high.

* * * * * * *

Yes, except for the award for tuberculosis. With current methods of therapy patients with tuberculosis should not receive a statutory award.

* * * * * * *

It is the opinion of the undersigned that the statutory awards, as listed, are sound in comparison with the other rated disabilities for which no such awards are provided, except in the case of tuberculosis. The undersigned sees no medical basis for the payment of a minimum monthly rate for life of $67, in the case of completely arrested tuberculosis, particularly in the case of veterans who are eligible for medical and vocational rehabilitation. The undersigned believes that the measures available to evaluate the disease process are such that a determination can be made with a degree of accuracy as to whether such a condition is "completely arrested." Nor does the undersigned see any medical basis in the system which provides gradually reduced rate over an 11-year period, based on chronology. Such determination, in the opinion of the undersigned, should be made in terms of the individual's medical, social, and vocational status.

* * * * * * *

Statutory awards are medically sound. In general, the amount of compensation is justified. An exception would be in the award for tuberculosis. Arrested or cured tuberculosis in minimal or moderate advanced lesions present no permanent disability and no award is necessarily justified. If a tuberculous lesion becomes active, the claim should be adjusted accordingly. Permanent disability ratings and monetary payment for tuberculosis are not medically sound in most cases.

* * * * * * *

Tuberculosis: Recommend drastic revision by placing tuberculosis in all its forms on the same disability status as basic percentage awards. Advise that all compensation cease 5 years after complete arrest with downward annual gradations within this period in lieu of the 11-year existing triple step regulatory declination in percentage ratings. Achievements in the modern therapy of tuberculosis in reducing the period of disability justifies this concept.

Summary and conclusions

A considerable number of respondents maintained that the statutory awards are not medically sound. The number in this group exceeded by 18 percent the number of respondents who expressed the opinion that the statutory awards are medically sound.

Statutory awards are not in accord with the basic concept of "average impairment in earning capacity."

Loss or loss of use of a creative organ does not prevent one from performing manual labor.

A number of respondents (26 percent) stated that the statutory award for tuberculosis is not medically sound. There were no contrary opinions expressed in opposition to the group of respondents who commented on tuberculosis.

The statutory period (11 years) for tuberculosis is considered medically unacceptable.

MEDICAL VALIDITY OF DIFFERENT MONETARY AWARDS FOR PERMANENT TOTAL (100 PERCENT) DISABILITY

Coded question T

In your judgment is there medical validity for different monetary rates for disabilities which are all rated 100 percent?

Background

The background material to this question has been presented in the beginning of this chapter and in chapter I under "Total disability" in this section.

Discussion

The discussion is contained in the summary and conclusion to this question.

Coded Question T

Table 57.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	51	33
Qualified	9	6
No:		
Unqualified	64	41
Qualified	7	5
Indeterminate	15	10
Unanswered	7	5
Grand total	153	

TABLE 58.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	3	1	2			2
Neurology	7	1	1	3			2
Internal and general medicine	13	3		7	2	1	
Tuberculosis	9	3		3		2	1
Peripheral vascular diseases	4	1		3			
Cardiovascular diseases	7	1		4	1	1	
Allergy	6	3	1	2			
Gastroenterology	6	2			2	2	
Tropical diseases	7	3		4			
Gerontology	6	1		4			1
General surgery	11	6		2	1	2	
Orthopedics	10	2		4	1	3	
Neurosurgery	6	3	1	2			
Plastic surgery	6	2	1	2			1
Audiology and ear, nose, throat	7	3	3	1			
Ophthalmology	6	3		2		1	
Urology	7	2	1	4			
Rehabilitation and physical medicine	8	2		6			
Dermatology	6	1		3		2	
Industrial medicine	9	3		5		1	
Others	4	3		1			
Total	153	51	9	64	7	15	7

TABLE 59.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	22	31	9	47	8	40	4	20	5	25	3
Qualified	4	6	1	5	------	------	2	10	2	10	
No:											
Unqualified	28	40	4	21	10	50	10	50	11	55	1
Qualified	4	6	2	11	------	------	1	5	------	------	
Indeterminate	8	11	1	5	2	10	2	10	2	10	
Unanswered	4	6	2	11	------	------	1	5	------	------	
Total	70	------	19	------	20	------	20	------	20	------	4

Representative comments of the majority (there is no medical validity for different monetary rates for disabilities all rated 100 percent)

No. But there is sentimental validity. This is not negligible.

* * * * * * *

Usually not, but the amputee, e. g., has a sentimental appeal, lacking in a patient with pernicious anemia, severe obstructive emphysema, or the like.

* * * * * * *

The statutory awards seem to me to be reserved for those veterans with the greatest emotional appeal. (The same public response makes it easier to raise money for the polio fund than for the heart fund, in spite of the fact that the latter kills and cripples 100 times as many as the former.) I see no medical validity for this state of affairs.

* * * * * * *

No. I see no reason why there should be a conflict between the statutory awards and the disability rating under schedule. It leads to confusion. As stated previously, there are lesions of the genitourinary tract, for which statutory

awards are not available, which impair the earning capacity more than those included under statutory awards at the present time. A question also arises in my mind as to the monetary payment of $67 a month for individuals having had tuberculosis which has been arrested over a period of years, as indicated by X-rays survey, bacteriologic studies, and clinical examination.

* * * * * * *

The higher statutory awards for blindness, amputations, and multiple injuries are probably not unreasonable. On the other hand, there are dozens of other equally disabling conditions which are not so compensated. Statutory awards for tuberculosis seem much too high in the light of current advances in diagnosis and chemotherapy.

* * * * * * *

No. It cannot be on the basis of prognosis, for the patient with malignant hypertension has a 6- to 8-month prognosis while the loser of a hand and foot may live a normal lifespan. With adequate rehabilitation and selective placement, the amputee can equal or even surpass other workers of equivalent intellectual capacity while the patient with venous insufficiency and chronic renal failure due to thrombosis of the inferior vena vava has not only a poorer prognosis, but is more markedly restricted in terms of work capacity.

* * * * * * *

No. Some disabilities rated 100 percent may need more financial assistance than others in order to subsist. For instance, a cardiac patient who is in failure at rest will require much more monetary benefits in comparison to a bilateral below-knee amputee who is able to work.

* * * * * * *

A patient may be totally disabled either as a result of a serious disease such as a heart disease or as a result of a disfiguring, weeping pemphigus, which requires extensive nursing care, frequent dressings, and the use of expensive medicines. This patient will have a permanent disability because there is no cure for the disease, although present-day expensive drugs keep a few of these patients alive and active. This patient needs the same amount of money as any other patients suffering from the disabilities for which they receive statutory awards. In my opinion, therefore, there is no medical validity for different monetary rates for disabilities which are all rated 100 percent.

* * * * * * *

No. The validity appears to rest on nonmedical factors such as need for aid and attendance and mental anguish.

* * * * * * *

No. The exception to this is the bedridden patient requiring nursing care.

* * * * * * *

A man with 100 percent disability may be completely bedridden and unable to earn a living. Whereas an individual with a statutory award may very well be able to earn a living. Do not believe there is medical validity for different monetary rates.

* * * * * * *

No; provided 100-percent disability means total functional disability; however, there may be some patients who are totally disabled as regards earning capacity who can care for themselves—in like manner, there are some who are also totally disabled and who cannot care for themselves, and in such instances it seems reasonable to make provisions for the actual personal and nursing services required.

* * * * * * *

No. A 100 percent disability would seem to be 100 percent disability regardless of cause. The amount of nursing care needed, of course, varies widely even though earning impairment may be 100 percent. Nursing care should be given in Veterans' Administration facilities or when not desired or impossible—appropriate additional compensation should be made for the nonfacility nursing care individually determined in each case.

* * * * * * *

If 100 percent disability actually meant that the patient was 100 percent disabled and unable to supplement his own income then I believe that there should be no different monetary rates for disabilities which are rated 100 percent.

* * * * * * *

Strictly speaking, there is no medical validity. It would appear to me that a 100 percent disability should mean 100 percent loss of earning power. For

certain conditions described under No. 5, I feel that special allowances might be made because of the additional help or aid required in these cases (completely helpless patients).

* * * * * *

No. A man is either 100 percent disabled and therefore unemployable or he isn't. No valid medical criteria can be established for differentiating between various degrees of total unemployability.

* * * * * *

No. They should all be rated alike. As a matter of fact, many amputees rated 100 percent with statutory awards are able to return to former employment and/or even better and more lucrative employment, often as the result of a good rehabilitation program.

* * * * * *

Not medical validity but in some cases social and occupational validity.

* * * * * *

Not medical validity but in some cases there is either social or occupational validity for differing monetary rates for disabilities all rated 100 percent.

* * * * * *

Not medical, but the social is important, too.

* * * * * *

No. If a case is 100 percent disabled and the Government believes as a veteran he should be taken care of, a definite living payment should be determined for 100 percent disability. If dependents are to be included, then the yearly payment should be adjusted accordingly.

* * * * * *

I believe that the monthly payments to these individuals should be adjusted to properly take care of them, rather than to give them a statutary award. If they deserve more than other people it would be better to pay them more each month for their 100 percent disability than it would be to pay them a statutory award. The whole question for the statutory award for years has been criticized by many people in my specialty as being the wrong answer to what we all admit is an important question.

* * * * * *

I can see no medical validty for different monetary rates for disabilities which are all rated 100 percent. Probably the disability payment should be higher for the 100 percent rating. Doing away with the statutory awards and the 10 and 20 percent payments would make funds available for this.

* * * * * *

No. If additional awards are to be made for losses of certain functional parts these should probably be bulk awards of a one-time settlement type.

* * * * * *

No. It may be more equitable to strike a mean between the two levels.

* * * * * *

Representative comments of the minority (there is medical validity for different monetary rates for disabilities, all rated 100 percent)

Yes. And I believe that such awards have greater validity than some of the 10 or even 20 percent ratings.

* * * * * *

I believe there is validity for higher compensation for the majority of the statutory awards excluding tuberculosis, since they involve irreparable physical disability and are generally given higher compensation by insurance accident policies.

* * * * * *

Yes, in some cases, particularly when aid and assistance are necessary in performing bodily functions, etc. I do not feel that tuberculosis, however, is one of these conditions.

* * * * * *

Yes, where the care and needs of the patient require special attention and service and equipment and where the disfigurement or loss of parts will be an excessive burden to the patient.

* * * * * *

Yes. The awards take into consideration such factors as the need for frequent medical treatments, pain and suffering, anatomical loss or disfigurement.

* * * * * * *

There is indeed justification for different monetary rates for different disabilities all rated 100 percent. The arguments for compensation for physical and mental anguish as in cases of marked disfigurement, total blindness, loss of genitalia, severe or persistent painful states are as valid as those for compensation of reduced earning capacity.

* * * * * * *

If the disability is due to a condition which may be expected to shorten the life expectancy or is a cause of protracted suffering, then awards up to $420 monthly should be paid if definitely service connected. Statutory awards should consider life expectancy and protracted suffering especially if there is no hope for amelioration.

* * * * * * *

Yes. There is a great difference in real disability among the many conditions which are rated as 100 percent both in handicaps and in mental and physical suffering.

* * * * * * *

Yes. To my mind, the rate of $181 a month for total disability implies merely inability to hold a satisfactory job to enable the veteran to make a living. Whether $181 monthly is sufficient for this is a different matter, and should be studied in the light of the present economic situation. Higher disabilities, ranging up to $420 monthly, are justified for veterans who are not only unable to support themselves economically, but who have additional disabilities which require assistance from others in carrying out the ordinary functions of life, and who have someone, either paid or a nonpaid member of the family, to look after them. In the latter case, such duties might prevent another member of the family from earning money.

* * * * * * *

Yes, because some patients who are unable to earn a living are unable to take care of their personal needs whereas others require assistance—in some cases 24-hour nursing care—often at great expense. Allowance should be made for these differences.

* * * * * * *

In my judgment there is medical validity for different monetary rates for disabilities which are all rated 100 percent. The conditions allowing for rates up to $420 are those which require the services of an attendant of some type, which, of course, places an additional financial burden on the recipient; thus, in my opinion, additional compensation in such cases appears justifiable.

* * * * * * *

The statutory awards seem valid to me for reasons stated in No. 1 above, which are mainly social rather than medical. There is also a definite medical validity for different monetary rates for disabilities which are all rated 100 percent. In reviewing the disabilities rated 100 percent, one finds that the vast majority demand long-term hospitalization which is provided free. Individuals with disabilities for which statutory awards are provided are, in most instances, ambulatory candidates for rehabilitation programs and job placement. They can work but obviously have a disability which, in the average case, decreases greatly their earning capacity. The medical validity of the statutory award for the loss of use of a creative organ seems very questionable.

* * * * * * *

Yes. Some disabilities are not only permanent but greatly impair the patient's social status as well as his physical strength.

* * * * * * *

There is some medical validity if it is frankly admitted that there are varying degrees of total disability. In essence the ratings imply that people with total disability still have actual and varying capacities for earning money. The distinctions are in a sense social and represent the reaction of the public, including employers, to obvious mutilation of the body.

* * * * * * *

In question 5, section 1, it was shown that 100 percent disability is not necessarily 100 percent loss of earning capacity. In those particular cases where the patient is totally disabled, bedridden, or in constant need of practical nursing care, the sum of $420 is conceivably not excessive; this particular patient requires

institutional care. Therefore, sociological factors of degree of loss of earning capacity and degree of helplessness must be considered in establishing the different monetary rates for 100 percent disabilities, indirectly a medical validity.

Summary and conclusions

A majority of the medical respondents, 46 percent, believe that there is no medical validity for different monetary rates for disabilities which are all rated 100 percent. There should be no conflict between the statutory awards and the disability rating under the schedule. For example, the veteran with very high blood pressure has a short time to live, while another veteran who has lost a hand or a foot may live a normal life span; with adequate present-day rehabilitation and selective placement, the amputee can equal or outstrip other veterans in terms of work capacity. A 100 percent disability should mean 100 percent loss of earning power; however, additional allowances might be made because of the additional help or aid required in completely helpless patients. The problem is not medical; other factors such as economic and social are involved.

MEDICAL ADVANCEMENT AND EFFECT UPON STATUTORY AWARDS

Coded question U

Have there been any medical developments in chemotherapy; surgery; diagnosis; treatment; prosthesis, etc., in the past 10 years, within your medical specialty, to affect the conditions in the statutory awards?

Background

Since the last revision of the Veterans' Administration Schedule for Rating Disabilities in 1945, scientific medicine has developed, and advanced remarkedly in treatment, chemotherapy, surgery, prostheses, hearing aids, and so forth. Specific advancements and developments in medicine have been in the chemotherapeutic, antibiotic, kineplastic surgery (amputation in which the stump is so formed as to be utilized for motor purposes), rehabilitation, diagnosis and treatment of tuberculosis, including thoracic surgery. What has been the impact of all of this upon the statutory awards—if any? What was the opinion of a medical specialist in a selected specialized field of medicine? For such answers, the President's Commission on Veterans' Pensions sought the opinions of medical specialists in various fields of specialized medicine.

Coded Question U

Table 60.—*Distribution of grand total of respondents' replies*

Replies	Number	Percent
Yes:		
Unqualified	98	64
Qualified	1	1
No:		
Unqualified	23	15
Qualified		
Indeterminate	3	2
Unanswered	28	18
Grand total	153	

TABLE 61.—*Distribution of replies by respondents' medical specialties*

Selected medical specialty	Number of respondents	Classified replies					
		Yes		No		Indeterminate	Unanswered
		Unqualified	Qualified	Unqualified	Qualified		
Psychiatry	8	4		1			3
Neurology	7	2		4			1
Internal and general medicine	13	11	1				1
Tuberculosis	9	8				1	
Peripheral vascular diseases	4	3		1			
Cardiovascular diseases	7	3		1			3
Allergy	6	2		1			3
Gastroenterology	6	3		1		1	1
Tropical diseases	7	2		2			3
Gerontology	6	3		1			2
General surgery	11	9		1		1	
Orthopedics	10	9					1
Neurosurgery	6	3		2			1
Plastic surgery	6	1		2			3
Audiology and ear, nose, throat	7	5		1			1
Ophthalmology	6	4		1			1
Urology	7	5		2			
Rehabilitation and physical medicine	8	7		1			
Dermatology	6	3					3
Industrial medicine	9	7		1			1
Others	4	4					
Total	153	98	1	23		3	28

TABLE 62.—*Distribution of replies by employment of respondents*

Reply	Classified respondents, by code letters										
	PP		VA		NAV		ARM		AF		Others
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number
Yes:											
Unqualified	49	70	12	63	12	60	14	70	7	35	4
Qualified	1	1									
No:											
Unqualified	6	9	1	5	5	25	3	15	8	40	
Qualified											
Indeterminate	1	1	1	5					1	5	
Unanswered	13	19	5	27	3	15	3	15	4	20	
Total	70		19		20		20		20		4

Discussion

Fifty percent, or one-half of the respondents were of the opinion that there were medical developments in drug treatment and other treatment, diagnosis, and so forth, within the past 10 years to affect the statutory awards, made particular comments concerning the effect of these medical developments upon tuberculosis. Representative comments of this group are given below under "tuberculosis." None of the respondents in this group said "No".

Four of 8 respondents, practicing in the specialized field of psychiatry, stated that there have been medical developments to affect the statutory awards; one respondent in this group disagreed and stated that there have not been any medical developments in the past 10 years to affect the statutory awards. Three respondents in this group did not answer the question. Twelve respondents, practicing in the

field of internal medicine, maintained that there have been medical developments in the past 10 years to affect the statutory awards. One respondent, in this field, was vague in his reply to the question; and another of the group did not answer the question.

Eight of 9 respondent medical specialists, practicing in the specialized field of tuberculosis, said that there have been medical developments in the past 10 years in the treatment of tuberculosis by drugs and surgery to affect the statutory award of tuberculosis. Representative comments of this group is incorporated with others below, under "tuberculosis." One of this group of medical specialists was vague in his reply to the question.

Nine of eleven respondents practicing general surgery expressed the opinion that there have been medical developments in the past 10 years to affect the statutory awards; 9 of 10 respondents in the field of orthopedic surgery believed the same—that there have been medical developments to affect the statutory awards.

Seven of eight respondents, practicing in the field of rehabilitation and physical medicine; and 7 of 9 respondents in industrial medicine, replied that there have been medical developments within the past 10 years to affect the statutory awards.

There were few differences of opinion by nongovernmental respondent medical specialists, and governmental respondent medical specialists, except from the Air Force, and what difference there was indicates the majority opinion—that there have been medical developments in chemotherapy, surgery, diagnosis, treatment, prosthesis, etc., in the past 10 years, to affect the conditions in the statutory awards.

Representative comments of the majority (there have been medical advancements to affect the statutory awards)

Advances have been made in keratoplasty which render certain types of corneal opacities remediable by surgery. I have recently reviewed the records of World War II blind with the Department of Physical Medicine and Rehabilitation. We found a small group of these veterans in whom the defect might be remedied. All are being reevaluated with surgery in mind.

* * * * * *

Yes. Chemotherapy and antibiotics, hearing aids artificial larynx (speech training), etc., may tend to reduce the degree of disability in some cases.

* * * * * *

Yes. Cardiac surgery can now in a relatively few cases lessen disability.

* * * * * *

Yes. Therapy in cardiac and hypertensive disease now much more effective, also diabetes, gout, arthritis, pernicious anemia, etc.

* * * * * *

Improvements in the treatment of peripheral vascular diseases especially thromboangitis obliterans may make it possible to reduce the awards.

* * * * * *

Yes, for example, tendon transplants in peripheral nerve injuries.

* * * * * *

Yes. Use of antibiotics and adrenergic blocking agents, sympathectomy, arteriograms, arteriorrhaphy, aneurysmectomy, arterial grafts, etc.

* * * * * *

Yes. The new drugs, chlorpromazine and reserpine, have been found to cause improvement, and in fewer cases, recovery of many severely psychotic patients. Better staffing and equipping of hospitals has also resulted in improvement or recovery of patients who would otherwise have remained candidates for statutory awards. Psychosurgery might also fall in this category.

* * * * * *

Yes. Improved diagnostic techniques for epilepsy as well as treatment of epilepsy. Improved treatment for migraine and myasthenia gravis, tics and better control of some forms of Paralysis Agitans, athetosis and dystonia.

* * * * * * *

Medical developments in the last 10 years have, without question, affected conditions of statutory awards. However, in the geriatric patient they generally do not affect earning capacity because in most instances employability is determined by age, rather than disability.

* * * * * * *

Yes. Rehabilitation of paraplegics has reached the point where the grants for car and home, along with 100 percent disability, are sufficient without further statutory award, that is, the average paraplegic today can care for himself after maximum rehabilitation.

* * * * * * *

Yes, since World War II, including those veterans of World War II, with whom I have had much experience during and since World War II, there is no question that particularly in the case of the amputees, the better surgery and treatment which these men received during World War II, including antibiotics and chemotherapy have resulted in less disability among them, than in those veterans of World War I and previous wars. It has been conclusively shown in the past 10 years or more, since the beginning of World War II, that people who lose limbs can, in the great majority of cases, that is, something over 95 percent of them, can be surgically treated, fitted with a modern prosthesis and trained to use it in such a way that they will be rehabilitated to a marked extent so that most of them are physically and mentally able to carry out gainful occupations. The majority can do work of a type that is nonstrenuous and nonlaborious in nature, so that they can get along very well.

* * * * * * *

Yes. Constant research in upper and lower extremity prosthesis have produced very effective substitutes for arms and legs which permit veterans to engage in occupations which were thought to be beyond an amputee's ability 10 years ago. In addition, the rehabilitation of paraplegias, polios and hemiplegias has produced a more independent and economically sound individual.

* * * * * * *

Definitely yes. These new developments affect the statutory awards and also other disabilities which brings up the advisability of reexamining and rerating all permanently disabled in these categories.

Representative comments of the minority (there have been no medical advancements to affect the statutory awards)

Not significantly.

* * * * * * *

I know of none. Most of the advance or progress in medicine in the last 10 years has been in the acute infectious diseases and these are never involved in percentage ratings.

* * * * * * *

No, or very little. Epilepsy may be controlled by therapy, but the therapy must be continued indefinitely. The application of principles of rehabilitation has not, as yet, had much influence on the disabling neurological diseases, because of the limited number of facilities available, as well as other factors.

* * * * * * *

No. Most of these conditions arise in chronic degenerative conditions, or are secondary to trauma or vascular disease for which no remediable measures have been found.

* * * * * * *

No. While it is true that paraplegic rehabilitation has improved the lot of the paraplegic, he comes under the category of absolute disability. He is still potentially a severely disabled person with almost impossible opportunities for adjustment. When society changes its mind and attitude toward the handicapped and the disabled, that will be a much more important factor than any of the medical developments in changing our interpretation of these statutory awards.

Tuberculosis

There are given below representative comments of respondents to the question of medical developments in the past 10 years affecting the statutory awards. These respondents emphasized in their comments that medical developments in the last 10 years should have affected the statutory award for tuberculosis, that is, the permament minimum award of $67 a month, and the 11-year observation period following release from hospital and treatment.

Yes. I do not believe any form of tuberculosis belongs in the statutory field of disabilities. The percentage of cures and improvements today renders previous ratings outdated and archaic.

* * * * * *

Yes. Tuberculosis of the skin is almost invariably well and easily managed. Dermatitis herpetiformis is usually easily managed. Lupus erythematosus is much more easily "cured" (discoid variety) than formerly. There are many others but the above are examples.

* * * * * *

None are applicable except for the rare tuberculosis of the gastro-intestinal tract, which can presently be treated as tuberculosis anywhere else in the body.

* * * * * *

Yes. Chemotherapy, resectional surgery, and pulmonary function studies.

* * * * * *

Yes. The new chemotherapy and newer surgical procedures apparently have completely changed the picture in minimal pulmonary tuberculosis and to some extent in moderately advanced. Likewise, the outlook for tuberculosis adenitis is much brighter. I do not believe statutory life payments for arrested disease is medically justified. The incidence of tuberculosis, pulmonary, among troops on active duty is comparable or slightly lower than for the population as a whole.

* * * * * *

Yes. The advent of effective antituberculous chemotherapy and the increasing feasibility of excisional therapy for tuberculosis has made the outlook for the tuberculous patient much more optimistic. Tuberculosis can no longer be considered a "dread disease," except in some far advanced cases. The period of morbidity and the possibility of reactivation is definitely decreased.

* * * * * *

Yes, to some extent, particularly lower extremity prosthesis. In tuberculosis, chemotherapy has produced profound changes in the prognosis, treatment, and actually the surgical procedures employed for tuberculosis of joints.

* * * * * *

Yes; conditions such as osteomyelitis and tuberculosis of bones and joints are handled better today and the conditions controlled and often eliminated by the use of newer chemotherapeutic and surgical measures which result in much less disability. Prosthetic replacements during the past 10 years have improved, allowing patients to wear them and to perform work with greater ease than was heretofore possible. Notable in this last group are cineplastic rehabilitation of amputations and the use of end-bearing prostheses at the ankle and knee.

* * * * * *

Chemotherapy and antibiotics together with other tested forms of treatment are curing tuberculosis. Haematogenous osteomyelitis is now extremely rare. The prosthetic limbs offered our lower extremity amputees are the best available and have been and are being improved.

* * * * * *

Chemotherapy such as streptomycin and isoniazids have reduced the hazards of tuberculosis.

Modern prostheses have reduced the disability for loss of use of one foot.

* * * * * *

Yes. Pronounced progress has been made in the past 10 years in the management of infections in the urinary tract by the introduction of the newer chemotherapeutic agents. This applies to pyelonephritis, chronic cystitis, and tuberculosis of the genitourinary tract. It is especially applicable in tuberculosis of the urinary tract as included in the statutory awards.

* * * * * *

Now we have many cases of tuberculosis with no residuals. These should be considered for reduced ratings, reserving in each case the right of the veteran to have his award raised to 100 percent should tuberculosis become reactivated in any part of his body, at any time.

* * * * * *

Yes. Chemotherapy of all forms of tuberculosis has improved the outlook greatly and has reduced both the duration of active disease and the amount of structural damage resulting. A reduction of the 11-year period of graduated, reduced percentage ratings is justified in the cases of tuberculosis. Elimination of the minimum monetary payment in some cases is also justified.

* * * * * *

Yes. Chemotherapy in tuberculosis. The disability rating should be reduced in 2 years in successfully treated cases.

* * * * * *

There has been increasing use of surgery for chronic pulmonary tuberculosis in the past 10 years. Successful excision of major disease-bearing lung portions has resulted in earlier attainment of arrest of disease with increased expectancy of survival and employability approaching normal standards. Correspondingly, this should achieve a reduction of total Government expenditure for total disability awards for pulmonary tuberculosis, and other infectious diseases.

* * * * * *

Many. A great many persons recover from tuberculosis of minimal extent with no impairment of function that can be detected by any means, and no loss of earning power. To a lesser extent the same is true of more advanced types of tuberculosis; the cure in these cases takes longer, but in many cases the residuals do not interfere with health or earning power.

* * * * * *

The development of more satisfactory, functionally usable prostheses has increased the earning capacity of most amputees during the past 10 years. Likewise, the development of new therapeutic procedures in the treatment of tuberculosis, both medical and surgical, has significantly reduced the hagards and disabilities of tuberculosis.

* * * * * *

Yes. The treatment and prognosis of tuberculosis has changed greatly in the past 10 years.

* * * * * *

Revision of tuberculosis ratings is in order.

Summary and conclusions

A majority margin of 4 to 1 of the respondents who participated in this survey said there has been medical developments in drug treatment, surgery, diagnosis, treatment, prosthesis, etc., in the past 10 years, to affect the conditions in the statutory awards. Fifty percent of the majority emphasized in their comments that there have been very marked advances in chemotherapy and surgery of tuberculosis in the past 10 years, and that these should affect the conditions of statutory awards, and none of the respondents said "No" to these medical developments in the field of tuberculosis. Other medical developments were in amputation; surgical and mechanical improvements in the fabrication and fitting of amputation prosthesis; improvements in rehabilitation techniques; advances in the treatment of osteomyelitis, and other chronic infections. All of these medical developments have changed the outlook of the veteran affected, and should serve to decrease the degree of disability in many cases.

SUMMARY TABLE ON STATUTORY AWARDS

A summary table on the statutory awards, showing percent of grand total of all questions and replies on the statutory awards is found on the following page. A summary and conclusions on all of the respondents' replies is contained in the last chapter of this report.

77289—56——15

TABLE 63.—*Summary on statutory awards: Distribution of answers to questions*

Question code letter	Classified replies											
	Yes				No				Indeterminate		Unanswered	
	Unqualified		Qualified		Unqualified		Qualified					
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
S	34	22	5	3	60	39	6	4	6	4	42	28
T	51	33	9	6	64	41	7	5	15	10	7	5
U	98	64	1	1	23	15	------	------	3	2	28	18

NOTE.—Grand total, 153.

CHAPTER V. SUMMATION OF GENERAL MATTERS

INTRODUCTION

Section IV in the medical questionnaire of the President's Commission on Veterans' Pensions also contained questions of a general nature. These questions were asked in order to round out the medical information needed to complete this survey.

There were 3 questions requesting general and specific answers, and 1 question asking the respondent to comment generally on the problem of disability rating and compensation. The questions are restated in this chapter and replies analyzed. Tabulation of the statistical data, as done in the previous chapters of this report, is not made. However, statistical data in other forms are provided wherever possible.

The questions and analysis of the replies in this survey are presented in the following pages.

Question No. 1

In your opinion, are the various sections of the Rating Schedule and the related statutory awards in balance? That is, in your field of specialization, are the percentages in the schedule, taken together with the statutory awards, too high, or too low, in relation to other disabilities from diseases and injuries?

Background

To many people, experienced in rating disabilities, a glance through the Veterans' Administration schedule for rating disabilities leaves the impression that the medical criteria, as correlated to the different percentage awards and to different diseases and injury residuals contained therein, are out of proportion; and that the various statutory awards are disproportionate to the percentage awards. This question was asked of the medical specialists in the Commission's medical survey.

Statistical data

The percent distribution of replies by respondents is presented in table 64. The table shows the number of replies to the question; percent distribution of grand total 153 returns. The replies were classified into: (1) Replies of respondents who thought that the rating schedule and the related statutory awards were in balance, without

exceptions; (2) replies of respondents who maintained that the various sections of the rating schedule, and the related statutory awards, were not in balance; and (3) replies classified as unanswered. No. (2) was further subclassified into: (*a*) Replies of respondents who thought the various sections of the schedule, and related statutory awards, were, generally, in balance with exceptions to either their particular specialty, or to other sections and portions of sections, or exceptions to the statutory awards; (*b*) percentages and statutory awards too high; (*c*) percentages and statutory awards too low; (*d*) percentages and statutory awards too high and too low; and (*e*) not in balance, without exceptions.

TABLE 64.—*Sections of the rating schedule, and related statutory awards are, or are not, in balance: Distribution of grand total of respondents' replies*

Respondents' replies	Number	Percent
1. In balance, without exceptions, subtotal	44	29
2. Not in balance:		
(*a*) In balance, with exceptions	26	17
(*b*) Percentages and statutory awards, too high	33	22
(*c*) Percentages and statutory awards, too low	9	6
(*d*) Percentages and statutory awards, too high and too low	8	5
(*e*) Not in balance, without exceptions	14	9
Subtotal	90	59
3. Unanswered	19	12
Grand total	153	100

Discussion

Over one-half of the respondents (59 percent), stated that the various sections of the rating schedule and the related statutory awards were not in balance; 17 percent of this group believed that, in general, various sections were in balance, but with exceptions; 22 percent of the respondents maintained that the ratings in the schedule and the related statutory awards were too high, and only 6 percent felt that the ratings were too low.

Twenty-nine percent of the respondents said that the various sections of the rating schedule and the related statutory awards were in balance, without exceptions.

Representative comments of the respondents are grouped into the classification of replies as shown in table 64, and presented in the following pages.

Representative comments of respondents who believe the rating schedule and statutory awards are in balance without exceptions

The various sections of the schedule appear to be in balance.

* * * * * *

The percentages and statutory awards are in balance.

* * * * * *

I believe in general that the percentages are in balance.

* * * * * *

In general, the percentages in the rating schedule and the related statutory awards are in balance.

* * * * * *

The percentages in the schedule taken together with the statutory awards appear to be in balance, neither too high nor too low.

* * * * * *

In general, it is felt the rating schedule and related statutory awards are in balance and very well done.

* * * * * *

Yes. Study of the rating schedule makes obvious the careful survey, study and conclusion that was necessary to arrive at a rating schedule of this magnitude. Regardless of minor differences in opinion this is an excellent rating schedule. Continued study of it will allow fair and equitable changes in it.

Representatives comments of respondents who stated that the various sections of the schedule and related statutory awards are in balance, but with exceptions

Yes; except for arrested tuberculosis. About right. (One individual should not enjoy both statutory awards and basic percentage disability payments).

* * * * * *

In general the rating schedule is relatively well balanced but the related statutory awards frequently offset this balance. This is particularly true in tuberculosis.

* * * * * *

The various sections on rating schedules appear to be in fair balance, as are the statutory awards except for tuberculosis which I have already commented upon.

In my field of specialization the percentages for the schedule are generally comparable in relation to other disabilities.

* * * * * *

I note no striking unbalance. The sections on tuberculosis and psychiatric conditions are naturally more detailed. Certainly both of these sections should be carefully reviewed and revised in the light of current knowledge and usage.

* * * * * *

With the exception I have brought out previously with reference to the loss of a creative organ, I believe that the section dealing with genitourinary disabilities and the statutory awards are in balance and not too high nor too low.

* * * * * *

Am fairly satisfied with the schedule, but cannot understand why an amputee should receive more than a complete cardiac cripple.

* * * * * *

The percentages, except for those rated at 10 percent and certain others mentioned previously, seem to be in proper balance.

* * * * * *

In general, the total percentages appear to reflect fairly well the disability with the exception, possibily, of the lower percentages for reasons discussed earlier.

* * * * * *

In my opinion the various sections of the rating schedule and the realted statutory awards are in balance, however, as previously stated there is no medical reason for statutory awards. One hundred percent disabilities are for the most part of equal gravity and should receive equal compensation. If the level is too low as is suggested by the use of statutory awards, then consideration should be given to increasing compensation for the 100 percent disabled.

* * * * * *

There is a reasonable degree of balance within each body system section of the schedule and between the several body systems. The imbalance is marked between statutory awards and scheduled disabilities, statutory awards being too high.

* * * * * *

In my opinion, the various sections of the rating schedule and the related statutory awards are in reasonably good balance. However, I do feel that the statutory awards are now obsolete and that all awards should be readjusted to a percentage basis.

In general, however, I feel that the percentages in the schedule, taken together with the statutory awards, are somewhat too high, particularly as concerns musculo-skeletal disabilities.

* * * * * *

In general they seem to be quite reasonable. However, I feel that the discrepancy between the amount awarded for 100-percent disability and the statutory awards is too great and an attempt should be made to reach a figure somewhere in between.

* * * * * *

My impression is that the percentages in the schedule for the section under "the skin" are in balance with the percentages in the various other sections of the rating schedule, but the main consideration is that criteria for rating disability for the vast majority of skin diseases are not considered and, in this respect, the section on the skin seems to differ from many other sections, in that the ratings for numerous other diseases are much more definite. There are no statutory laws for skin disease as far as I can determine.

* * * * * *

The monetary awards are probably in balance. However, the medical criteria and the percentage of disability should be reevaluated.

Representative comments of respondents who maintain that the various sections in the schedule and related statutory awards are not in balance, and are too high

The rating schedule and statutory awards are not in balance. In regard to other disabilities in my field of orthopedics, the percentage of disability together with the statutory awards are too high in relation to other disabilities in other fields of medicine than mine [orthopedic].

* * * * * *

Percentages in my field of specialization are too high in relation to other disabilities [orthopedic].

* * * * * *

The only changes I would recommend would be a possible 10 percent reduction in all percentage disabilities in our field of orthopedics.

* * * * * *

No, The surgical-orthopedic disabilities especially when statutory awards are added are higher than medical disabilities. Medical illnesses can be as disabling as any other illness.

* * * * * *

No. They seem quite out of balance, and almost always for arthritis (which in most instances is largely a matter of normal aging of weight-bearing joints) and muscle injuries seem excessively high. Ditto for the psychoneuroses.

* * * * * *

Not always. Part III, Permanent and total nonservice disabilities. In practice "unemployability" is hardly ever measured. The status of a person being unemployed does not constitute "unemployability." Orthopedic disabilities are heavily weighted as against constitutional illness such as cardio vascular renal for example, I have seen the terminal stage of reports rated 30 percent and death occur 3 months later.

* * * * * *

They are not in balance and some conditions with statutory awards are too high, for example, the frankly psychotic person is incapacitated to a higher degree than is the person who had both legs amputated and who is provided with satisfactory prostheses.

* * * * * *

It is common feeling that psychoneurosis in general is rated too high, particularly in certain brackets such as the 30 percent bracket, in relation to other diseases and injuries. This could be checked with the Central Office of the VA. I understand that many of these psychoneurotics who have been receiving 30 percent in the past have been dropped to 10 percent. On the other hand, as I said previously, those psychoneurotics who are now considered totally disabled and are receiving only 80 percent should be reviewed and reevaluated to see if 100 percent here would not be more equitable.

* * * * * *

No. Statutory awards for tuberculosis are not in balance with rating schedule. Generally speaking they are much too high in tuberculosis. Rating schedule percentages plus statutory awards with total of up to 50 or 60 percent are usually rated much too high.

* * * * * * *

If one accepts the concept of statutory awards, it appears that tuberculosis in the light of present medical armamentarium is rated too high.

* * * * * * *

Compared to other disabilities in the schedule, skin diseases are rated too high in some instances, such as psoriasis, acne vulgaris, and certain superficial fungus infections.

* * * * * * *

Percentages in the Schedule taken together with the statutory awards are too high in relation ot other diseases and injuries. I do not favor statutory awards for specific disabilities but consider that additional compensation for *any* disability should be provided when special devices, attendants, etc., are required.

Representative comments of respondents who maintain that the various sections in the schedule and related statutory awards are not in balance, and are too low

I would consider that the percentages for the psychoses are too low in relation to other disabilities from diseases and injuries.

* * * * * * *

I do not believe they are entirely in balance. It appears that the schedules are too low in some areas in comparison with the statutory awards in relation to other disabilities from injuries and diseases.

* * * * * * *

In general, too low for serious diseases of the heart with diminished cardiac reserve or early heart failure.

* * * * * * *

In general, I think the disabilities in the fields of intermal medicine, with the exception of tuberculosis and certain other infectious diseases now curable by modern drugs, are rated too low relatively. I think this is attributable to the greater difficulty in concise evaluation of medical conditions and in the fact that systemic disease has more tendency to recurrence and progression and hence more effect on the prognosis.

Representative comments of respondents who maintain that the various sections in the schedule and related statutory awards are not in balance, and are too high, and too low

Some statutory awards are too high. Some ratings are too low yet produce as much disability as the statutory awards especially if they tend to shorten life expectancy or are one productive of protracted pain.

* * * * * * *

The awards are not in balance. An individual totally disabled should receive the same compensation. A distinction could be made between battle incurred conditions. Some of the disabilities are too low and some too high.

* * * * * * *

As noted previously, there are some disparities between the various rating designations in the schedule and the statutory awards, especially as related to tuberculosis. In my field of specialization, as pointed out in answer 3, section 1, page 5, there are no statutory awards. Some ratings in the cardiovascular field are too low, some probably too high.

Representative comments of respondents who maintain that the various sections in the schedule and related statutory awards are not in balance without execptions

As detailed in changes suggested—some awards would not seem to be well balanced.

* * * * * * *

In my opinion the percentages for tuberculosis in relation to other diseases are not too high or too low, but they are in general maintained too long. The basis for compensation is arbitrary in terms of years; I believe it should be elastic in terms of actual progress medically toward recovery. The statutory awards are relatively low in comparison with statutory awards for other conditions but in cases where the existence of disabling tuberculosis was equivocal in the first place, or where complete recovery has occurred, I see no basis for any statutory award.

* * * * * * *

This has been covered to a great extent previously. All in all, I feel that the schedule is quite liberal to the tuberculosis veterans.

* * * * * * *

They are not in balance even within my specialty [tuberculosis].

* * * * * * *

The relatively few conditions for which statutory awards may be granted are compensated out of proportion to equally disabling conditions of less dramatic appeal, e. g., some hemotologic disorder, heart disease, etc.

* * * * * * *

No. In area of diseases associated with senescence disabilities allowed for conditions so frequent and nearly universal that by comparison all people over 60 would be entitled to disability benefits.

* * * * * * *

While I am not competent to comment upon percentage disabilities in the VA on a statistical basis, I have never seen an engioneurotic edema case with prolonged 40 percent disability, nor an adult eczema case with persistent eczema warranting 50 percent disability. I have seen only one migraine patient who warrants a 50 percent disability. There is a small number of intractable severe chronic asthmatics who, at times, and sometimes permanently, warrant 100 percent disability.

My impression is that the question of balance is comparable to that in other diseases.

Summary and conclusions

Analysis of the opinions of the respondents to this question reveals that 59 percent of the respondents felt that the various sections of the rating schedule and the related statutory awards are not in balance. A proportionately smaller number of respondents (29 percent) felt that the various sections of the schedule and related statutory awards are in balance. One-fifth of the respondents maintain that the percentages in the schedule taken together with the statutory awards are too high. Only 1 respondent out of 20 stated statutory awards are too low.

In tuberculosis, the percentages and statutory awards are too high. Statutory awards are, otherwise, also too high in comparison to patients who are disabled, for example, with heart disease. A percentage award together with the statutory award is too high in orthopedic (amputations) and muscle injury disabilities. Disability ratings in the psychoneuroses are in general rated too high, particularly in the 30 percent bracket.

Disability ratings are too low for other psychoses than above, and in relation to the statutory awards, other than helplessly bedridden and in constant need of aid and attendance. In general, disability ratings are too low for serious diseases, for example, heart disease, in relation to the statutory awards, other than helplessly bedridden and in constant need of aid and attendance, especially where they shorten life expectancy, or are ones productive of protracted pain.

Question No. 2

What effect have modern developments in medical rehabilitation had upon the problem of disability and compensation?

Do these developments have any significance to present standards used in the evaluation of disabilities?

Background

Some background to this question has been given in the preceding chapter under the question of ratings fairly representing the average impairment in earning capacity resulting from the various degrees of physical impairment (coded question O). Disability has been correlated to earning capacity. Early in this century rehabilitation of the physically disabled worker became increasingly recognized. The degree to which a man was either fit or unfit to do a job was based upon the degree to which he was considered disabled, that is, the degree to which he was anatomically whole. Consequently, some of the early workmen's compensation laws carried provisos for the rehabilitation of the injured workman. Workmen's compensation legislation set out to provide medical care and replace lost income for injured workers, and rehabilitation of the worker to optimal family, social, and economic life. This concept was incorporated into the first compensation law for the United States veteran in the act of October 6, 1917, War Risk Insurance Act, as amended, and has been carried in veterans' compensation laws since that date. The rise of rehabilitation has improved means of regaining lost health and overcoming loss of function. The area of permanent disability has been narrowed by rehabilitation techniques and procedures. Modern rehabilitation is considered to be "restoration of the handicapped to the fullest physical, mental, social, vocational, and economic usefulness of which they are capable." What has been the affect and effect of these practices on the problem of veterans' disabilities and compensation. The answer to this question is made by the various medical specialists solicited in this survey.

TABLE 65.—*Effect of modern developments in rehabilitation on disability and compensation: Distribution of grand total of respondents' replies*

Respondents' replies	Number	Percent
Little, or no effect, subtotal	13	9
Marked effect:		
(*a*) Degree of disability and compensation, reduced	74	48
(*b*) Chances for employment, increased	28	18
(*c*) Marked effect, replies not classified	21	14
Subtotal	123	80
Unanswered	17	11
Grand total	153	100

Discussion

The two parts of this question are combined for statistical purposes as answers coincide to the two parts of the question, and are expressed in the comment. The statistical data is incorporated into table 65. A preponderance (80 percent) of the respondents in reply to this question stated that modern developments in medical rehabilitation have

affected the problem of disability and compensation. One half of the respondents maintained that the degree of disability is reduced and compensation affected in proportion to the reduction of the degree of disability. Only a small percent of the respondents felt that modern developments in rehabilitation have had little, or no effect on the problem of disability and compensation. Eleven percent of the respondents' replies were either vague, foreign to the question, or no opinion. Representative comments of the respondents are presented below.

Representative comments of respondents who believe that modern developments in rehabilitation have had little or no effect on the problem of disability and compensation

Although these developments have certainly been great and valuable, their application to the problem of disability and compensation for practical purposes has been minimal.

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Very little as yet. The magnitude of the problem is too great for the available facilities.

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There has only been a very slight decrease of disabilities.

Reevaluation becomes more important in view of recent developments in the treatment of NP diseases.

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From the standpoint of internal medicine, rehabilitation would seem to have exerted little effect.

Apparently there is no practical significance at this time.

* * * * * * *

In my opinion, modern developments in medical rehabilitation in themselves on the whole, have had little effect upon the problem of disability and compensation; except as has been stated previously, the present management of tuberculosis makes it necessary that the problem of compensation be reevaluated in this particular instance.

* * * * * * *

Essentially none. Rehabilitation is 95 percent an achievement of the patient, not of the doctor nor the science. The successful cripple should not be penalized for his success. Conversely it should not benefit a man that he should be lazy or unwilling.

* * * * * * *

It is probably too early to determine what effect modern developments in medical rehabilitation have upon the problem of disability and compensation. The modern developments should require a period of observation of 10 to 25 years before firm conclusions can be drawn. Diseases and disabilities now rated to standardized prognoses may require adjustment as experience is gained with modern developments in rehabilitation.

Representative comments of respondents, who said that modern developments in rehabilitation have affected the problem of disability and compensation, in that the degree of disability and compensation are reduced

Considerable. There are many diseases which are included in the schedule which should be totally curable under present medical developments. No compensation should be based on the title of the disease alone, but only on the residuals which may occur and are distinctly present.

* * * * * * *

Medical rehabilitation in general has made great strides forward in motivating and training patients to lead a more productive, useful life. Therefore, I believe that disability and compensation should have been noticeably lowered.

Obviously, if the above statement is in fact a true evaluation of the problem, and the 1945 evaluation of disabilities was correct (which I doubt), present disability ratings in general should be lower.

* * * * * * *

In respect to the musculoskeletal system, impairments of hearing and speech, cardiovascular disease, etc., modern developments in medical rehabilitation have done much to lessen or compensate for degrees of disability previously accepted for a given condition.

Yes; standards might be modified in a given case on the basis of whether or not accepted rehabilitation measures had been successfully employed to favorably modify the average disability for a given disease.

* * * * * *

Rehabilitation should help to diminish disability. It should teach new skills. I believe they should tend to lower present percentage awards.

* * * * * *

Medical rehabilitation as developed in recent years has greatly decreased the seriousness of disability due to injury or disease. So far as I am aware, it has not affected, materially, compensation.

These developments increase the job opportunities and earning capacity of disabled people. In 1954 more than 60,000 physically handicapped were rehabilitated and secured substantially gainful occupation. It is my opinion, that this indicates the significance of the developments in standards for evaluation of disabilities.

* * * * * *

Have had good effect in psychiatry in that the percentage of recovery is much higher than heretofore. There is a caution, however, in the new drugs which, while they render an individual better from a behavior standpoint, frequently do not touch the underlying condition. Thus, the patients' families are confronted with difficult problems in patients released from hospitals.

One development has significance and that is that we no longer use a lot of the diagnostic terms which are listed in the rating schedule.

These developments indicate that regular reexamination of the condition of the patient is called for. Many more patients are now being released from mental hospitals and are able to look after themselves. Consequently, they would require reevaluation.

* * * * * *

In some instances it has reduced the real disability and the compensation could be reduced equitably.

I marvel continually at the number of veterans I now see with a diagnosis of tuberculosis with no evident residuals. The VA also has used aids (prosthetics of various sorts), given training to those with any service-connected handicap who wished it, and often developed the individual's ability to a degree where he is better fitted to earn more than he would have been, had he not been in service. This is, and has been, open to all service-connected veterans. Such things should be considered in revising the schedule, but the veterans, who took advantage of the opportunities offered all, should not be penalized. The adjustment should be to encourage others to help themselves.

* * * * * *

In general should lessen disability considerably and with it the need for compensation.

Yes; by so-called comprehensive or total medical care, including rehabilitation procedures of all kinds, physical, prosthetic, educational, emotional and psychological, the degrees of disability should be lessened.

* * * * * *

Modern developments in medical rehabilitation have tended to lessen the actual degree of disability in many areas and thus lessen the amount of compensation necessary.

Yes, some of the developments, such as retraining, prostheses, etc., should result in reevaluating ratings and statutory awards toward the end of lowering them. Others have significance in that they result in ameliorating symptoms or causing remissions of the condition so that permanent ratings will be used less frequently.

* * * * * *

Disability and compensation claims have been markedly reduced and held down by active rehabilitation programs.

Some disabilities that formerly were considered permanent and may be permanent should be reevaluated following rehabilitation, as their earning capacity may increase, thus compensation should be lowered.

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They should with proper motivation lead to reduced disability and reduced compensation although reduced motivation cases should suffer the greatest falls in compensation.

* * * * * *

I believe that modern developments have produced a state in which compensation based on previous disabilities is now too high for many of the disabilities.

For example, the bilateral below-knee amputation can be fitted with an excellent artificial leg and can be trained to walk with a normal gait and could function in sedentary type of occupation as well as any sound individual.

Representative comments of respondents, who said that modern developments in rehabilitation have affected the problem of disability and compensation, in that chances for employment are increased

Increase the employability and earning power of veterans.

(*a*) The problem is a new one and is variable in results. My experience is too slight to recommend a change in standards. The problem of motivation of employee and employer to working with disabilities is involved. Increase in automation and other skilled labor permits employment without being fully qualified for manual labor in a great many cases. The increase in college education and vocational courses available to the veteran also permit many individuals with physical handicaps to earn good incomes. A 40-hour week with rest periods and labor-saving devices also permits employment of handicapped individuals at present.

* * * * * *

Medical rehabilitation has greatly reduced residual disability in a considerable proportion of instances. The remarkable advances in rehabilitating disabled individuals to a point where they are self-supporting should certainly reduce the compensation costs now being awarded by the Government. The elaborate and extensive physical medicine and rehabilitation services in all VA hospitals, if made full use of by disabled veterans, would greatly reduce compensation now being paid.

It is my belief that the entire rating schedule for disability compensation should be reviewed in view of benefits and earning capacity of disabled who have been rehabilitated.

The crux of the situation is that at the present time many disabled veterans now have a greater employability potential than ever before. For the reasons stated above, present standards used in the evaluation of disabilities seem to be too high and are not realistic in view of the remarkable potential of physical medicine and rehabilitation.

* * * * * *

Modern developments in medical rehabilitation have had a profound influence on problems of disability and compensation. During World War II many workers who had previously been thought to be unemployable were gainfully employed. Their performance in competition with normal workers proved conclusively that selectively placed handicapped workers can equal the productivity of nonhandicapped workers with no increase in absenteeism or industrial accidents.

These developments certainly have significance to present standards used in the evaluation of disabilities because present standards were largely based on the concept of "static disability" which is a false presumption in many instances. Present standards fail to take into account the fact that all disabilities are relative. A disability that incapacitates a man for one occupation may in no way decrease his suitability for another job for which he is either well qualified or can be trained by vocational rehabilitation."

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Earlier rehabilitation of totally disabled cases reduces Government expenditure.

(*a*) The successful use of excisional pulmonary surgery returns totally disabled patients with pulmonary tuberculosis much sooner to substantially gainful occupations.

* * * * * *

In the cardiovascular field modern developments in medical rehabilitation have had a marked effect.

It would seem that many veterans who have been judged totally disabled from a cardiovascular standpoint can—with modern rehabilitation methods—be made self supporting.

* * * * * *

In general they have aided in the convalescence of patients and have greatly increased chances for profitable employment. In the case of tuberculosis a rehabilitation program is part of the standard treatment, and aids in the cure. The VA tuberculosis hospitals have good rehabilitation programs. As a result of some of these programs men come out with increased rather than impaired capacity.

* * * * * *

Have improved earning capacity with standard physical disability and thus reduced compensation required on this basis. To some extent have improved motivation.

Imply substitution of functional approach rather than older basis of physical deformity. Functional approach would be an "index" including physical and mental attitude. Experience has not yet developed such an "index" but such an approach might be made subject of study.

* * * * * *

The improvement in treatment, especially in geriatrics, rehabilitation, and reconstructive surgery have made the final product more fit to face society and earn a satisfactory living with the same disability which would have incapacitated them many years ago.

Yes, the total picture of the final individual after maximum therapy should be evaluated. No permanent rating should be given until every possible attempt has been made to have the patient reach maximum improvement, both functionally and cosmetically. Until such time the rating should be considered temporary.

Representative comments of respondents who believe that modern developments in rehabilitation have had a marked effect on the problem of disability and compensation, and whose replies were not classified

Tremendous.

Many are rehabilitated and can be reclassified.

* * * * * *

They should have a great effect. The attitude of employers is changing considerably. A campaign to teach our people that their real interest is in maximal removal of disability and rehabilitation is needed.

Their main significance is that the evaluation should be temporary, pending maximal rehabilitation, with the expectation on everybody's part or considerable success.

* * * * * *

They have considerable effect. Especially on those who are well motivated. Permanent pensions tend to reduct this effect, Lump-sum settlements for less than 30 percent ratings would aid rehabilitations.

* * * * * *

A radical effect, although not too much in the cardiovascular field.

The trend has been to emphasize abilities, not disabilities. The rating schedule and the whole compensation system do not promote this philosophy which in itself is necessary for the partially disabled veterans' mental health, attitudes, and all-around adaptation to life situations. The standards must be completely rewritten in this philosophy.

* * * * * *

They are tremendously advantageous if the veteran is given the opportunity and will give evidence of taking advantage of it.

If rehabilitation has been offered, attempted, and failed because of inability to rehabilitate or obtain some employment or vocational placement and the veteran has given proof of cooperation, it should have value in establishing disability pension need.

Summary and conclusions

Modern developments in medical rehabilitation have had an impact upon the problem of disability and compensation. Medical and vocational rehabilitation has increased the earning power and usefulness of a large group of seriously disabled. Rehabilitation techniques have enabled a considerable proportion of people who would have been classed as totally disabled not many years ago to resume productive roles, and restoring the individual to society, living useful lives and being employed in gainful occupations.

The effect of modern developments in medical rehabilitation has greatly improved the problem of disability and compensation, in that, degree of disability has been reduced, and should lower the disability rating and compensation.

The standards for rating disabilities should be changed as developments in rehabilitation come. These modern developments in rehabilitation have significance to the standards now used. Current standards were established before the development of modern medical rehabilitation and have not been modified to reflect these developments. Actual functional disability having been lessened, compensation for such disability should not be as great as has been exercised in the past.

Question No. 3

The schedule for rating disabilities is based "on average impairment of earning capacity":

In your judgment should factors other than loss of earning capacity such as pain, suffering, social handicap, and mental anguish be compensated?

From your study of the schedule do you believe that such factors have been reflected in the ratings in your field of specialization?

Background

Much of the background to this question has been given in the preceding questions in this report. The factor of pain has been considered in the rating schedule under the rating section for skin diseases. Factors of social and industrial inadaptability have been considered, and are requisite criteria for the various degrees of disability ratings under the neurological and psychiatric sections of the Schedule for Rating Disabilities. The President's Commission on Veterans' Pensions required additional information on factors, other than average impairment of earning capacity, that could be considered in determination of the degree of disability and compensation. The questions on this subject were presented to the medical specialists participating in the survey. Each part of the question is analyzed separately. The summary and conclusions are incorporated at the end of this presentation.

Statistical data

Table 66 shows the percent of grand total, by respondents' replies, to this question, that is, respondents who do, and respondents who do not favor that the compensation base include factors such as pain, suffering, social handicap, and mental anguish, and so forth, in addition to "average impairment of earning capacity."

TABLE 66.—*Compensation for factors such as pain, suffering, social handicap, mental anguish, other than loss of earning capacity. Distribution of respondents' replies*

Respondents' replies	Number	Percent
Respondents who favor compensation for the factors, as posed in the question	85	55
Respondents who do not favor compensation for factors, as posed in the question	63	41
Undetermined replies	4	3
Unanswered	1	1
Grand total	153	100

Discussion

Analysis of the opinions of the respondent medical specialists in this survey reveals these highlights:

The issues posed, and the question, surprisingly, was commented upon by all but one respondent. The replies of four respondents were not determinate of either a positive or negative position to the issues posed in the question.

A clear majority, 15 percent more, of the respondents shows the group favors, that the compensation base include factors such as pain, suffering, social handicap, and mental anguish, and so forth, in addition to impairment of earning capacity. Representative comments of this group are presented below.

Forty-one percent of the respondents in this survey indicate that they are not in favor of basing compensation on factors such as pain, suffering, social handicap, and mental anguish, and so forth, other than on "average impairment of earning capacity." Representative comments of this group are presented below.

Summary and conclusions

The summary and conclusions are incorporated with the second part of this question.

Second part of question No. 3

From your study of the schedule, do you believe that such factors have been reflected in the ratings in your field of specialization?

Statistical data

The data was assembled under the two headings of the first part of the question: (a) Percent of grand total, of respondents' replies, of those respondents who favor compensation for factors such as pain, suffering, social handicap, mental anguish, and so forth, other than loss of earning power; (*b*) percent of grand total, of respondents' replies, of those respondents who do not favor compensation for factors such as pain, suffering, social handicap, mental anguish, and so forth, other than loss of earning power; (*c*) respondents whose replies were classified as indeterminate, or unanswered, in the first part of question No. 3, section IV of the questionnaire.

The replies to the second part of the question were further subclassified into "Yes," "No," "Indeterminate," and "Unanswered." The data is shown in table 67.

TABLE 67.—*Factors such as pain, suffering, social handicap, mental anguish, etc., are, or are not, reflected in the ratings of the schedule: Distribution of respondents' replies*

Respondents' replies	Number	Percent
(*a*) Respondents who favor compensation for these factors, posed in the question	85	56
Yes, are reflected in the ratings	59	39
No, are not reflected in the ratings	21	14
Indeterminate	4	2
Unanswered	1	1
(*b*) Respondents who do not favor compensation for the factors posed in the question	63	41
Yes, are reflected in the ratings	38	25
No, are not reflected in the ratings	20	13
Indeterminate	1	1
Unanswered	4	2
(*c*) Respondents whose replies were classified as indeterminate, or unanswered, in the first part of the question	5	3
Grand total	153	100

Discussion

A majority of the respondents, of the two groups, (*a*) 39 percent, and (*b*) 25 percent, as shown in table 66, state that the factors of pain, suffering, social handicap, and mental anguish are reflected in the ratings in the schedule. These two groups when combined indicate that 64 percent of the respondent medical specialists in the Commission's survey are of the opinion that the factors of pain, suffering, social handicap, and mental anguish are reflected in the ratings in the schedule.

Respondents in the two groups, as classified under this question, who expressed the opposite viewpoint that the factors of pain, suffering, social handicap, and mental anguish are not reflected in the ratings in the schedule, were almost equally divided, as a minority, 14 percent and 13 percent, and combined, 27 percent.

Representative comments of the second part of the question are incorporated in the comments of the respondents classified as: (*a*) Comments of respondents who favor compensation for these factors, posed in the question; and (*b*) comments of respondents who do not favor compensation for the factors posed in the question.

Representative comments of respondents who favor compensation for factors such as pain, suffering, social handicap, mental anguish, other than loss of earning capacity

The comments also include replies to the second part of question No. 3.

Yes, unless the objective findings by competent specialists negate them beyond reasonable doubt. The number of cases getting compensation for subjective complaints will decrease in proportion to the M. D.'s increased proficiency in his speciality.

* * * * * * *

Yes. Higher ratings are given when the individual examiner is impressed with marked subjective symptoms in the evaluee.

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When the above items affect the earning capacity they should be compensated.
Yes, I believe that such factors as pain, disfiguration are reflected in the ratings.

* * * * * * *

I believe in some cases these factors should be compensated; i. e. incurable cancers, disfiguring scars of face, and those individuals with permanent colostomies, intractable diarrhea in the colitedes. (definite social handicap!)

I believe that generally speaking these factors have been reflected somewhat in a higher rating.

* * * * * * *

In my judgment, factors other than loss of earning capacity such as pain, suffering, social handicap, and mental anguish should be compensated only if they are continuing in character as distinguished from transient disabilities.

Yes, to some extent in that disfigurement resulting from certain skin lesions is given adequate consideration in determining percentage of disability.

* * * * * * *

I believe that in psychiatric disabilities all these other factors are already being considered in fixing compensation rates. I don't know about other fields but I suspect they are being considered one way or another.

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Earning capacity can be related to social handicap, pain or suffering and mental anguish. However, these should be current and persisting to deserve such significance and with proper and adequate treatment. For example, with proper psychological and psychiatric rehabilitation, mental anguish could be greatly lessened or abolished. Compensation should not be given for past pain, etc.

Yes, probably too much so in the field of my specialty.

* * * * * * *

I think if pain, suffering, social handicap and mental anguish have been proved to exist and are a result of service, they should be evaluated carefully and individually for compensation. Compensation could be stopped when relief eventually comes, if it does.

I think probably they have been and that may be one of the reasons why, in the face of it, I possibly have been unfair in feeling that the majority of ratings are too high.

* * * * * * *

In my opinion, factors other than those of average impairment of earning capacity should be taken into consideration regarding rating of disabilities. Pain, suffering, social handicap, mental anguish, social and psychological adjustment to physical handicaps and disabilities should be taken into consideration in rating disability. Although these factors in many instances are difficult to evaluate, in many instances they may be the principal cause of the loss of earning capacity. On the other hand, many persons may continue to follow gainful occupation and have a low disability rating in spite of the presence of these other factors for which no compensation is granted. Therefore, it seems to me that these other factors should be considered in rating disability.

I believe that such factors have been reflected in the ratings in conditions dealing with physical medicine and rehabilitation, especially in the lower ratings.

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I believe any individual who is able to return to society and his physical condition is such that he can earn his livelihood, barring the presence of emotional and psychic conflicts, should not be compensated. If, however, there is a definite loss of earning capacity such as pain, suffering, social handicap, emotional conflicts, compensation is indicated.

I do not believe they have been adequately considered.

* * * * * * *

Not only loss of earning capacity, but other factors, such as pain, social handicap, mental anguish, and above all a shortened life span and expectancy should be taken into account in rating disabilities and assigning compensation therefor.

My study of the rating schedule has not convinced me that the above-enumerated factors have been sufficiently taken into cognizance.

* * * * * * *

Only under severe situations where the pain, disfigurement, etc., would possibly affect the earning capacity.

In general, no. An exception is the removal of 1 creative organ such as hysterectomy without symptoms, removal of 1 ovary or testicle without symptoms.

* * * * * * *

Yes, if, or when, it is possible to reasonably determine such. It is very difficult to determine in some instances whether pain, suffering, and mental anguish are bona fide.

Not clearly so, unless a rather generous rating can be interpreted as "giving benefit of the doubt."

* * * * * * *

The day has long passed when earning capacity is the sole yardstick; these other factors are of equal or greater importance.

Unfortunately no; I agree with the committee and our President that a full review is needed, and a complete revision made.

Representative comments of respondents who do not favor compensation factors such as pain, suffering, social handicap, mental anguish, other than loss of earning capacity

The comments also include replies to the second part of question No. 3.

These subjective complaints are extremely difficult to evaluate fairly; they are prone to lead to gross exaggeration. I should lean more heavily on physical evidence of loss of earning power.

I believe that allowance has been made for them.

* * * * * * *

No, they are too difficult to evaluate fairly. The adaptable sturdy characters would be penalized.

Yes, in psychiatric ratings.

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Probably not. These are imponderables which cannot be measured, and to include them in the present framework would hopelessly complicate the problem of rating boards.

In respect to gastroduodenal ulcer, which is ordinarily a disease which produces little disability or loss of time from work, it would seem that we are compensating the individual for pain and inconvenience only.

* * * * * * *

Not monetarily. Give medals, ribbons, etc., but not pension.

Yes. Frequently an unknown disease presumed horrible and acquired in a distant jungle is an emotional not medical basis for an award.

* * * * * * *

No, I should think that the basis of earning capacity is a very good yardstick to be used.

Yes, these factors have been reflected in the ratings, as when taken with respect to disability.

* * * * * * *

No. These are vague, subjective, readily simulated, and difficult to evaluate. Rating on these bases would be costly, unjust, and impractical.

Yes. For example, 100 percent disability for profound deafness and organic aphonia. These conditions should not, and do not result in inability to pursue a gainful occupation except in rare instances.

* * * * * * *

No; such considerations could never be adequately and honestly assessed and would be much abused.

Yes; particularly with respect to amputations and disfiguring scars.

* * * * * * *

This is most difficult to evaluate. From a humanitarian standpoint, it is not only justified but is due the individual. Practically however, it is not feasible. In the present-day system it seems impossible for only one group or groups to pass judgment on such factors bordering on the abstract.

In the case of total blindness it appears that an attempt has been made to consider these factors beyond the loss of earning power.

* * * * * * *

Not except as they reflect in the loss of earning power with due regard for emotional factors.

No; for the reasons noted in (1) above. Grave prognosis and imminence of serious complications should have more consideration in disability rating. For example, a severe uncontrollable hypertensive patient should not of necessity have to have a cerebral vascular accident to be totally disabled.

* * * * * * *

No. None of these can be definitely stated as to degree. Subjective pain is a most difficult symptom to evaluate. Two individuals with the same defect will have different pain threshholds. These variations may be due to many factors which are too complicated to fully evaluate in every case and often impossible to ascertain legally.

No; I do not believe they have.

* * * * * * *

It is impossible to calibrate objectively such factors as pain, suffering, social handicaps, and mental anguish. Usually, they will have a direct bearing on earning capacity and should not, in themselves, be compensated.

No.

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No. It is difficult enough to rate the loss of earning capacity. It would be an insurmountable task to rate pain, suffering, social handicap, and mental anguish. If any 1 of these 4 factors were compensated, it would encourage the veteran to remain ill and to continue to complain because his compensation would be rated according to his complaints.

No.

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No. Otherwise, your pension scheme becomes a common-law injury scheme. Even today the idea of wage loss, which is at the base of all our compensation schemes, is being replaced by actions in common law due to the growing concept that personal injury means more than physical disability; that is, it means also pain, suffering, social regression, and mental anguish.

No.

* * * * * * *

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No; I believe we should stick to loss of earning capacity in rating disability. There are too many variables in trying to compensate for pain, suffering, social handicap, and mental anguish. As a matter of fact, these are partly compensated for in the Veterans' Bureau system of statutory awards aforementioned.

Such factors as pain, suffering, have only been reflected in added compensation of statutory awards.

Summary and conclusions

A clear majority of the respondents (56 percent) believe that factors other than loss of earning capacity such as pain, suffering, social handicap, and mental anguish should be compensated. A minority of the respondents (41 percent) are of a different opinion and believe that factors other than loss of earning capacity such as pain, suffering, social handicap, and mental anguish should not be compensated. A considerable percentage (64 percent) of the two groups (majority and minority opinions) to this question, believe that the factors of pain, suffering, social handicap, and mental anguish are reflected in the disability ratings in the Schedule for Rating Disabilities.

Question No. 4

What other comments do you have on the problem of disability rating and compensation?

This question was put to the medical specialists for the purpose of obtaining any information that may have been overlooked in this brief compilation of questions on the problem of the Schedule for Rating Disabilities, basic percentage awards, statutory awards, reexaminations, etc., or any other comments the respondents desired to make. Only 15 percent of the respondents failed to comment on this question.

No two comments, in answer to the question, were alike, although certain ones could be classified under a general heading. Comments of the respondents are grouped under selected headings as indicated, and presented below. It was impractical to give all the comments, and those that were selected are presented because they bear on issues of substantial importance. The comments are only the views of the individual respondent, and are given here with that in mind.

Some comments of the respondents on the Schedule for Rating Disabilities, ratings, statutory awards

Under the above comments I have made the following points: Statutory awards of any kind are not the proper answer to the problem of compensating for disability. If a person is disabled for life, he should be paid each month for the remainder of his life, in proportion to his decreased earning capacity, with other factors, such as pain, suffering, social handicap, and mental anguish to be considered as minor factors.

Whereas the amputation of a leg or an arm may constitute total disability for one individual, it may not disable the other at all. In some way these differences should be reconciled in considering disability. For instance, at the age of 20, in World War II, a man with an amputation of a lower extremity, who is able to use a prosthesis well, whether the amputation is above or below the knee, may be justified in being awarded total disability as a laborer, sunce he was probably not qualified to do anything other than that before he went into World War II.

Fifteen years later this individual may have attained a good education at the expense of the Government, and become one of the outstanding income producers in his community. In the latter case, the man was totally disabled initially, but as the years went by, he became not disabled at all.

* * * * * * *

Progressive chronic diseases should be rated high enough to rate retirement.

Statutory awards are basically wrong. All disabilities should be rated on the same scale, based on actual impairment in earning capacity. Additional awards should be available in special cases such as blindness, paraplegia, etc., where

special expense is necessary for attendants, prostheses, transportation, etc. However, they should be awarded separately and kept entirely distinct from disability ratings and pensions. To accomplish the latter it seems unnecesasry to have physical evaluation boards as now constituted. With the rating tables available to the medical officers knowing the case, reports could be submitted to one central board for awards, with personal appearance only when desired by the member because of disagreement with the findings or desire for legal aid for special reasons. One board for each major area would then suffice for that purpose.

* * * * * * *

While I have rendered criticisms in the report, I would like to state that I believe the rating schedule is a fairly good guide in obtaining equity. Medicine is not and never will be an exact science, therefore we can only establish a guide and rely on the honest judgment of both the doctor and the rater to obtain justice. I have expressed and still feel that statutory awards detract from this goal as it ties the hands of both the doctor and the rater in doing justice in an individual case.

* * * * * * *

One item not covered specifically above is otosclerosis. This is a progressive deafness and there is no medical validity for the recognition of service aggravation due to the continued progress of the disease while the individual is in service. In my opinion, the deafness of clinical otosclerosis should not be considered service connected. Under "Presumptions of service-connection aggravation, B," sec. III, page 10, of the questionnaire, the regulation should exclude otosclerosis from service aggravation because of its naturally progressive nature. However, I understand that many patients with clinical otosclerosis have had their hearing disability adjudged service connected.

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In my opinion both disability rating and compensation are too high. Service- and non-service-connected disabilities, the abuse and attempted abuse of compensation all need an urgent revision.

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In general it is my opinion that the disability ratings are fair and satisfactory. However, in terms of compensation it is my opinion that the compensation rates for total disability and for the percentage disabilities of 75 percent or more is too low. I would be in favor of increasing the compensation for service-connected disabilities at least 30 percent and diminish or abolish compensation for non-service-connected disabilities. I would further recommend that all non-service-connected disabilities be made ineligible for disability ratings and disability compensation. The principle of ineligibility for non-service-connected accidents, injuries, and illnesses, and disabilities of various types should apply for diagnosis and treatment as well as ineligibility for compensation.

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I feel that in general the rating and compensation are fair, although the milder degrees of disability need revision, in my opinion, with a lowering of the amount of compensation provided.

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In general, I think that the disability ratings and compensation are reasonable; however, as previously mentioned, I think that it is obvious that a person who is considered 100 percent disabled cannot live on $181 and the statutory awards in some areas have tended to take care of this problem. However, I think that a figure somewhere between the 100 percent disability figure and the highest figure per statutory awards should be applied to all 100 percent disability cases.

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In view of the increase in the cost of living since the present schedule was established, recommend a comparable overall percentage increase in compensation awards.

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For a better view of the overall picture, it would be of extreme advantage to have studies made of the actual earnings of disabled veterans compared with those of nondisabled veterans or nonveterans. In general, it is my opinion that there should be a more strict differentiation between conditions arising during military service and conditions arising because of military service. Wounds incurred in action or by implements of war, injuries directly due to military training or non-combat operations, tropical diseases, or such things as frostbite due to service in

certain geographical areas, and psychoses arising during combat should be compensable. There are very few other diseases or injuries which would not have occurred if the individual had remained in civilian life.

In Code 7093, hypothyroidism, is response to therapy taken into account?

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I believe that the use of psychological testing would be of benefit in improving the evaluation of psychosocial aspects of injury and disease as well as nonphysical disability. VA centers should have qualified experts in various fields who can be called upon to insure more uniform ratings over the country in specific types of disabilities. So far as scarring is concerned, either from thermal or other types of trauma, I believe that ratings could be handled at one central office with the use of unretouched photographs on the basis of location of the lesion (with respect to exposure), severity (extent and functional impairment), and disfigurement.

Schedule for Rating Disabilities should be revised by a committee or panel of specialists representative of medicine, social science, economic science, and ancillary sciences, and establish criteria

It is a tough problem but it can be made more realistic than shown in the schedule.

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Disability rating can never be accurately standardized. A study needs to be made of actual earnings as affected by the various disabilities. This would be long and time consuming but of great value to all agencies dealing with the disabled. This would serve to point up the differences existing between medical and industrial disability.

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In general it seems to me that recent improvements in medical practice in the VA warrant the exercise of more medical judgment and less dependence on arbitrary standards. Against this, of course, is the danger of exercise of favoritism in individual cases. But I believe it is worth trying.

I note from the President's letter to General Bradley that VA awards are to be brought into relation with other social advances made over the same period as the development of the VA system of compensation. This seems to me to be an exceedingly important matter, involving the whole financial structure of the country. I hope a pension and compensation system, equable for all concerned, can be worked out.

There should be some way to revise awards, in the larger interest of the country, where awards are now fixed permanently by law, and the veterans concerned are no longer to be considered truly disabled by any logical medical standards or by standards of employability.

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Believe that a very complete revision of the rating schedule is in order, to be done by experts in the various medical fields with review by the rating experts. In addition to probable deletions and additions, inconsistencies and contradictions now present should be eliminated. A realistic attitude must be taken toward diseases which devlop or are discovered while in service which obviously have no relation to that service (e. g. essential hypertension, neurocirculatory asthenia, varicose veins, arteriosclerotic heart disease, congenital heart disease, etc.) Since attitudes and knowledge of diseases change, no veteran of any conflict must be protected by law from reexamination at any time.

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In general, it may be stated that the problem of disability rating and compensation is most difficult to establish equitably for all individuals unless each case is decided on its individual merit alone without reference to averages. This, of course, would only be possible if the same individual handled all cases and arrived at the decision in all cases, using predetermined guides and standards in such evaluation. Obviously this would not be possible. When the ratings must be made by many individuals it seems necessary to adopt certain standards for such ratings and adopting ratings which will represent adequate or better consideration of the majority of individuals.

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In regard to ocular disability, it should be realized that all ratings are based on subjective findings, and it is believed that the objective findings should be given more weight in awarding disability ratings than subjective findings.

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In general the percentage awards for disability are compatible with earning capacity. To be brought up to date some impartial civilian committee in each specialty should be set up to make recommendations as to nomenclature, additions, deletions and percentage disability.

Statutory awards, certain groups protected by law, total disability, and presumption of service-connection, is too general and requires individualization to the greatest possible extent.

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This is a problem that is becoming more important every day and will involve most of our male citizens and a proportion of our female citizens in the next 25 years due to almost universal military obligation.

I believe all of the best insurance men, State compensation experts, veterans' bureaus, etc., should study each other's methods and rating schedules and from this might evolve an excellent manual for rating disabilities. I believe the veterans' bureaus have done an outstanding job in this field in the last 30 years but it might be improved by consultation with other agencies aforementioned.

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Once again, in my opinion, there should be a meeting of individuals related to certain specialties and from different services for the purpose of elaborating an IBM card covering all degrees and possibilities of diseases and injury and that compensation should then be based on a comparative schedule going from 100 percent for instance for progressive muscular atrophy to perhaps 1 percent for a small facial or exposed cicatrix. This should include all grades of factors listed in 3 (a) above.

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All too often, those of us who are skilled or trained only in clinical work are asked to participate in rating programs which should be in the hands of specially trained personnel with suitable clinical and social and economic training. In my limited experience with rating problems I have been impressed with the rather pronounced lack of logic in the way that rating procedures are carried out. It is just as bad to expect a highly trained clinician who deals exclusively with clinical patients to give an opinion on social or economic disability rating as it is to expect an office worker with no clinical training to render an opinion on physical disability as determined by the schedule. Too often this rating work seems to be a matter of rote rather than reason. For myself, I feel that I would be totally inadequate as a rating physician without a broad background in all phases of the problem, and in my discussions with other men in a comparable position I find that such is also the case. In this particular area I understand there is a civilian group of physicians which actually has established an organization which is made up of so-called compensation physicians and it would seem that individuals of this type, working in conjunction with the specialist and the sociologist, would be in the position to give the best opinions available in the field of physical or mental disability.

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In general, the problem is very well handled. As noted throughout the answers to this questionnaire, the undersigned has only minor criticisms to offer. A general review of the subject by physicians especially well-qualified in a specialty or subspecialty should adequately adjust the rating and scheduling problem toward greater consistency with advances made in modern medicine.

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I believe all persons with a disability should be evaluated by experts in the fields of medical rehabilitation and vocational training as to the prospects of physical improvement and restoration to gainful employment. More effort should be made along these lines then in the development of disability ratings which all too often tend to perpetuate disability.

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From people who have observed the rating of veterans, I have been informed that cases which are service connected due to aggravation of a disease are compensated for the entire degree of the disease even though it existed prior to service. This is opposed to the standard set forth by the VA and is unjustified. There should be definite proof of aggravation and this aggravation should be over and above that incurred in ordinary civilian life. Aggravation beyond the natural history of the disease may be compensatory. The natural history of the disease will be known only if medical specialists examine the veteran. As the Rating Board is now constituted, consisting of one general practitioner and two laymen, a natural history of the disease may be unknown to them or not considered in their rating.

The majority of the problems of rating are medical. Therefore, it is recommended that the rating of veterans be given to doctors and taken out of the hands of laymen. In the majority of instances, specialists in the various fields of medicine, surgery, and psychiatry should rate a veteran.

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I believe that except for statutory awards for loss of an anatomical unit or function, each case must be judged on an individual basis in relation to what is known about the immediate and remote effects of the disease in question and in relation to the person as a whole.

I believe the whole schedule for rating disabilities should be rewritten in light of present-day knowledge and facilities for social rehabilitative services.

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My first reaction upon seeing this rating schedule was that it was legalistic, arbitrary and represented an effort to make medical judgments by administrative rules. In the complex and variable problem of human disease, injury and capacity to work this is manifestly impossible. I recognize, however, the dilemma faced by the Veterans' Administration. Ideally, one would visualize a disability and pension board, composed of physicians representing the appropriate specialties along with personnel men, and would make medical judgments of the veterans' employability on an individual basis. From the practical standpoint, however, the medical judgments of such boards would vary widely from time to time and place to place, and this would lead to inequity. Frankly, I do not know the answer.

I believe that attempts to legislate the incubation period of disease and arbitrary awards for specific diseases should be discouraged. If the medical staff of the VA, with the help of the present capable consultants, could establish criteria for the diagnosis of disease, incubation periods, presumptive service connection, etc., it would be a great help in making the present method sound and equitable.

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I would recommend that 10 and 20 percent disability monthly compensation be eliminated completely particularly and specifically for psychoneurosis and all subjective patterns such as pain and stiffness.

Disability for and above 30 percent to and including 100 percent should be compensated for at a higher rate and should include a number of factors: Age, ability, previous job, rating on discharge from the service and obligations and family burdens.

There should be in each area a special board to modify and increase or reduce monthly compensation disability according to the needs and justification that this board feels are indicated. This board should consist of: (1) A physician from the regional office of the VA familiar with the whole problem of claims and compensation. (2) A specialist in the field that the compensation falls into, and he should be qualified as such a specialist by one of the American boards in that field and he should not be employed by the VA. (3) A representative of the legal profession familiar with the rights and claims of veterans in general. (4) A representative of some form of industry that employes enough men including veterans to have experience in the placement of the handicapped. (5) Some general practitioner of sufficient maturity and experience so that his opinion in claims and compensation could be relied on by the VA.

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It seems to me, after going over the disability rating books, that a medical panel to review the whole schedule would be in order.

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Sharpen and define more completely the criteria for diagnosis, and where possible, include more objective measurements of impairment, complications and residuals.

Long-range plan to restudy and revise completely the schedule for rating disabilities. At such a time set up plan for continuity of revision to keep pace with new medical developments in diagnosis and treatment.

Such a plan could be implemented and activated by a Committee on Revision, with a membership of about 50 persons, including physicians, lawyers, claims and rating personnel, actuaries, insurance experts, and others experienced in the whole field of disabilities and pensions. This number would allow for division of the work into several phases or areas and establishment of subcommittees for each to carry out the work actively and effectively. Auxiliary advisory subcommittees could be called in to represent the specialties and subspecialties, to serve as experts, in an advisory capacity in revision of the Schedule in special or limited areas.

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I don't believe there should be rating examinations as such. The veteran should be examined by the Department of Medicine and Surgery so he can get the best care. The medical staff of the rating boards or Claims Division should be part of the Department of Medicine and Surgery. The criteria should be completely revised with an up-to-date nomenclature and philosophy of accurate diagnosis, best definitive and rehabilitative care. The emphasis in the past has seemed to me an attempt to go out of the way and to lean backward to establish a disability and then legally and by infrequent, inadequate exams to maintain it.

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I believe there should be a reevaluation of medical criteria on which disability ratings are based. Statutory awards if possible in urology should be lessened for the loss of a single creative organ when it does not interfere with an individual's earnings or functional capacity.

I only regret that because of the deadline to meet I did not have sufficient time to offer a more comprehensive answer to this questionnaire.

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The philosophy of some individuals who seek ratings (and I might add those who help them such as service organizations) is to establish criteria that fall in a certain percentage rating. Whether or not such a rating actually corresponds to percentage loss of earning capacity is relatively unimportant. The mere fact that the individual seems to be the greater motivating factor in gaining entree to the rating board. Such a philosophy can only too easily permeate the rating board. Furthermore, it is not always possible for the most competent of physicians to present a picture on paper from the medical standpoint that actually reflects the loss of earning capacity. Although there are obvious reasons for keeping the examiner and rating board apart, I believe that greater liaison and coordination could be beneficially established.

It seems that in contrast with the obviously incurred disability the so-called submerged chronic diseases which occur or recur while in service present a greater problem. Whether or not it would be feasible to separate them off and rate them differently is a moot question. And then it might be asked if it is equitable to give the service incurred and service aggravated with equal disabilities resulting from the same disease the same amount of compensation?

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To summarize, it is important to understand that the entire pension scheme and disability rating scheme is a pure fiction if we feel that this rating table expresses in a scientific way the economic, or psychological or physical effects of these injuries. At best they can only be arbitrary agreements, expressing not physical effects but reflecting the cultural forces or pressures of the Nation at large. These arbitrary schedules have a definite and indispensable place but they must be recognized for what they are, and equity lies in their consistency since it applies to all the people.

Treatment, corrective surgery, and rehabilitiation

Any disability which can be corrected by operation (which is not involved in high mortality) should not be a reason for continual compensation. Conditions which do not interfere with proper functioning of the body (like loss of toes and certain fingers, slight deafness, etc.) should not be reasons for continuous compensation.

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Individuals who do not take advantage of available treatment facilities afforded them by the VA should have their compensation adjusted periodically to reflect the individual's motivation for becoming a more productive member of society.

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Believe veterans receiving disability compensation should appear before a board of medical officers from time to time for reevaluation of the degree of disability and recommendations as to the corrections by surgery or other means and the lowering of percentage and the compensation or removal of veteran from the disabled list. In certain fixed or permanent disabilities an exception should be made. Where there is question as to the degree of disability the veteran should be hospitalized in a VA hospital, for medical, surgical, neurological survey to determine the degree and permanency of the disability. If surgery is recommended for correction or improvement of the impairment then the veteran should be given his choice of having it done in a VA hospital or civilian or private hospital. If veteran is unwilling to have defect corrected, why should the Government continue to pay him compensation for a correctable and nonpermanent disability? Of course there will be some exceptions with advanced age and other disabilities.

Many individuals want to be independent but with poor judgment they never appear to earn a livelihood or accumulate any savings regardless of the wages they earn—granting disability compensation to these people does not help them adjust, improve their judgment or give them any more initiative or desire to work or save money. If granted disability compensation they become more dependent and do less work.

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Often, surgical procedures are performed to produce ankylosis of joints such as of the spine, of the wrist, of the knee and of the hip which renders the patient more functional. In like manner, transfers of muscle tendons are performed to improve function of joints which also render the patient more functional and due consideration should be given to the final functional result which should thereby provide a lowered disability rating.

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Disability rating and compensation awards are an admittedly difficult task; and in particular for the agency rendering such decisions, for the applicant is usually antagonistic toward the group acting on his application. The difficulty resolves itself into the awarding of an adequate compensation, and yet not to deter the patient from maximally utilizing his residual functional capacity. The medical rehabilitation programs available to a governmental pensioner allow for a complete exploration of his capabilities and their utilization in a directed program outlined by competent personnel. Periodic reevaluation is essential to note any change in an apparently static condition, to acquaint the patient with newly available methods of treatment and to demonstrate to the pensioner the continued interest in his disability.

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Rating is an extremely complex and difficult problem to do fairly and adequately. Psychiatric evaluation of the effect of the patient's disability on his social and vocational life should be taken into account. More emphasis on medical reeducation and vocational rehabilitation.

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I am of the opinion that physical and vocational rehabilitation be a major objective resulting in suitable gainful employment thus making the veteran free and independent. Modification of schedule may be needed when this is accomplished.

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In view of the rapid development of rehabilitation services, both within the governmental medical services and the civilian centers throughout the country, it seems to me that a very much simpler method of compensation for physical disabilities should be in effect throughout the VA. In several fields this rehabilitation service has been under the most able leadership in the institutions of governmental medicine, but the rapid uptake by the civilian profession should gradually diminish the awards made as dollar compensations and pensions to veterans.

Tuberculosis

Though the problem of rating tuberculosis has been mentioned previously in the questionnaire, it seems appropriate to reiterate that advances in the specific treatment of tuberculosis have been greatly modified the chronicity and disability from this disease, though its incidence may not have decreased greatly, and that there should be no permanent award for inactive tuberculosis.

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The doctors themselves can do a lot to reduce disability and hence compensation payments. Most of us are guilty of talking to the new patient with a chronic disease in terms of the disease only. We should emphasize the "end point," i. e., the rehabilitated, self-supporting individual, from the time of our first conversation with the patient. The more patients who are treated definitively in military hospitals and returned to duty, in itself an "end point," the fewer there will be who become eligible for compensation later on. The question of service connection in tuberculosis arising after discharge from service could be settled once and for all by performing a tuberculin test on each dischargee as part of his separation physical examination.

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In my work over a period of several years, I have made repeated use of the schedule for rating disabilities and I have found it to be extremely valuable and in general, a most valid instrument for determining percentage of disability. As is to be expected, medical advances make it necessary that it be revised periodically in order to provide for these new developments.

In occasional instances, subjective symptoms influence the percentage of disability. I would recommend that insofar as possible, objective evidence only be used.

I would like to reemphasize my feeling regarding ratings for tuberculosis that:

There is no medical justification for statutory awards for tuberculosis, particularly for a lifetime minimum award of $67 per month for one who has once had tuberculosis.

Compensation for tuberculosis should be totally discontinued after 2 years of inactivity. (It is suggested that individuals be given 100 percent for first year of inactivity, 50 percent for second year of inactivity, and 0 percent after the end of the second year of inactivity.)

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That they have not been adequately considered is evident by disability rating in individuals who should earn their livelihood without difficulty such as item 7500 where a kidney has been removed and the other is functioning normally. His schedule rating is 30, yet he may carry on activities similar to an individual with both kidneys functioning normally. This is likewise true in item 7506 under tuberculosis. With the introduction of our newer chemotherapeutic agents, it is difficult for me to perceive why an individual who has had one kidney removed for tuberculosis, and followup studies revealed no involvement of the other kidney or bladder, should receive a disability rating of 30. Obviously, if at a later date evidence of reneal tuberculosis would appear, then there should be a change in his schedule rating. It would be my opinion that financial expenditures now associated with specified schedule ratings could be markedly reduced through an adequate followup policy on individuals suffering from disabilities associated with participation in a war. Such a followup policy would lower the schedule ratings in individuals who are carried on a specified schedule rating for extended periods of time without reexamination. In other instances, where a raise in the schedule rating was justified, this would be ascertained at the time of the periodic examination. This followup system is not as important in the group of totally disabled as the innumerable members of the group classified as partial disability and rating a specific schedule rating from that standpoint. There are unquestionably numerous individuals receiving remuneration for partial disability who are actively occupied in a gainful occupation and in whom the schedule rating should be reduced. That is, I do not believe that a specific schedule rating for partial disability should be followed for an extended period of time without ascertaining the individual's right to such compensation, as evidenced by his recheck physical examinations.

Periodic physical examination of the veteran

In view of the extreme difficulty of applying arbitrary ratings, it would appear most fair and sensible to focus attention for improvement of the present system on a more thorough evaluation of individual claims, using all available information bearing on the claimant as a person. I further believe that the interval between reexaminations should be decreased. Unless it is, the changing status of disease activity will be unknown.

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The present laws, regulations, and criteria reflect the intent of the people of the United States, through their Representatives in Congress. There has been little agitation for a bonus for veterans after World War II as compared to the period after World War I. To my mind, this indicates that the present handling of veterans is far superior to the way they were treated after World War I.

Periodic reexaminations of veterans should eliminate most of the 10 percent compensation cases, and provided that the degree of minimum physical impairment warranting a 10 percent rate was raised. It would be feasible to revise the rating schedule so that the present 20 percent physical impairment would carry the 10 percent monetary award.

The 10 percent physically impaired veteran should be entitled to medical and hospital care for non-service-connected ailments in lieu of a monetary award. In this way he would be helped to maintain a higher standard of health and well-being.

A major problem would seem to be related to reevaluation and examination of borderline cases, earning a good livelihood and at the same time receiving VA benefits. Chronic recurrent diseases which have become quiescent and do not interfere with individual earning capacity should be evaluated at certain intervals and reduction in compensation brought about.

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Rating of disabilities can only be as good as the medical examination reports they are based on. It has been our experience that the more thoroughly worked up a case is from a medical standpoint the more accurate will be the final rating of such veteran. This is another way of saying that the better the medical examiner, the better will be the rating from the standpoint of accuracy and fairness.

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In general, skin diseases are rated too highly. In a recent study of about 150 consecutive skin pension examinations, I found the tendency of rating boards to rate a disability higher than what I felt was warranted. This tendency was noted most in such conditions as acne vulgaris, psoriasis, atopic eczema, and neurodermatitis.

Many veterans with skin diseases that existed prior to service were receiving compensation for this disease although it was no worse than before their active service.

Veterans with disabilities of 10, 20, and 30 percent should be examined more frequently than every 5 years which is the present policy.

A closer check should be made on men before they enter the Armed Forces for history of skin disease. I refer in particular to atopic eczema, ichthyosis, psoriasis.

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One-lump-sum payment

It is unfortunate that disability ratings and compensation place a heavy premium on ill health causing conscious or subconscious interference with a veteran's return to full health. It would be preferable if a certain specific total settlement could be made for a disability that this total amount be subdivided into monthly payments for a 30-year period. In the event of a veteran's death, his money would go to his nearest of kin. This would obviate the necessity for frequent re-examinations and the veteran would have no vested interest in his ill health and could be motivated at an earlier date.

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It is extremely important that any plans of compensating an individual for injuries sustained in the performance of a duty should become a help and not a deterrent to his rehabilitation. Unfortunately this disadvantage is inherent in most current compensation practice. The well-motivated individual who cooperates with attempts to rehabilitate him jeopardizes his eligibility for compensation when he increases his earning capacity. The Canadian system or disability awards has in some measure eliminated this disadvantage.

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For many years, I have had the belief that a psychoneurosis, in most instances, will be disabling as long as a person will be paid compensation for the psychoneurosis. Human nature, being what it is, except in rare instances, will not permit the sacrifice of a monthly check for which a person does not have to work. Gratuities are not hard to take. Furthermore, the majority of people are convinced that they are nervous as long as they are rewarded financially for their nervousness. It is my opinion that it would be medically sound to limit the payment of compensation for psychoneurosis to 2 years.

The rating of 10 percent for a neurological or psychiatric disability appears incongruous. If a person is only 10 percent disabled, he actually is not incapacitated. It is suggested that a person, who is disabled ta the extent of less than 30 percent, receive no money. Of course, I am well aware of the danger that many veterans, who are presently rated 10 percent would receive 30 percent. However, that situation could be controlled.

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I believe that many times regular payments for minor ailments and illnesses, physical and mental, have the effect of keeping the individual an invalid. Insurance companies and other countries have found that the wise thing is to clear the whole situation up at once rather than make payments for continuance of symptoms. I would imagine that the VA has great difficulty in grading a person downward as far as compensation is concerned. I think that it would be wise that certainly all mild conditions be terminated quickly, as far as monetary awards are concerned. I am of the opinion that persons suffering service-connected disabilities should receive everything possible to help them earn a livelihood, if possible. I believe the non-service-connected disabilities should be cleared up within a period of 2 or 3 years after separation from service. I think that a thorough study of the Canadian system of handling this problem of compensation

and disability rating would help to set our course in these matters. I fear that with the heavy patient load the whole system might break down under its impact and the service-connected veteran lose out in the overall retrenchment.

Standardization and modernization of medical nomenclature, in the schedule for rating disabilities

I would suggest that:

The nomenclature be standardized with the Armed Forces and the AMA nomenclatures.

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It is felt that a total revision of the nomenclature should be made. A rather detailed report was forwarded from this office earlier, using up-to-date disease nomenclature and indicating disability percentage.

Disabilities incurred in peacetime and wartime and equally disabling

Wartime and peacetime disabilities are equally disabling and incapacitating and should be equally compensated. Disabilities should not be allotted merely for the performance of an operation but for functional impairment, e. g., subtotal gastrectomy is 40 percent without any symptoms. Conditions which are curable should not be ratable.

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A clear and distinct division should be made between such unequivocal disabilities proximately arising in the service and those which are classified as "incidents of the service." Also, there should be no difference in awards for wartime service-connected disabilities in contrast to those incurred in peacetime as long as the draft system exists. A man who loses a limb in a training accident is rendering equally valiant service to his country in time of peace as in time of war. If there is to be any difference (and I can see no reason for it as wartime makes the disability no greater percentagewise) it should be in the form of a bonus payment.

Longevity and disability

In some categories of disease no apparent consideration is given to the prognosis in establishing degree of disability. For instance, considering the expected life span as well as the actual immediate functional impairment, an individual, especially a young one, with leukemia, Hodgkins disease, etc., is considerably more handicapped than one who has lost his left thumb and index finger, yet the former may rate only 30 percent, the latter 40 percent disability.

Actual loss of an organ, such as spleen, lobe of lung, etc., should not in my opinion be grounds for disability payment unless functional impairment results.

On the other hand, an individual with disease carrying a fatal prognosis (malignancies, primarily) should be entitled to 100 percent disability, regardless of functional impairment.

Provisions should be made in the laws or regulations for decrease or discontinuance of disability payments for those individuals who, through negligence, misconduct, or other failure to accept rational treatment, prolong or prevent cure of their disability.

Administrative duplication—Armed Forces and Veterans' Administration both rating same disabilities, in same individual

The present rating by both services and the Veterans' Administration in the majority of enlisted, temporarily retired, personnel appears to be needless reduplication of effort and not an economical practice.

Chapter VI.—Summary of Results of the Analysis

Introduction

This staff study and report of the statistical data, and analysis of the results of medical respondents' replies to the Commission's questionnaire for a medical appraisal of the Veterans' Administration schedule for rating disabilities, and related statutory awards and presumptions, is both disturbing and encouraging. It is disturbing because it highlights so many medical imperfections of the Veterans'

Administration schedule for rating disabilities, the statutory awards, and the presumptions. It is encouraging because it points out where changes and improvements may be brought about.

This study and report is a composite of opinion, data, and inference; the data compiled and analyzed in accordance with scientific principles and procedures. The opinions expressed in the questionnaire by the medical respondents are their own, and do not indicate a position, one way or another, of a professional group; nor are the respondents considered as spokesmen. This report is only a sampling of expert medical opinion on the problem. There is an interest and concern of this group of medical experts in the problem of the rating schedule, the presumptions, and statutory awards. Only 8 percent of the total number of medical specialists solicited in this survey either declined or did not participate in this project.

PRESUMPTIONS

Presumption of sound condition, on entry into the service

The opinions expressed by the medical respondents were in agreement, that in the mass medical examinations, because of the necessity of enlarging the Armed Forces as rapidly as possible, physical examinations were hurried and, in many instances, incomplete; and that some baseline for later determination of service-connected disabilities is required—that this should be a calculated risk.

Presumption of service connection

Chronic diseases.—The medical nomenclature of the chronic disease list is obsolescent and obsolete. The respondents were in agreement that the entire list of chronic diseases should be resurveyed, and medical criteria established, at least, to be used as guides in determination of service connection. The respondents were unable to comprehend and reconcile why a determination of service connection in any disease should be accomplished by fiat. Service connection can be determined in accordance with accepted and sound medical principles. The degenerative diseases of old age, such as arteriosclerosis, osteoarthritis (arthritis) and ulcers (peptic) were singled out as heading the list of chronic disease for reconsideration and presumptive service connection. It is not possible to be definite in some claims for presumption of service connection in a disease which occurred within the presumptive period of 1 year. These questionable cases are settled, not by regulator or administrative determinations but by the doctrine of reasonable doubt in favor of the veteran, in each individual case. More thorough physical examination at the time of separation from the service would reveal minor changes of many of the listed chronic diseases which would become evident later. Brain hemorrhage, or brain thrombosis, attributable to high blood pressure, or arteriosclerosis would not necessarily be regarded as service connected, since they are both likely outcomes of a progressive disease which would have occurred in the individual irrespective of service in the Armed Forces. Many chronic diseases are known to occur irrespective of occupation or military service, i. e., diabetes, pernicious anemia, epilepsies, etc. The basis for singling out the listed chronic diseases is not apparent, except that they are considered as serious.

Tuberculosis.—Recent developments in methods of diagnosis and treatment for tuberculosis have not caused any change to be made, regulatory nor administratively, in the presumptive time interval of 4 years as a qualification for presumptive service connection. Modern methods of diagnosis and treatment have progressed and are more sensitive since the enactment of the original presumption 35 years ago. Earlier diagnosis is possible; the present chemotherapeutic and surgical methods of treatment have modified the prognosis and residual disability. A silent unrecognizable period of 4 years is not in accord with modern accepted sound medical principles. An incubation period of 4 years is too long. The time interval for presumptive service connection of tuberculosis is too liberal, a shorter period is more equitable. Tuberculosis, other than pulmonary, should have a shorter presumptive time interval.

Tuberculosis is considered a communicable disease, and modern methods of preventive medicine include source finding. Finding the source of infection gives a clue as to the time of acquiring the infection.

Psychoses.—Modern psychiatric concepts of external precipitating stress, premorbid personality, and predisposition are used in evaluation and diagnosis of a patient. Stress is generally referred to the immediate emotional, economic, environmental, or cultural situation, and directly related to the reaction (breakdown) shown in the patient. In cases of schizophrenia breaking down within a year or two following discharge, modern psychiatry recognizes that it is the stress of adjusting and adapting to civilian life after discharge from the service. Most veteran schizophrenic cases would have broken down sooner or later, even if they had not entered the service but had stayed at home. Other classes of psychoses differ. Schizophrenia constitues the majority of cases, and considering all the other psychiatric classifications, a time interval, for presumptive service connection, of 2 years for hospitalization only is considered too liberal. A shorter time interval, for all psychiatric diseases, than 2 years is considered as equitable and valid. In presumptive service connection of senile psychoses, and psychoses due to cerebral arteriosclerosis, the presumption is not medically valid. Any psychosis resulting from the exigencies of service would manifest itself prior to separation. The problem of service connection is one of service aggravation of a latent preexisting condition by stress in the service rather than origin in service.

Tropical diseases.—It is not necessary to list a number of diseases as being presumptively service-connected, as having been incurred in the Tropics. In accordance with sound medical principles any serviceman having served in the Tropics, later found to have a tropical disease, the service connection can be determined in accordance with sound medical principles. The diseases listed have been considered as predominantly prevalent in tropical areas. Amebiasis, leprosy, malaria, and dysentery are found everywhere. The list needs revision or deletion. New diseases, discovered since the enactment of this list, are not included. The time interval of 1 year is equitable as an average. Service connection should be established when any disease could not have been incurred in the serviceman's civilian environment in the locality in which he resides, and not limited to specification. Accepted sound medical principles and treatises should be the guide, each case to be determined on its own merits. Since

American servicemen serve in all parts of the hemisphere, service connection for diseases exotic to the United States should not be limited to tropical diseases; for example, Japanese hemorrhagic fever.

Total disability.—The yardsticks for total disability, as established in the Schedule of Rating Disabilities, and extension 5 thereto, are not entirely medically valid. Percentage disability erroneously grades ability to work. The yardstick for age 65 years lets down the bars completely. The yardsticks waive specified requirements for total disability under the qualification of unemployability, and is acceptable medically—if it can be ascertained that the veteran in question is truly unemployable because of the disability. There is no supporting medical basis for specific mathematical provisions permitting a waiver; for example, a disability rated at 60 percent, or combination of two disabilities adding to 70 percent or more, entitles the veteran to 100 percent of the monetary allowance. While there is a basic area having medical validity—the veteran has, or has not, physical or mental capacity to engage in some occupation—the total process goes beyond medicine and dilutes the medical validity by becoming a medical-legal, or medical-social determination. The yardsticks appear to measure 48 inches rather than 36 inches, and are arbitrary. The loss of 1 hand or 1 foot is not a permanent total disability. The yardsticks for total disability are considered impracticable from a medical viewpoint, by imposing a sliding scale for a disability and adding three interpretative guides for unemployability. The whole concept of the presumption of total disability needs complete revision, based on actual disability of the veteran in our modern-day society.

Most of the respondents considered that, of the entire population, the 65-year age group could qualify one way or another for a 10-percent disability rating; for example, under psychoses in the schedule, the criteria for a 10-percent disability rating is "slight impairment of social and industrial adaptability"; under psychoneurosis, the criteria of "moderate," with mild symptoms when findings interfere with employability, the rating is 10 percent; arteriosclerosis generalized, "with slight weakening of bodily vigor," the rating is 10 percent, etc.

There is no set percentage or yardstick by which an individual can be considered totally disabled, be it a percentage of a single disability or combination of disabilities, or at a certain age. Each individual case needs to be appraised in reference to the training, skill, job versatility, motivation, nature of the disease or injury, its complications and residuals, and impairment in these skills and abilities by the disease or injury.

THE VETERANS' ADMINISTRATION SCHEDULE FOR RATING DISABILITIES

Under this subject will be summarized the following items: Percentage ratings; nomenclature; medical criteria; ratings and average impairment in earning capacity; medical data to set percentage ratings; various sections in balance; impact of modern rehabilitation upon disability and compensation; other factors than loss of earning capacity; and physical reexaminations of the disabled veteran.

There seemed to be a lack of unanimity of the respondent medical specialists polled in the Commission's survey as to whether the disability ratings in the schedule were in accord with present-day accepted medical principles. The general concensus was that the

schedule is generally in accord, except in certain medical categories and instances. In round figures, it would appear as if there was virtually a unanimous majority opinion that the disability ratings were in accord with present-day medical principles. However, a closer analysis showed that a considerable number of respondents who were of the majority opinion had agreed with the minority that numerous disability ratings and items in the schedule need revision in the light of changes in modern treatment (both surgical and medical) and disability ratings changed where diseases are improved by operations, prostheses, and other mechanical aids—particularly in the light of the new drug and surgical treatment of pulmonary tuberculosis. A large number of the disability ratings do not properly take into account recent advances in medical rehabilitation, improved prostheses, reconstructive orthopedic surgery, and improved plastic surgery procedures.

The development of a uniform, nationally accepted medical nomenclature for diseases is comparatively recent. Within the Armed Forces, and within the Veterans' Administration particularly, the Claims Division and the Department of Medicine and Surgery do not use the same nationally recognized standard medical nomenclature—some do, and some do not. It would appear that two-thirds of the respondent medical specialists in this survey believed that the disease nomenclature is in accord with present-day medical standards. However, on a closer inspection of these replies it was found that the majority opinion was not clear-cut, as many comments were added in the replies taking exception to specific portions of the schedule as not being in accord with present-day medical standards. This opinion was expressed as well by all of the minority. For example, some of the majority took exception to the outmoded terminology in the psychiatric section of the schedule; this viewpoint was taken by all of the respondents practicing psychiatry. Standard nomenclature of diseases should be required for the physical disability processing and evaluation of the serviceman while in the service and after he becomes a veteran beneficiary. There is confusion of disease nomenclature between the agencies which have to use the Schedule for Rating Disabilities in their physical disability processing and evaluation, and medical examiners of the Department of Medicine and Surgery, who have to be able to speak in two languages during this disability processing: one for translation from the standard nomenclature used by the Department of Medicine and Surgery, and the other for translation into a pen picture of the disease and disability for the Department of Veterans' Benefits. There is no common denominator in physical disability processing.

Medical criteria are certain individual detailed medical items which, when grouped together, construct a model to which similar medical items are compared—thereby establishing a standard. They are used in the Veterans' Administration Schedule for Rating Disabilities, and fitted to the various percentages of gradations from 10 to 100 percent to measure arbitrarily degrees of disability. The respondent medical specialists polled in this survey were of a majority opinion that the medical criteria accurately reflected the residuals of the injury or disease for different percentage ratings. The majority state this to be so generally, with exceptions as noted in some of the representative comments of the majority. The minority opinion

maintained, on the other hand, that the criteria did not reflect accurately the residuals of the injury or disease for different percentages. The majority and minority opinion did agree that a revision of the criteria was required and that the medical criteria should be modernized and more closely correlated to percentage gradations, disability, and average impairment in earning capacity. The criteria for tuberculosis, as singled out for example, require revision.

In determining the percentage of disability on an arbitrary scale of gradations of 10 to 100 percent, the Veterans' Administration considers the basis of disability evaluations to be the ability of the body as a whole, or of the psyche (mental), or of a system or organ of the body—according to the general or localized effects of disease or injury under the circumstances of ordinary activity—that is, in daily life, including employment. A majority of the respondent medical specialists stated that it was not medically feasible to assign gradations of 10 percent with any accuracy when determining the percentage of bodily and mental impairment, and they were badly divided as to what alternative basis of gradations they would recommend. Still, a sizable minority were definite and clear in their opinion that it is medically feasible to assign gradations within an accuracy of 10 percent when determining the percentage of bodily and mental impairment. Both the majority and the minority recognized the fact that any scale adopted was an arbitrary scale. It is not medically feasible to assign gradations within an accuracy of 10 percent when determining the percentage of bodily and mental impairment in any patient with tuberculosis, according to the eight medical respondents practicing this medical specialty.

Disability in a veteran has always been correlated to his earning capacity. Service-connected disability awards have been granted on the basis of total disability, and a proportionate amount of total for partial disability. The Veterans' Administration Schedule determines that the percentage of ratings listed therein represents, as far as can practicably be determined, the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations, and the various grades of severity as set forth in the schedule. The respondent medical specialists were nearly equally divided pro and con on the question: "Do the disability ratings fairly represent the average impairment in earning capacity resulting from the various degreees of severity of physical impairment?" There was general agreement, however, that the ratings of 30 percent and above fairly represented average impairment of earning capacity, and 2 out of 3 respondent medical specialists were of the opinion that the 10 percent and 20 percent disability ratings in the Veterans' Administration schedule do not constitute a material impairment in earning capacity. For example, a 10 percent disability rating does not constitute an actual impairment of earning capacity—except in some such disabilities as in the case of a typist with a finger disability; and, in another example, it does not impair the earning capacity to have a testicle removed.

Early in the study of the Veterans' Administration compensation program and Schedule for Rating Disabilities, the President's Commission was faced with the problem of rules and precedents for measuring loss of earning power. The Schedule for Rating Disabilities was changed in several intervening periods from 1917 to 1945, each

change being authorized by legislation beforehand until the revision of the schedule in 1945 was followed by legislative action. The framers of the original United States veterans' compensation law did not expect their framework to remain unchanged during the next four decades. They regarded much of it as experimental, and hoped experience would lead to subsequent improvements in the Schedule for Rating Disabilities. Improvements in schedules have been made, but little basic change has occurred, and many of the early objectives have become obscured. Since the Schedule for Rating Disabilities is written mostly in medical terminology and medical vocabulary, and since the concept of "average impairment of earning capacity" is basic in the schedule, the President's Commission sought information from medical specialists as to any known medical data which could be used to set percentage ratings to represent the average impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations.

Two-thirds of the respondent medical specialists commented that they did not know of any medical data which could be used to set percentage ratings to represent the average impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations. Their comments varied.

Of the group of respondents who stated they knew of medical data that could be used for the purposes as requested in the question, some made references to certain medical publications, some made references to commercial insurance companies, State industrial commissions, and other State compensation commissions. Other respondents in this group referred to miscellaneous sources. These recommended sources were studied by the staff of the President's Commission and some, like State workmen's compensation, have been incorporated in other reports.

There can never be any satisfactory rule-of-thumb method of applying medical knowledge. The natural history of a disease, coupled with frequent reevaluation and rerating, would seem to be the only reasonable manner of arriving at the proper percentage of impairment in earning capacity.

It is particularly difficult to establish percentage ratings to represent the average impairment in earning capacity resulting from neuropsychiatric conditions.

Ratings are bound to be variable if determined on a basis of average impairment of earning capacity, and not on disability for specific occupation. For certain types of injury and disease, and for certain occupations, this might be accomplished fairly satisfactorily.

So far as is known, there is no accurate medical data which can be used to set percentage ratings to represent the average impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations. Civil occupations are varied, as well as the physical and mental requirements for these occupations, which in itself precludes collecting accurate medical data. Attempts to do so have been made in the various States for workmen's compensation purposes. Some textbooks have been written on the subject. It would appear that a composite average of percentage ratings from various diseases or injuries, and their residual conditions, to represent average impairment in earning capacity has no basis in medical fact.

On the other hand, loss of a foot would be more incapacitating to a

laborer than it would be to a physician. For some diseases and injuries like epilepsies, heart disease, amputations and disabilities of the extremities, some medical data are being accumulated as schedule of ratings of functional disabilities, but do not take into effect the impairment in earning capacity. Some studies on this subject are being made in the Veterans' Administration Department of Medicine and Surgery. Some medical data may be compiled in industrial insurance companies.

There seems to be a beginning for collecting medical data and comparing it with loss and impairment of earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations.

It would appear that the Veterans' Administration is in a position to obtain such data on average impairment of earning capacity as the result of service-connected injury or disease by an actual study of the earnings of veterans in the various categories of disability and comparing these to the earnings of nondisabled veterans. The information would be more valuable than a composite of opinions or clinical impressions obtained in answer to the problem of average impairment of earning capacity.

Study of the problem of rules and precedents for measuring the loss of earning power resulting from various diseases or injuries and their residual conditions revealed that, subsequent to 1917, Veterans Compensation Acts were searching for remedial measures that would suit particular disability situations—frequently by statutory awards for specific disabilities which circumvented the prohibition of the basic concept of the law—for percentage disability ratings to be based upon average impairments of earning capacity. To many experienced in rating disabilities, a glance through the Veterans' Administration schedule for rating disabilities leaves the impression that the medical criteria, as correlated to the different percentage awards and to different diseases and injury residuals, are out of proportion. Also, that the various sections of the schedule reflect questionably and disproportionately the percentage awards and the statutory awards. In the survey of medical specialists by the President's Commission, in order to determine whether the percentages in the schedule taken together with statutory awards were too high or too low, in relation to disabilities as residuals of diseases and injuries, 59 percent of the respondents stated that various sections of the rating schedule and the related statutory awards were not in balance; 22 percent of the respondents believed that percentages of disabilities and ratings in the schedule taken together with the statutory awards were too high; and only 6 percent of the respondents felt that the ratings of disabilities in the schedule taken together with the statutory awards were too low.

In tuberculosis, for example, the percentages and statutory awards are too high. Statutory awards, otherwise, are also too high in comparison to persons disabled, for example, with heart disease. A percentage award together with the statutory award is too high in orthopedic (amputations) and muscle injury disabilities. Disability ratings in the psychoneuroses are, in general, rated too high—particularly in the 30 percent bracket.

Disability ratings are too low for other psychoses than above, and in relation to the statutory awards—other than the helplessly bedridden—are in constant need of aid and attendance. In general, disability ratings are too low for serious diseases—for example, heart disease—

in relation to the obvious statutory awards, other than helplessly bedridden, and in constant need of aid and attendance, especially where they shorten life expectancy, or are ones productive of protracted pain.

Should factors other than loss of earning capacity—such as pain, suffering, social handicap, and mental anguish—be compensated? And have these factors been reflected in the ratings of disabilities in the various sections of the schedule? Fifty-six percent of the respondent medical specialists favor compensation for factors other than loss of earning capacity—such as pain, suffering, social handicap, and mental anguish, etc. Thirty-nine percent of this group, plus 25 percent of the minority group, indicate that 64 percent of the medical specialists believe that such factors, other than loss of earning capacity, are reflected in the ratings of disabilities in the various sections of the schedule.

Disability has been correlated to earning capacity. The degree to which a man was either fit or unfit to do a job was based upon the degree to which he was considered disabled—that is, the degree to which he was anatomically whole. Consequently, some of the early workmen's compensation laws carried provisos for the rehabilitation of the injured workman to optimal family, social, and economic life. This concept was incorporated into the first compensation law for the United States veteran. The rise of rehabilitation has improved means of regaining lost health and overcoming loss of function "to the fullest physical, mental, social, vocational, and economic usefulness" of which the disabled individual is capable. Disability ratings and compensation should reflect modern rehabilitation developments.

Modern developments in medical rehabilitation have had an impact upon the problem of disability and compensation, 80 percent of the respondent medical specialists stated. Medical rehabilitation has increased the earning power and usefulness of a large group of seriously disabled. Rehabilitation techniques have enabled a considerable proportion of people who would have been classed as totally disabled not many years ago to resume productive roles, restoring the individual to society, to live a useful life and to be employed in a gainful occupation.

The effect of modern developments in medical rehabilitation has greatly improved the problem of disability and compensation in that the degree of disability has been reduced and should lower the disability rating and compensation, as stated by 48 percent of the respondent medical specialists.

The standards for rating disabilities should be changed as developments in rehabilitation come. These modern developments in rehabilitation have significance to the standards now used. Current standards were established before the development of modern medical rehabilitation and have not been modified to reflect these developments. Actual functional disability having been lessened, compensation for such disability should not be as great as has been exercised in the past.

Veterans drawing disability compensation have been required to undergo a physical examination at various time intervals to determine the continuance of monetary awards for their disability. Some have been biennial physical examinations, discontinued and reinstituted by legislation. Other rules for physical examinations were established by legislation implemented by regulation. At present, physical

examinations are performed as indicated by Veterans' Administration regulations. These regulations further specify that reexaminations will not be performed under certain qualifying conditions: for example, reexaminations are not made in service-connected disabilities, when the disability rating is a prescribed minimum rating in the schedule for rating disabilities. There are over 350 minimum 10 percent ratable conditions listed in the schedule for rating disabilities, and over 150 more 20 percent minimum ratings out of a total of some 1,000 ratable conditions. In addition, there are around 250 conditions listed in the schedule for rating disabilities which have a zero percent rating. Also, low disability ratings of 10, 20, and 30 percent in nonstatic cases are not reviewed and no physical examination is performed, except at least once within a 5-year period—or upon claim for a higher disability rating by the veteran concerned. A number of recommendations were made by the respondent medical specialists for the frequency of physical examinations in nonstatic cases, and the time interval for scheduling the examinations. Some said every 2 months, others every 3 months, 6 months, according to the percentage of disability as specified by the medical specialist in charge of the patient; others specified different intervals. One-half of the respondents favored annual physical examinations up to a maximum time interval between examinations of 2 years, then repeated. One-eighth of the respondents favor physical examinations scheduled for every 2 years after the initial rating had been given. Tuberculosis cases should be examined every year, according to five respondents.

STATUTORY AWARDS FOR SPECIFIC DISABILITIES

Statutory awards for specific disabilities are given principally for "loss of, or loss of use of," except for the awards for helplessly and permanently bed-ridden, and aid and attendance. Statutory awards are not given for the residuals of diseases in all specialized fields of medicine. For example, there are no statutory awards for skin conditions or tropical diseases, except for loss of vision from some of these diseases such as leprosy, loss of use of limbs from filariasis or leprosy, or paralysis of muscle groups from encephalitis, or other infectious diseases like poliomyelitis, and so forth. The question of equal compensation for equal physical impairment leaves room for argument. For example, the individual with a facial injury resulting in a grotesque and unsightly facial deformity receives no statutory award. A considerable number of respondents, 43 percent maintained that the statutory awards are not medically sound. The number in this group exceeded by 18 percent the number of respondents who expressed the opinion that the statutory awards are medically sound. Statutory awards are not in accord with the basic concept of "average impairment of earning capacity." Loss, or loss of use of, a creative organ does not prevent one from performing manual labor.

A number of respondents (26 percent) stated that the statutory award for tuberculosis is not medically sound. There were no contrary opinions expressed in opposition to the unsoundness of tuberculosis awards. The statutory period (11 years) for tuberculosis is considered medically unacceptable.

Forty-six percent of the medical respondents believe that there is no medical validity for different monetary rates for disabilities

which are all rated 100 percent. There should be no conflict between the statutory awards and the disability rating under the schedule. For example, the veteran with very high blood pressure has a short time to live, while another veteran who has lost a hand or a foot may live a normal life span. With adequate present-day rehabilitation and selective placement, the amputee can equal other veterans in terms of work capacity. A 100 percent disability should mean 100 percent loss of earning power; however, additional allowances might be made because of the additional help or aid required in completely helpless patients. The problem is not medical; other factors such as economic and social are involved.

A majority margin of 4 to 1 of the respondents who participated in this survey said there have been medical developments in drug treatment, surgery, diagnosis, treatment, prosthesis, and so forth, in the past 10 years to affect the conditions in the statutory awards. Fifty percent of the majority emphasized in their comments that there have been very marked advances in chemotherapy and surgery of tuberculosis in the past 10 years, and that these should affect the conditions of statutory awards; none of the respondents said "no" to these medical developments in the field of tuberculosis. Other medical developments were in amputations, surgical and mechancial improvements in the fabrication and fitting of amputation prosthesis, improvements in rehabilitation techniques, advances in the treatment of osteomyelitis, and other chronic infections. All of these medical developments have changed the outlook of the veteran affected, and should serve to decrease the degree of disability in many cases.

Several interesting constructive comments were made by the respondent medical specialists to the President's Commission in the final section of the questionnaire in this survey of expert medical opinion on the Schedule for Rating Disabilities, and related presumptions and statutory awards. Outstanding were the comments listed in chapter V of section II this report under question No. 4, and the heading "Schedule for Rating Disabilities Should be Revised by a Committee or Panel of Specialists Representative of Medicine, Social Science, Economic Science, and the Ancillary Sciences to the Foregoing, and Establish Criteria."

The problem of the Veterans' Administration Schedule for Rating Disabilities is a difficult one. It can be made more realistic, and should be thoroughly revised at least every 5 years under a panel of disinterested experts, representing various sciences, such as, medicine, economic science, social science, and the ancillary sciences. Since disability ratings must be made by many individuals, it is necessary to adopt certain standards for such ratings that will represent adequately and equitably a consideration of the majority of disabled veterans. At the present time, the Schedule for Rating Disabilities, does not express in a scientific way, the economic, or psychological, or physical effects of injuries. At best, the ratings in the schedule are arbitrary agreements, expressing not physical effects but reflecting the cultural forces or pressures of the Nation at large. The Schedule for Rating Disabilities is an arbitrary schedule, and has a definite and indispensable place, but it must be recognized as arbitrary, and equity lies in consistency of the criteria and standards contained therein.

APPENDIXES

LETTER FROM THE COMMISSION TO MEDICAL SPECIALISTS, NONGOVERNMENTAL

APPENDIX A

PRESIDENT'S COMMISSION ON VETERANS' PENSIONS,
Washington, D. C., October 5, 1955.

DEAR ———: The President has asked this Commission to make a study and report to him. The assistance of medical specialists is vital in this study and we have therefor come to you for help.

The President on January 17, 1955, established this Commission on Veterans' Pensions to systematically assess the structure, scope, philosophy and administration of pension, compensation, and related nonmedical benefits furnished under Federal legislation to our veterans and their families, together with the relationships between these benefits and others which are provided for our citizens without regard to their status as veterans. The objective of this effort is to modernize these benefits and services so that veterans and their survivors receive equitable treatment consistent with the orderly development of public policy. The Commission is to furnish the President with a report, including recommendations, which he can use as a basis for making recommendations to Congress.

As a major part of its study, the Commission is making a thorough review of veterans' and military disability benefits, including the medical standards and criteria which are used in rating disabilities. The basic guides to disability rating in these programs are provided by the Veterans' Administration in the Schedule for Rating Disabilities, 1945 Edition, as amended in the various extensions. The original medical criteria for rating disabilities for veterans' benefits were established shortly after World War I. Subsequent modifications have been many, the last major revision is the 1945 schedule. There have also been piecemeal enactments establishing legal presumptions of service-connection and granting additional awards for specific disabilities. Disability ratings are intended to reflect average impairment of earning capacity. Rates of payments for various degrees of disability have been increased repeatedly. As a result, these standards need reappraisal in the light of modern medical prosthetic and rehabilitation techniques. A review of the medical validity and equity of the schedule is thus necessary since it is the foundation for the disability benefits system.

The Federal Government assumes a major responsibility in its programs for assistance to disabled wartime and peacetime veterans. As shown in the enclosed statistical data, over 2 million veterans are receiving compensation payments totaling over $1.4 billion a year for service-connected disabilities. Of these, 57 percent are paid monthly basic percentage rates for 20 percent and less disability; approximately 6 percent for total or 100 percent disability.

About 120,000 of the above veterans receive statutory awards in addition to, or in lieu of the basic percentage awards under the schedule. Of these, 67,000 receive a monthly award of $37.60 or $47 in addition to the basic compensation the veteran may be entitled to as the result of percentage awards. These include 60,000 veterans with loss, or loss of use of 1 hand, foot, eye, or blindness in 1 eye, and 700 with loss, or loss of use of a creative organ. The remaining 53,000 cases are those where the higher statutory awards are paid in lieu of the basic percentage awards. These include 41,000 veterans of all periods of service paid a minimum statutory award of $53.60 or $67 monthly for arrested tuberculosis of all types, and 12,000 cases paid statutory awards, generally ranging from $223 to $420 a month, for multiple disabilities or for regular aid and attendance.

In the pension program for non-service-connected disabilities, there are 600,000 veterans receiving over half a billion dollars annually.

To help this Commission appraise the Schedule for Rating Disabilities, we are forwarding a questionnaire for you to answer. Because of the deadline set for the entire study, we should like to have your reply by October 31, 1955, at the latest. Your comments and answers will be treated with the utmost confidence and your name will not be used in connection therewith without your consent.

Since clerical costs will be involved in developing the material from your files and preparing the reply, the Government is prepared to reimburse you in the sum of $100. A voucher (form 1034) for this amount is enclosed. If this arrangement is satisfactory, please sign the acceptance at the bottom of this letter on the original; sign the completed voucher and return both to us.

Enclosed is the questionnaire with explanatory material describing the percentage awards, the statutory awards, and the presumptions; three statistical tables; the Veterans' Administration's Schedule for Rating Disabilities, with the extensions, and a copy of the press release relating to the Commission's general assignment. Self-addressed penalty envelopes are enclosed for your convenience in returning the completed questionnaire and the schedule. The copy of the schedule has been loaned to us by the Veterans' Administration and is considered restricted matter. Accordingly, it should not be shown to unauthorized persons and should be returned to this Commission. Please do not hesitate to ask for clarification or additional information.

The members of this Commission thank you for your cooperation and professional help in their task.

Sincerely yours,

OMAR N. BRADLEY,
General of the Army, Chairman.

Accepted:

(Sign here) ----------, M. D.

LETTER FROM THE COMMISSION TO MEDICAL SPECIALISTS, GOVERNMENT AGENCIES

APPENDIX B

PRESIDENT'S COMMISSION ON VETERANS' PENSIONS,
Washington, D. C., October 10, 1955.

DEAR DOCTOR: The President has asked this Commission to make a study and report to him. The assistance of medical specialists is vital in this study and we have therefore come to you for help.

The President on January 17, 1955, established this seven-member Commission on Veterans' Pensions to systematically assess the structure, scope, philosophy and administration of pension, compensation, and related nonmedical benefits furnished under Federal legislation to our veterans and their families, together with the relationships between these benefits and others which are provided for our citizens without regard to their status as veterans. The objective of this effort is to modernize these benefits and services so that veterans and their survivors receive equitable treatment consistent with the orderly development of public policy. The Commission is to furnish the President with a report, including recommendations, which he can use as a basis for making recommendations to Congress.

As a major part of its study, the Commission is making a thorough review of veterans' and military disability benefits, including the medical standards and criteria which/are used in rating disabilities. The basic guides to disability rating in these programs are provided by the Veterans' Administration in the Schedule for Rating Disabilities, 1945 edition, as amended in the various extensions. The original medical criteria for rating disabilities for veterans' benefits were established shortly after World War I. Subsequent modifications have been many, the last major revision is the 1945 schedule. There have also been piecemeal enactments establishing legal presumptions of service connection and granting additional awards for specific disabilities. Disability ratings are intended to reflect average impairment or earning capacity. Rates of payments for various degrees of disability have been increased repeatedly. As a result, these standards need reappraisal in the light of modern medical, prosthetic, and rehabilitation techniques. A review of the medical validity and equity of the schedule is thus necessary since it is the foundation for the disability benefits system.

The Federal Government assumes a major responsibility in its programs for assistance to disabled wartime and peacteime veterans. As shown in the enclosed statistical data, over 2 million veterans are receiving compensation payments totaling over $1.4 billion a year for service-connected disabilities. Of these, 57 percent are paid monthly basic percentage rates for 20 percent and less disability; approximately 6 percent for total of 100 percent disability.

About 120,000 of the above veterans receive statutory awards in addition to, or in lieu of the basic percentage awards under the schedule. Of these, 67,000 receive a monthly award of $37.60 or $47 in addition to the basic compensation the veteran may be entitled to as the result of percentage awards. These include

60,000 veterans with loss, or loss of use of one hand, foot, eye, or blindness in one eye, and 7,000 with loss, or loss of use of a creative organ. The remaining 53,000 cases are those where the higher statutory awards are paid in lieu of the basic percentage awards. These include 41,000 veterans of all periods of service paid a minimum statutory award of $53.60 or $67 monthly for arrested tuberculosis of all types, and 12,000 cases paid statutory awards, generally ranging from $223 to $420 a month, for multiple disabilities or for regular aid and attendance.

In the pension program for non-service-connected disabilities, there are 600,000 veterans receiving over half a billion dollars annually.

To help the Commission appraise the Schedule for Rating Disabilities we request you to complete and return the enclosed questionnaire direct to the Commission. Because of the short deadline set for the entire study, we should like to have your reply by November 11, 1955. Your comments and answers will be treated with the utmost confidence and your name will not be used in connection therewith without your consent.

Enclosed is the questionnaire with explanatory material describing the percentage awards, the statutory awards, and the presumptions; three statistical tables; and a copy of the press release relating to the Commission's general assignment. Self-addressed penalty envelopes are enclosed for your convenience in returning the completed questionnaire. Please do not hesitate to ask for clarification or additional information.

The President's Commission thanks you for your cooperation and professional help in their task.

Sincerely,

E. M. BRANNON,
Major General, United States Army,
Executive Director.

APPENDIX C

COMMISSION QUESTIONNAIRE

Budget Bureau No. 111–5501
Approval Expires December 31, 1955

President's Commission on Veterans' Pensions, Washington 25, D. C.

MEDICAL APPRAISAL OF VETERANS' ADMINISTRATION SCHEDULE FOR RATING DISABILITIES AND RELATED STATUTORY AWARDS AND PRESUMPTIONS

GENERAL INSTRUCTIONS

A study is being conducted by the President's Commission on Veterans' Pensions to determine the extent to which the Veterans' Administration Schedule for Rating Disabilities, and the related statutory awards and presumptions, are medically valid and equitable. This questionnaire is being sent to selected eminent members of the medical profession, in and out of the Government service, covering various medical specialties in different areas of the Nation. In order to facilitate your reply to questions, disability ratings and related matter pertinent to your specialized field of medicine are in the following pages of the Veterans' Administration Schedule for Rating Disabilities (1945 edition).

The questions are grouped under four headings relating to (1) the Veterans' Administration Schedule for Rating Disabilities, which provides the basis for the basic percentage awards paid by the Veterans' Administration, (2) statutory awards, (3) presumptions, and (4) general matters. Under each of these headings there is a brief description of existing laws and regulations with pertinent questions. The respondent should enter his answer in the blank space following each question. Additional space is provided on the back of the page, and if it is used the continuation should be identified with the question number. The respondent is asked to answer or comment on all questions, including those he considers nonspecific to his medical specialty. Additional comments are also invited.

The Veterans' Administration pays two main types of monetary awards, or rates, to veterans whose disabilities are determined to have been incurred or aggravated while in active military service. The first and most generally used are the percentage awards in 10 gradations based on the rated degree of disability. The second are the statutory monetary awards authorized by legislation for specific disabilities, including loss or loss of use of limbs, creative organ, blindness, deafness, arrested tuberculosis, etc.

Veterans who are in receipt of compensation for disabilities of 50 percent or more are entitled to extra amounts for their wives, minor children, and dependent parents. For veterans who are 100 percent disabled this extra compensation ranges from $14 for a wartime veteran with 1 child to a maximum of $91 for a veteran with a wife, 3 or more children, and 2 dependent parents. If the veteran is partially disabled, but not less than 50 percent, the additional compensation for dependents is a corresponding proportion of the rates paid to totally disabled cases.

In all categories, rates for "peacetime" veterans are 80 percent of the rates for wartime veterans.

Among other special veterans' benefits for service-connected disabilities are included continuing medical and hospital care; prostheses; mechanical aids; a one-time award of $1,600 toward purchase of an automobile or other conveyance for loss or loss of use of one or both hands or feet, or of both eyes; and a single grant of up to $10,000 to cover not more than one-half the purchase price of a special house to veterans for loss or loss of use of lower extremities, such as to preclude locomotion without aid of braces, crutches, canes, or wheel chairs.

SECTION I. THE VETERANS' ADMINISTRATION SCHEDULE FOR RATING DISABILITIES AND THE BASIC PERCENTAGE AWARDS

The percentage or basic awards are presently based on 10 degrees of disability, ranging from 10 percent to total or 100 percent. These degrees of disability are determined on the basis of the Veterans' Administration Schedule for Rating Disabilities. The schedule is a compilation of percentage ratings with correlated medical criteria based on disabilities resulting from disease or injury.

As stated in paragraph 1 on page 1 of the schedule, "the percentage ratings represent as far as can practicably be determined the average impairment in earning capacity resulting from such diseases and injuries and their residual conditions in civil occupations * * *." Studies have never been made, however, to ascertain how the actual earnings of the disabled veterans compared with those of nondisabled veterans or nonveterans. The general instructions on the first 25 pages outline the use of the schedule on such points as combined disability, convalescent ratings, etc.

The present monthly benefit rates set by law for the various degrees of disability for wartime service-connected disabilities are as follows:

10 percent disability	$17	60 percent disability	$109
20 percent disability	33	70 percent disability	127
30 percent disability	50	80 percent disability	145
40 percent disability	66	90 percent disability	163
50 percent disability	91	100 percent total disability	181

These awards are continuing in nature for as long as the specified degree of disability exists.

The present schedule was prepared by the Veterans' Administration in 1945. The 1945 schedule was the outgrowth of a series of revisions going back to 1917. For example, the 1921 table was based on the concept of average impairment of earning capacity from injuries for civil occupations, and ranged from 10 to 100 percent disability in gradations of 5 percent. The 1925 schedule followed the so-called California system of rating disability under workmen's compensation, in which the award to the worker was based on his disability for his specific occupation rather than on an average impairment of earning capacity and ranged from 10 to 100 percent in gradations of 1 percent.

In 1933 the Veterans' Administration, as authorized by the President pursuant to law, returned to a schedule based on average impairment of earning capacity constructed to provide 10 grades of disability 10 to 100 percent in gradations of 10 percent. In developing the ratings it is understood that the "average" impairment was taken to be that in manual labor. The Veterans' Administration again revised the schedule in 1945 and it is the one in use today, with changes embodied in nine "extensions."

The 1925 schedule, however, is still used as the basis for certain ratings "protected" by law for World War I veterans, as well as in determining existence of a compensable disability on the part of deceased veterans in determining eligibility of their dependents for death pensions.

Initial disability ratings are made at any time by the Veterans' Administration following a valid claim for compensation or pension and Veterans' Administration official physical examination. When a claim is filed within 6 months from date

of separation, an initial rating is made, based on the records of the military department, without a Veterans' Administration official physical examination, unless it would appear that error might result from such rating.

Reexaminations for disability rating purposes are scheduled by Veterans Administration Regulations as follows. (*a*) Convalescent ratings in 6 months or in 1 year; (*b*) for nonstatic disabilities initially rated 80 to 100 percent in 2 years, 40 to 70 percent in 3 years, 10 to 30 percent in 5 years; (*c*) increase in disability of 10 percent or more, according to frequencies in (*b*); (*d*) decrease in disability rating of 10 percent or more in 2 years regardless of the rating; (*e*) unchanged disability rating, 5 years after the date of the last examination.

By regulation reexaminations are not made in service-connected disabilities when (*a*) the disability is established as static; (*b*) lesions and symptoms have persisted without material improvement for a period of 5 years or more; (*c*) disability from disease is permanent in character and of such a nature that there is no likelihood of improvement; (*d*) in veterans of World War I and other veterans over 55 years of age, except under the most unusual circumstances; (*e*) rating is a prescribed scheduled minimum rating.

Reexaminations are made for non-service-connected pension disabilities, where a permanent total disability is in effect on nonstatic conditions, within 30 months of the initial rating. Reexaminations for non-service-connected pension disabilities are not made on veterans of World War I and other veterans over 55 years of age, or where permanent total disability is confirmed by history of the case.

Questions regarding schedule and percentage awards

1. In reviewing the parts of the 1945 schedule covering your specialized field of medicine:

(*a*) Are the disability ratings in accord with present day accepted medical principles?

(*b*) Is the disease nomenclature in accord with present day medical standards?

(*c*) Do the medical criteria reflect accurately the residuals of the injury or disease for different percentage ratings?

2. (*a*) In your field of specialization, are the disability percentages too high from the standpoint of actual functional impairment? Too low? Which ratings, if any, are too high or too low?

(*b*) Do the impairments rated at 100 percent actually represent total functional impairment?

3. Are the ratings in your medical specialty consistent with the ratings in other sections of the schedule?

4. Given a diagnosis specifying the degree of severity for a condition:

(*a*) Is there a reasonable basis for determining the percentage of bodily and mental impairment?

(*b*) Is it medically feasible to assign gradations within an accuracy of 10 percent? If not, what scale of gradations do you regard as feasible?

5. In your opinion, do the ratings fairly represent the average impairment of earning capacity resulting from the various degrees of severity of physical impairment?

(*a*) Do the disabilities rated at 10 and 20 percent constitute an actual impairment of earning capacity?

(*b*) Do you know of medical data which can be used to set percentage ratings to represent the average impairment in earning capacity resulting from various diseases or injuries and their residual conditions for civil occupations?

6. As regards disabilities within your specialized field of medicine how frequent should the reexamination be scheduled? Please comment.

SECTION II. STATUTORY AWARDS FOR DISABILITY

These special, monetary awards by law are authorized for specified disabilities and are payable as long as the condition exists. Historically these were enacted from time to time by Congress and are of two kinds:

A. *Permanent monthly rates of $47.00 payable in addition to the basic percentage rates for the same and other disability.*—This class includes anatomical loss, or loss of use of (1) one foot, (2) one hand, (3) creative organ, or (4) blindness in one eye.

B. *Permanent monthly rates paid for specified disabilities in lieu of the basic percentage rates.*—These may exceed the 100 percent basic rates for total disability which is $181, and are as follows:

1. Loss, or loss of use (*a*) both hands, (*b*) both feet, (*c*) blind in both eyes, (*d*) one hand and one foot, (*e*) permanently bedridden, or (*f*) helpless in need of aid, $279–$420.

2. Loss, or loss of use, of two extremities at level, or with complications, preventing natural elbow or knee action with prosthesis in place; or blind in both eyes requiring aid and attendance, $329–$420.

3. Loss of two extremities so near shoulder or hip as to prevent use of prosthetic appliance; or anatomical loss of both eyes, $371–$420.

4. A group of World War I veterans are "protected" by law for similar but not identical disabling conditions, $181–$300.

5. If a disabled veteran is entitled to two or more rates, including double total disability, the Administrator in his discretion may allow a higher rate not to exceed $420.

6. Tuberculosis, all forms, completely arrested are paid a minimum monthly rate for life, of $67. This rate is not paid in addition to other rates but represents the minimum. The law also provides graduated reduced percentage ratings over an 11-year period of 100 percent for the first 2 years; 50 percent for the next 4 years; 30 percent for the next 5 years; then a 30 percent permanent rating given for arrested far advanced lesions; and a 20 percent permanent rating for arrested moderately advanced lesions; and a zero percent for all other forms. However, the monetary payment does not go below the minimum of $67.

(*a*) A group of World War I veterans are "protected" by law and receive the minimum $67 following a 100 percent rating for 6 months after discharge. This group is awarded a minimum permanent 25 percent rating for arrested or apparently cured tuberculosis and no observation or reexamination required over a period of time.

(*b*) The permanent $67 rate for completely arrested tuberculosis is not payable in combination with the permanent statutory award for loss, or loss of use, of creative organ; 1 foot; 1 hand; blindness in 1 eye.

The rates quoted for statutory awards are those paid for wartime disabilities; veterans with "peacetime" service disabilities receive 80 percent of the wartime rates.

Questions regarding statutory awards

1. Are the statutory awards in your specialized field medically sound in comparison with other rated disabilities for which no such awards are provided? Do the statutory awards provide equal compensation for equal physical impairments?

2. Under the schedule, a permanent and total (100 percent) disability is paid a rate of $181 monthly. Under the statutory awards, alternative higher rates are paid ranging up to $420 monthly for certain disabilities. In your judgment, is there medical validity for different monetary rates for disabilities which are all rated 100 percent?

3. In your opinion, do the disabilities for which statutory awards are authorized, within your medical specialty, represent more serious handicaps to earning capacity than do other equally rated disabilities for which only basic percentage awards are available under the schedule?

4. Have there been any medical developments in chemotherapy; surgery; diagnosis; treatment; prosthesis, etc., in the past 10 years, within your medical specialty, to affect the conditions in the statutory awards?

5. Do you have additional comments or recommendations on statutory awards?

SECTION III. PRESUMPTIONS RELATING TO SERVICE-CONNECTION OF DISABILITY

In determining service-connection for rating disabilities, the general rule is that the evaluations must be based on accepted medical principles.

In the veterans' programs certain prescriptions, enacted into law or established by regulation for administrative or other resons, modify this general rule. For example, the law provides that, where the evidence may not clearly demonstrate service-connection of a disease, all reasonable doubt should be resolved in favor of the veteran. There are also a number of "presumptions" relating to service-connection of disabilities, as follows:

A. *Presumption of sound condition.*—Every person employed in the active military service is presumed to have been in sound condition when examined, accepted, and enrolled for service except as to defects, infirmities, or disorders noted at the time of the examination, acceptance, and enrollment, or where clear and unmistakable evidence demonstrates that the injured or disease existed prior to acceptance and was not aggravated by such active military or naval service.

B. *Presumption of service-connection—Aggravation.*—A pre-existing injury or disease is presumed to have been aggravated by active military service, where there is an increase in disability during active service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease.

C. *Presumption of service-connection—Diseases manifest after discharge.*—Certain chronic and tropical diseases are presumed to be service-connected. Resultant diseases or disorders originating because of therapy or from preventive measures for tropical diseases are accorded service-connection if manifested to a degree of 10 percent or more within 1 year after separation from active service except that: (1) For tropical diseases this time interval is variable to when accepted treatises indicate that the incubation period commenced during active service; (2) for active tuberculosis, all forms, the time interval is 3 years, and by regulation active pulmonary tuberculosis diagnosed within the fourth year is held to have preexisted the diagnosis for 6 months in minimal cases, 9 months in moderately advanced cases, and 12 months in far advanced cases; and (3) for multiple sclerosis the time interval is 2 years.

The following tropical diseases are presumed to be service-connected:

Amebiasis
Blackwater fever
Cholera
Dracontiasis
Dysentery
Filiariasis
Leishmaniasis, including Kala-Azar
Leprosy
Loiasis
Malaria
Onchocerciasis
Oroya fever
Pinta
Plague
Schistosomiasis
Yaws
Yellow fever

The chronic diseases which are presumed to be service-connected if they become manifest within 1 year after separation from service are:

Anemia, primary
Arteriosclerosis
Arthritis
Atrophy, progressive muscular
Brain hemorrhage
Brain thrombosis
Bronchiectasis
Calculi of the kidney, bladder, gall-bladder
Cardiovascular-renal disease, including hypertension
Cirrhosis of the liver
Coccidioidomycosis
Diabetes millitus
Encephalitis lethargica residuals
Endocarditis (this term is intended to cover all forms of valvular heart disease)
Endocrinopathies
Epilepsies
Hodgkin's disease
Leprosy
Leukemia
Myasthenia gravis
Myelitis
Myocarditis
Nephritis
Other organic diseases of the nervous system
Osteitis deformans
Osteomalacia
Palsy, bulber
Paralysis agitans
Psychoses [1]
Purpura idiopathic, hemorrhagic
Raynaud's disease
Sarcoidosis
Scleroderma
Sclerosis, amyotrophic lateral
Sclerosis, multiple
Syringomyelia
Thromboangitis obliterans (Buerger's disease)
Tuberculosis, active
Tumors, malignant or of the brain or spinal cord or peripheral nerves
Ulcers, peptic (gastric or duodenal)

[1] For purpose of hospital care and medical treatment including outpatient, a veteran, otherwise qualified of World War II and Korean conflict developing an active psychosis within 2 years from date of separation from service is deemed to have incurred such disability in active service.

D. *Presumption of total disability.*—Total disability is said to exist when there is present any impairment of mind or body which is sufficient to render it impossible for the average person to follow a substantially gainful occupation. Permanent total disability would exist when the impairment is reasonably certain to continue throughout the life of the disabled person.

In the Veterans' Administration programs the following are considered to be permanent total disabilities: The permanent loss of the use of both hands, or of both feet, or of 1 hand and 1 foot, or of the sight of both eyes, or becoming permanently helpless, or bedridden. Other provisions relative to total disability are listed on pages 5 and 6 of the 1945 Schedule for Rating Disabilities.

Questions regarding presumptions

1. In accordance with present accepted medical principles, is the presumption of soundness on entry into service medically valid?

(*a*) Is the presumption necessary under present development of medicine?

2. Do you believe the presumptions of service-connection for chronic diseases are based on accepted medical principles? If not, what diseases would you exclude or add?

(*a*) Have recent developments in methods of diagnosis and treatment for tuberculosis affected the presumptions regarding tuberculosis? If so, how?

(*b*) Is the time interval governing presumption of tuberculosis valid under present status of medicine?

(*c*) Should there be presumptions of service-connection in the psychoses?

If so, for what time interval after separation?

If not, why?

3. Do you believe the presumption of service-connection for tropical diseases is based on accepted medical principles?

(*a*) For what time interval after separation should the presumption establish service-connection?

(*b*) What revisions, deletions, or additions, if any, should be made to the list of tropical diseases?

4. Yardsticks for total disability have been established in paragraph 16, page 5, and paragraph 17, page 6, of the 1945 Schedule for Rating Disabilities, as amended by extension No. 5:

(*a*) What is the medical validity of these yardsticks?

(*b*) From your experience, what proportion of people would have a degree of disability 10 percent or more at age 65 on the basis of the standards in the schedule?

(*c*) Is there a set percentage of yardstick by which it can be said that a person with a single disability and rated some percentage (e. g., 10 percent, 60 percent, 70 percent) is totally disabled?

A combination of disabilities?

At a certain age?

SECTION IV. GENERAL MATTERS

The questions in this section are general to matters not covered in the preceding sections.

Questions regarding general matters

1. In your opinion, are the various sections of the rating schedule and the related statutory awards in balance? That is, in your field of specialization are the percentages in the schedule taken together with the statutory awards too high or too low in relation to other disabilities from diseases and injuries?

2. What effect have modern developments in medical rehabilitation had upon the problem of disability and compensation?

(*a*) Do these developments have any significance to present standards used in the evaluation of disabilities? Explain.

3. The schedule for rating disabilities is based "on average impairment of earning capacity":

(*a*) In your judgment should factors other than loss of earning capacity such as pain, suffering, social handicap, and mental anguish be compensated?

(*b*) From your study of the schedule do you believe that such factors have been reflected in the ratings in your field of specialization?

4. What other comments do you have on the problem of disability rating and compensation?

APPENDIX D

STATISTICAL TABLES RELATING TO VETERANS RECEIVING SERVICE-CONNECTED COMPENSATION

TABLE I.—*Veterans receiving service-connected disability compensation from Veterans' Administration as of Mar. 31, 1955* [1]*—Number of cases and annual cost, classified by degree of disability and type of award*

Combined degree of impairment (percent)	Total		Awards			
			Statutory [2] [3]		Basic percentage [3]	
	Number	Annual value (thousands)	Number	Annual value (thousands)	Number	Annual value (thousands)
Grand total	2,071,163	$1,426,274	120,952	$222,805	1,950,211	$1,203,468
None	2,962	1,856	2,962	1,856	----------	----------
10	841,005	176,268	2,089	1,610	838,916	174,658
20	344,311	149,914	28,308	23,001	316,003	126,914
30	315,405	194,793	19,279	17,754	296,126	177,039
40	163,146	134,258	10,599	13,545	152,547	120,712
50	116,024	148,723	5,713	10,448	110,311	138,275
60	88,471	139,447	10,788	22,462	77,683	116,985
70	42,605	79,171	8,119	18,993	34,486	60,178
80	26,409	57,678	7,970	20,725	18,439	36,953
90	7,512	19,592	4,275	12,230	3,237	7,362
100	123,313	324,574	20,850	80,181	102,463	244,392

[1] Figures cover veterans of all wars, Korean conflict, and peacetime service, and include direct and presumptively service-connected disabilities. Veterans wth 50 percent disability or more are entitled to additional allowances for dependents. These are included in the annual value of awards.

[2] Statutory awards are in addition to, or in lieu of, basic percentage awards. They are tabulated according to percentage of rated impairment.

[3] Approximately 64,000 cases receiving statutory awards also receive basic percentage awards, but are not included in number of cases shown as receiving the basic percentage awards.

Source: Veterans' Administration.

TABLE II.—*Veterans receiving service-connected disability compensation from Veterans' Administration as of Mar. 31, 1955* [1]*—Number of cases, classified by preponderant compensable disabilities according to Veterans' Administration major disability classification*

Major disability classification	Total	Percent of grand total
Grand total	2,071,163	100
Total tuberculosis of the lungs and pleura	91,830	4.4
Total psychiatric and neurological diseases	451,330	21.8
Psychoses	92,129	4.4
Psychoneuroses	247,449	11.9
Organic diseases of the central nervous system	99,499	4.8
The epilepsies	12,253	.6
Total general medical and surgical conditions	1,528,013	73.8
Bones and joints, acute, subacute or chronic diseases of	188,949	9.1
Amputations of upper and lower extremities, including fingers and toes	47,373	2.3
Other impairment of upper and lower extremities, including fingers, toes, spine, skull and ribs	340,790	16.5
Muscle injuries	238,903	11.5
Eye, diseases of and impairment of visual acuity	44,173	2.1
Ear and other sense organs, diseases of and impairment of auditory acuity	81,192	3.9
Systemic conditions	6,832	.3
Respiratory systems, diseases of:		
Nose and throat	19,885	1.0
Trachea and bronchi	72,021	3.5
Lungs and pleura (nontuberculosis)	26,105	1.3
Cardiovascular system, diseases of:		
Heart	56,645	2.7
Arteries and veins	85,485	4.1
Digestive system, diseases of	135,699	6.6
Genito-urinary system, diseases of	30,181	1.5
Gynecological conditions	1,622	.1
Hemic and lymphatic systems, diseases of	4,067	.2
Skin conditions	132,242	6.4
Endrocrine system, diseases of	13,943	.7
Dental and oral conditions	1,906	.1

[1] Figures cover veterans of all wars, Korean conflict, and peacetime service, and include direct and presumptively service-connected disabilities for which statutory or basic percentage awards are being paid.

Source: Veterans' Administration.

TABLE III.—*Veterans receiving specific statutory compensation awards from Veterans' Administration as of Mar. 31, 1955* [1]*—Number of cases and rates paid classified by type of loss*

Specific statutory disability	Number paid single or combined awards	Monthly wartime rate [2]
Grand total	120,952	----------
1. Arrested tuberculosis	41,390	$67
2. Arrested tuberculosis and creative organ	81	114
3. Loss or loss of use [3]	66,522	47
Creative organ	6,742	----------
1 hand	12,791	----------
1 eye	21,894	----------
1 foot	25,095	----------
4. Multiple loss or loss of use of	9,709	279–371
Both eyes	2,072	----------
Both hands	317	----------
Both feet	5,877	----------
Hand and foot	1,443	----------
5. Multiple loss of other combinations of eyes, feet, and hands	1,384	156–420
6. Other	1,444	279–326
Aid and attendance	1,432	----------
Aid and attendance and creative organ	12	----------
7. Combinations of 3, 4, 5, or 6	422	[4] 97–420

[1] Figures cover veterans of all wars, Korean conflict, and peacetime service, and include actual and presumptively service-connected disabilities.

[2] Peacetime rates are 80 percent of wartime rates. Veterans with not less than 50 percent disability are entitled to additional allowances up to $91 for dependents.

[3] Basic percentage compensation awards are payable in addition to the specific statutory awards to veterans in this category if they can qualify, and such awards generally ranging from $50 to $181 monthly were being paid to an estimated 64,000 veterans as of Mar. 31, 1955.

[4] These rates are applicable to the bulk of cases in this category.

Source: Veterans' Administration.

APPENDIX E

PRESIDENT'S COMMISSION ON VETERANS' PENSIONS

NON-GOVERNMENTAL RESPONDENT MEDICAL SPECIALISTS. MEDICAL APPRAISAL OF THE VETERANS ADMINISTRATION SCHEDULE FOR RATING DISABILITIES

PSYCHIATRY

Ackerly, S. Spafford, M. D. (Yale 1925): Louisville University School of Medicine, Louisville, Ky. Director Louisville Mental Hygiene Clinic. Professor Chairman, department psychiatry and mental hygiene, Louisville School of Medicine.

Braceland, Francis, J., M. D. (Jefferson 1930): Psychiatrist in chief, Institute of Living, Hartford, Conn. Former dean and professor psychiatry, Loyola. Past professor psychiatry, Mayo Foundation Graduate School.

Menninger, Karl A., M. D. (Harvard 1917): Menninger Foundation, Topeka, Kans.

Overholser, Winfred, M. D. (Boston 1916): Superintendent St. Elizabeths Hospital, Washington, D. C.

NEUROLOGY

Klingman, Walter O., M. D. (Michigan 1923): University of Virginia Hospital, Charlottesville, Va. Professor neurology and psychiatry, University of Virginia Medical School. Consultant National Institute of Health, Neurological Diseases and Blindness. Chief consultant neurology Veterans' Administration.

Merritt, H. Houston, M. D. (Johns Hopkins 1926): Professor neurology, P and S Columbia University.

Pollock, Lewis J., M. D. (Illinois 1906): Professor nervous and mental diseases, Northwestern University.[1]

Schwab, Robert Sidney, M. D. (Harvard 1931): Clinical assistant professor neurology, Harvard Medical School. Veterans' Administration consultant (Brockton). Consultant United States Naval Hospital, Chelsea (convulsive disorders).

INTERNAL MEDICINE

Adams, F. Deannette, M. D. (Harvard 1917): Assistant clinical professor of medicine, Harvard.

Bauer, Walter, M. D. (Michigan 1922): Chief, medical services, Massachusetts General Hospital. Jackson professor clical medicine at Harvard

Wilbur, Dwight L., M. D. (Stanford 1939): Member Hoover Commission medical task force "Federal medical services." Clinical professor medicine, Stanford University.

Brown, Charles L., M. D. (Oklahoma 1921): Seton Hall College of Medicine (Sean).

Lewis, Howard P., M. D. (Oregon 1930): Professor of medicine, Oregon University School of Medicine.

Minor, John M., M. D. (Harvard 1919): Associate professor of medicine (George Washington).

Reznikoff, Paul, M. D. (Cornell 1920): Professor clinical medicine Cornell University School of Medicine.

Youmans, John B., M. D. (Johns Hopkins 1919): Dean, School of Medicine, Vanderbilt University, professor medicine Vanderbilt.

GENERAL MEDICINE

Wood, Hugh, M. D. (Virginia 1921): Dean, Emory University School of Medicine, Emory University, Georgia. Professor clinical medicine (Emory).

TUBERCULOSIS

Amberson, J. Burns, M. D. (Johns Hopkins 1917): Professor of medicine (P and S).

King, Donald S., M. D. (Harvard 1918): Hitchcock Clinic, Hanover, N. H. Professor thoracic medicine, Dartmouth. Physician emeritus, Massachusetts General Hospital.

Long, Esmond R., M. D. (Rush 1926): Director, Henry Phipps Institute, director of medical research, National Tuberculosis Association.

Mayer, Edgar, M. D. (P and S 1913): Assistant professor clinical medicine, Cornell.

Pottenger, Francis M., M. D. (Cincinnati College of Medicine 1894): Medical director, Pottenger Sanitarium and Clinic. Emeritus professor clinical medicine, Southern California University. Consultant tuberculosis consultant, California.

CARDIOVASCULAR

Kossman, Charles E., M. D. (New York University College of Medicine 1931): Associate professor of medicine, New York University. Chief consultant cardiovascular diseases, Veterans' Administration.

Morgan, Hugh J., M. D. (Johns Hopkins 1918): Vanderbilt University Hospital, Nashville, Tenn. Professor of medicine, Vanderbilt.

Stroud, Wm. D., M. D. (Pennsylvania University 1916): Professor cardiology. (Graduate School Pennsylvania) assistant professor clinical medicine, Pennsylvania University.

ALLERGY

Burrage, Walter S., M. D. (Harvard 1926): Instructor of Medicine, Harvard. Chief consultant, allergy, Veterans' Administration.

Booke, Robert A., M. D. (Columbia 1904): Director, Institute of Allergy, Roosevelt Hospital, New York City.

GASTROENTEROLOGY

Palmer, Walter L., M. D. (Rush 1922): Professor medicine, University of Chicago.

Snell, Albert M., M. D. (Minnesota 1918): Clinical professor of medicine, University of California. Chief consultant gastroenterology Veterans' Administration.

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[1] Replies incomplete—not included in statistical data.

TROPICAL DISEASES

Dieuaide, Francis R., M. D. (Johns Hopkins 1920): Clinical professor of medicine, physician and surgeon.
Most, Harry, M. D. (New York University College of Medicine 1931): Professor preventive medicine, New York University. Chief consultant Veterans' Administration, tropical medicine.
Saunders, George M., M. D. (Harvard 1925): Associate clinical professor industrial medicine, New York University, medical director Socony-Vacuum Oil Co., Inc.

GERONTOLOGY

Ruffenstein, E. C., Jr., M. D. (Syracuse 1904): Professor emeritus medicine, Syracuse University Medical College.
Stieglitz, E. J., M. D. (Rush 1922): Consultant geriatrics, Veterans' Administration, associate, Washington School of Psychology, editor geriatrics.

SURGERY

Altemeier, William A., M. D. (Cincinnati University 1934): Professor surgery, Cincinnati University School of Medicine.
Allen, Arthur W., M. D. (Johns Hopkins 1913): Consultant in surgery, Massachusetts General Hospital.
Churchill, Edward D., M. D. (Howard 1920): Chief, general surgeon serving Massachusetts General John Homans professor surgery, Harvard.
DeBakey, Michael E., M. D. (Tulane 1932): Chairman department surgery, and professor surgery, Baylor.
Griswold, R. Arnold, M. D. (Louisville 1925): Director surgery service, Louisville General Hospital; professor and head department surgery, Louisville University.
Mayo, Charles W., M. D. (Pennsylvania University): Professor surgery, Mayo Foundation.
Zollinger, Robert M., M. D. (Ohio 1927): Chairman and professor of surgery, Ohio State University.

ORTHOPEDIC

Aitken, Alexander P., M. D. (Tufts 1928): Clinical professor, Tufts. Chief orthopedic surgery, Winchester Hospital, Massachusetts.
Alldredge, Rufus H., M. D., (Tulane, 1932): Associate professor clinical orthopedic surgery, Tulane.
Bunnell, Sterling, M. D. (California 1908): Visiting Staff, St. Francis Hospital, San Francisco, Calif., Consultant United States Army and Navy.
Cleveland, Mather, M. D. (P and S 1915): Senior consultant OrSETO, chief consultant, orthopedic surgery, Veterans' Administration.
Dively, Rex L., M. D. (Kansas 1917): Assistant professor surgery, Kansas.
Hampton, Oscar P., Jr., M. D. (University of Tennessee 1928): Orthopedic surgery.
Loutzenheiser, John J., M. D. (California 1922): Director orthopedic surgery, St. Mary's Hospital, San Francisco, consultant, Veterans' Administration Hospital, assistant clinical professor of orthopedic surgery, San Francisco, Calif.

NEUROSURGERY

Spurling, R. Glenn, M. D. (Harvard 1923): Clinical professor of neurosurgery, Louisville University.
Woodhall, Barnes, M. D. (Johns Hopkins 1931): Professor of neurosurgery, Duke University.

PLASTIC SURGEON

Blocker, Truman G., M. D. (Texas 1933): Professor of plastic and Maxillo facial surgery, Texas University.
Brown, James B., M. D. (Washington University 1923): Professor of clinical surgery, Washington University, professor of Maxillo facial surgery, Washington University, chief consultant, Veterans' Administration.

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AUDIOLOGY AND OTOLARYNGOLOGY

Canfield, Norton, M. D. (Michigan 1929): Associate clinical professor otolaryngology, Yale University consultant hearing, Gesell Institute of Child Development, chief consultant Veterans' Administration, audiology.
Maxwell, James H., M. D. (Michigan 1927): Professor otolaryngology, Michigan University.
McMahon, Bernard, M. D. (St. Louis University 1917): Director, department otolaryngology, St. Louis University.

OPHTHALMOLOGY

Kuhn, Hedwig S., M. D. (Rush 1919): Kuhn Clinic, Hammond, Ind.
Scheie, Harold S., M. D. (Minnesota University 1935): Chief consultant ophthalmology, Veterans' Administration, associate professor ophthalmology, Pennsylvania University and Pennsylvania Graduate School.

UROLOGY

Higgins, Charles C., M. D. (Washington University 1923): Staff, Cleveland Clinic.
Nesbit, Reed H., M. D. (Stanford 1924): Professor surgery and head genito-urinary section, Michigan University School of Medicine.
Robinson, John N., M. D. (Harvard 1931): Clinical professor urology, physician and surgeon.

PHYSICAL MEDICINE AND REHABILITATION

Huddleston, O. Leonard, M. D. (Colorado 1931): Resident medical director, Kobat-Kaiser Institute, Santa Monica, professor physical medicine, Southern California University.
Kessler, Henry H., M. D. (Cornell 1919): Orthopedic consultant for office of rehabilitation, New Jersey, medical director, Kessler Institute for Rehabilitation (New Jersey), medical director, New Jersey Rehabilitation Clinic.
Rusk, Howard, M. D. (Pennsylvania 1925): Professor physical medicine, director physical medicine and rehabilitation, New York University Medical College.
Zeiter, Walter J., M. D. (Illinois 1934): Head, department of physical medicine, Cleveland Clinic Foundation.

DERMATOLOGY

Downing, John G., M. D. (Harvard 1915): Professor dermatology, Tufts and Boston University.
Livingood, Clarence S., M. D. (Pennsylvania University 1936): Chief consultant, Veterans' Administration, dermatology. Physician in charge division of dermatology, Henry Ford Hospital.

INDUSTRIAL MEDICINE

Gannon, James A., M. D. (Georgetown University 1906).
Gray, Roscoe N., M. D. (Oakland College of Medicine and Surgery 1918): Surgical director, Aetna Life Insurance Co.
Sayers, Royd R., M. D. (University of Buffalo 1914): Medical director, United States Public Health Service (retired).
Weeden, Willis M., M. D. (Cornell 1919): Medical director, Workmen's Compensation Board, New York State.
Wright, Irving S., M. D. (Cornell 1926): Professor clinical medicine, Cornell.
Farnham, Ryak, M. D.[2]
Subtotal, 72.
Less [1] and [2]=2.
Total, 70.

[2] Not included in statistical data.

APPENDIX F

LIST OF MEDICAL RESPONDENTS, GOVERNMENT AGENCIES

I. Respondent Medical Specialists From Veterans' Administration, Department of Medicine and Surgery

Dr. Harry M. Roback, examining physician, VA regional office, Cleveland, Ohio, psychiatry.
Dr. Mabel G. Masten, examining physician, VA regional office, Miami 10, Fla., neurology.
Dr. John A. Insolera, chief, medical service, VA regional office, Newark, N. J., internal medicine.
Dr. F. L. Byerly, chief, tuberculosis unit, VA regional office, Winston-Salem, N. C., tuberculosis.
Dr. Louis R. Weiss, chief, allergy section, VA out-patient clinic, Boston, Mass., allergy.
Dr. Andrew G. Prandoni, examining physician, veterans benefits office, Washington, D. C., peripheral-vascular disease.
Dr. Morris L. Drazen, examining physician, VA regional office, New York, N. Y., cardiovascular.
Dr. Frank Kerrigan, chief, GI unit, VA regional office, New York, N. Y., gastroenterology.
Dr. Harold C. Conn, chief, professional service, VA hospital, Iowa City, Iowa, tropical diseases.
Dr. Ray Piaskoski, chief, physical medicine and rehabilitation, VA center, Wood, Wis., gerontology.
Dr. Claude C. Burton, chief, surgical service, VA center, Dayton, Ohio, general surgery.
Dr. John H. Drew, chief, neurosurgery, VA hospital, Boston, Mass., neurosurgery.
Dr. William Kiskadden, area consultant, Beverly Hills, Calif., plastic surgery.
Dr. Robert Fuller, examining physician, VA regional office, New York 1, N. Y., audiology and otolaryngology.
Dr. Jacquet Landsberg, chief EENT section, VA regional office, Brooklyn, N. Y., ophthalmology.
Dr. Maxwell Malament, chief, urology section, VA hospital, East Orange, N. J., urology.
Dr. Irving Tepperberg, chief, physical medicine and rehabilitation, VA regional office, New York, N. Y., physical medicine and rehabilitation.
Dr. David S. Gudes, examining physician, VA regional office, Detroit, Mich., dermatology.
Dr. Allan J. Houda, section war officer, VA hospital, Hines, Ill., industrial medicine.
Total 19.

II. Respondent Medical Specialists From Department of the Navy

Capt. G. N. Raines (MC) USN, head, neuropsychiatry branch, BuMed, psychiatry.
Capt. J. E. Nardini (MC) USN, United States Naval Hospital, Bethesda, Md., neurology.
Capt. A. L. Lawler (MC) USN, United States Naval Hospital, San Diego, Calif., internal medicine and general medicine.
Capt. J. A. C. Gray (MC) United States Naval Hospital, St. Albans, N.Y, tuberculosis.
Comdr F. G. Soule (MC) USN, United States Naval Hospital, San Diego, Calif., Allergy.
Comdr M. M. Driskell (MC) USN, United States Naval Hospital, Newport, R. I., peripheral vascular.
Capt. L. J. Pope (MC) USN, United States Naval Hospital, Philadelphia, Pa., gastroenterology.
Capt. Ralph Parker (MC) USN, United States Naval Hospital, Bethesda, Md., cardiovascular.
Comdr. R. R. Gleysteen (MC) USN, United States Naval Hospital, Quantico, Va., tropical diseases.
Comdr. G. M. Davis (MC) USN, United States Naval Hospital, San Diego, Calif., gerontology.

Capt. R. B. Brown (MC) USN, United States Naval Hospital, Bethesda, Md., general surgery.
Capt. F. P. Kreuz (MC) USN, United States Naval Hospital, Great Lakes,Ill. orthopedic.
Capt. R. W. Garrity (MC) USN, United States Naval Hospital, San Diego, Calif., neurosurgery.
Capt. J. Crawford (MC) USN, United States Naval Hospital, San Diego, Calif., plastic surgery.
Capt. G. S. Campbell (MC) USN (retired), United States Naval Hospital, Corona, Calif., audiology and otolaryngology.
Capt. S. J. Ryan (MC) USN, United States Naval Hospital, Bethesda, Md., ophthalmology.
Comdr. J. R. Dillon (MC) USN, United States Naval Hospital, San Diego, Calif., urology.
Lt. Comdr. A. A. Tratar (MC) USN, United States Naval Hospital, Oakland, Calif., physical medicine and rehabilitation.
Capt. C. D. Bell (MC) USN, United States Naval Hospital, Philadelphia, Pa., dermatology.
Capt. L. B. Shone (MC) USN, head, industrial health branch, BuMed, industrial medicine.
Total, 20.

III. Respondent Medical Specialists, Department of Army

Col. Paul S. Fancher, M. C., chief, department of medicine, Letterman Army Hospital, San Francisco, Calif., internal medicine.
Col. James A. Wier, M. C., chief, pulmonary disease service, Fitzsimons Army Hospital, Denver, Colo., tuberculosis.
Lt. Col. Arthur J. Berger, M. C., chief, allergy service, Brooke Army Hospital, Fort Sam Houston, Tex., allegy.
Col. Fred Mowrey, M. C., chief medical consultant, office of the Surgeon General, peripheral vascular.
Col. Richard P. Johnson, M. C., chief, cardiology service, Letterman Hospital, San Francisco, Calif., cardiovascular.
Lt. Col. Eddy D. Palmer, M. C., chief, gastroenterology, Walter Reed Army Hospital, Washington, D. C., gastroenterology.
Col. George M. Powell, M. C., chief, department of medicine, Fitzsimons Army Hospital, Denver, Colo., tropical diseases.
Col. Francis W. Pruitt, M. C., chief, department of medicine, Walter Reed Army Hospital, Washington, D. C., gerontology.
Col. Victor R. Hirschmann, M. C., chief, dermatology service, Madigan Army Hospital, Fort Lewis, Wash., dermatology.
Col. Linton S. Lyter, M. C., chief, department of surgery, Fitzsimons Army Hospital, Denver, Colo., general surgery.
Col. Joseph W. Batch, M. C., chief, Orthopedic service, Brooke Army Hospital, Fort Sam Houston, Tex., orthopedic.
Lt. Col. James L. Schricker, Jr., M. C., chief, neurosurgery service, Fitzsimons Army Hospital, Denver, Colo., neurosurgery.
Lt. Col. Hal B. Jennings, Jr., M. C., chief, plastic surgery service, Brooke Army Hospital, Fort Sam Houston, Tex., plastic surgery.
Maj. James P. Albrite, M. C., director, audiology and speech correction center, Forest Glen, Md., Walter Reed Army Hospital, Washington, D. C., audiology and otolarynology.[1]
Lt. Col. Theodore L. Hartridge, M. C., chief, otolaryngology service, Brooke Army Hospital, Fort Sam Houston, Tex., audiology and ENT.
Col. William L. Spaulding, M. C., chief, ophthalmology service, Walter Reed Army Hospital, Washington, D. C., ophthalmology.
Lt. Col. Clarence B. Hewitt, M. C., chief, urology service, Madigan Army Hospital, Fort Lewis, Wash., urology.

[1] Not included in statistical data.

Col. Sanford W. French, 3d, M. C., chief, thoracic and cardiovascular surgical service, Letterman Army Hospital, San Francisco, Calif., thoracic surgery.[2]
Lt. Col. Roy E. Clausen, Jr., M. C., chief, neurology service, Walter Reed Army Hospital, Washington, D. C., neurology.
Lt. Col. Oswal M. Weaver, M. C., department of neuropsychiatry, Letterman Army Hospital, San Francisco, Calif., psychiatry.
Col. Harold B. Luscombe, M. C., chief, physical medicine service, Walter Reed Army Hospital, Washington, D. C., physical medicine and rehabilitation.
Lt. Col. Edward J. Dehne, M. C., commanding officer, Army environmental health laboratory, Army Chemical Center, Md., industrial medicine.

Subtotal, 22.
Less, [1] and [2], 2.
Total, 20.

IV. Respondent Medical Specialists, Department of the Air Force

Col. George M. Plagens, USAF (MC), USAF Hospital, Eglin Air Force Base, Fla., psychiatry.
Maj. Robert L. Williams, USAF (MC), Hq, USAF, Washington 25, D. C., neurology.
Maj. Nestor M. Hensler, USAF (MC), USAF Hospital, Parks Air Force Base, Calif., tuberculosis.
Capt. Robert G. Lovell, USAF (MC), USAF Hospital, Lackland Air Force Base, San Antonio, Tex., allergy.
Col. Archie A. Hoffman, USAF (MC), Hq, USAF, Washington 25, D. C., peripheral vascular.
Col. Archie A. Hoffman, USAF (MC), Hq, USAF, Washington 25, D. C., cardiovascular.
Lt. Col. Philip G. Keil, USAF (MC), USAF Hospital, Maxwell Air Force Base, Ala., gastroenterology.
Lt. Col. Hamilton B. Webb, USAF (MC), Caribbean Air Command, APO 825, New Orleans, La., tropical diseases.
Col. James L. Tobin, USAF (MC), USAF Hospital, Sampson Air Force Base, Geneva, N. Y., gerontology.
Col. Marshall N. Jensen, USAF (MC), USAF Hospital, Sheppard Air Force Base, Tex., general surgery.
Lt. Col. Earl W. Brannon, USAF (MC), USAF Hospital, Lackland Air Force Base, San Antonio, Tex., orthopedic surgery.
Maj. Robert A. Mendelsohn, USAF (MC), USAF Hospital, Lackland Air Force Base, San Antonio, Tex., neurosurgery.
Capt. Nicholas M. Azzato, USAF (MC), USAF Hospital, Lackland Air Force Base, San Antonio, Tex., plastic surgery.
Lt. Col. Frank A. Perri, USAF (MC), USAF Hospital, Sampson Air Force Base, Geneva, N. Y., audiology and otolaryngology.
Lt. Col. Jules B. Chapman, USAF (MC), USAF Hospital, Lackland Air Force Base, San Antonio, Tex., ophthalmology.
Col. John A. Schindler, USAF (MC), 4503d Support Sq. Sagebrush Air Umpire section, Langley Air Force Base, Va., urology.
Col. Benjamin A. Strickland, Jr., USAF (MC), Hq. 12th Air Force, APO 12, New York, N. Y., physical medicine and rehabilitation.
Lt. Col. Thomas A. Gibson, USAF (MC), USAF Hospital, Maxwell Air Force Base, Ala., dermatology.
Maj. Charles N. Moss, USAF (MC), Hq. USAF, Washington 25, D. C., industrial medicine.
Col. James L. Tobin, USAF (MC), USAF Hospital, Sampson Air Force Base, Geneva, N. Y., internal medicine and general medicine.
Total: 20.

[2]Not included in statistical data.

V. Respondents in Government Service, Other Than Military

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Thomas B. McKneely, M. D. (Tulane 1930), medical consultant to Health, Education, and Welfare, Washington, D. C.
Archibald Sinson, M. D. (Columbia P and S 1924), health officer, division of disability operations, Old Age and Survivors Insurance, Baltimore, Md.

DEPARTMENT OF LABOR

R. B. Snavely, M. D. (University of Illinois College of Medicine 1925), medical director, Bureau of Employees Compensation, Department of Labor, Washington, D. C.

UNITED STATES CIVIL SERVICE COMMISSION

Alexander Tish, M. D. (New York University School of Medicine 1922), chief, disability retirement section, United States Civil Service Commission, Washington, D. C.
Total, 4.

APPENDIX G

LIST OF MEDICAL SPECIALTIES WITH PERTINENT REFERENCE PAGE IN RATING SCHEDULE AND EXTENSIONS

PSYCHIATRY

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
121–133, inclusive.

Extensions:
No. 5.
No. 4, paragraphs 19 and 20.
No. 7, paragraph 19.
No. 9, paragraph 1.

NEUROLOGY

Pages:
1, pargraphs 1 and 3.
3–7, paragraphs 10–21.
108–120, inclusive.

Extensions:
No. 3.
No. 5.
No. 7, paragraphs 12 and 18.
No. 9, paragraphs 1 and 10.

INTERNAL MEDICINE AND GENERAL MEDICINE

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
21, paragraphs 21 to page 23, paragraph 27, inclusive.
28–29.
64–67, inclusive.
73–74.
80–92, inclusive.
94.
95, code 7502.
96, code 7507.
101.
104–107. inclusive.

Extensions:
No. 3.
No. 4, paragraphs 12, 13, 15, 17, 18, 22, 23.
No. 4–B.
No. 5.
No. 6–A.
No. 7, paragraphs 2, 3, 6 to 10, 25, 28.
No. 9, paragraphs 1, 5, 7 and 10

LIST OF MEDICAL SPECIALTIES WITH PERTINENT REFERENCE PAGE IN RATING SCHEDULE AND EXTENSIONS—continued

TUBERCULOSIS

Pages:
1, paragraphs 1 and 3
3–7, paragraphs 10–21
68–71 inclusive
73–79 inclusive
28, Code 5001
66, Code 6311
72, code 6515
92, code 7331
96 and 97, codes 7505, 7506, 7514, 7525
101, Codes 7710–7711–12

Extensions:
No. 3.
No. 4, paragraphs 11, 14, 18.
No. 4–A.
No. 5.
No. 6 and No. 6–A.
No. 7, paragraphs 14, 15, 16
No. 9, paragraph 12

ALLERGY

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
72, code 6501.
74, code 6602.
86, code 7118.
102–103, codes 7806, 7899
111, code 8100

Extensions:
No. 5.
No. 9, paragraph 10.

PERIPHERAL VASCULAR

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
81, paragraph 6.
85–87 inclusive.
111, code 8100.

Extensions:
No. 5.
No. 7, paragraphs 8, 9, 10 and 25.
No. 9, paragraphs 5 and 10.

CARDIOVASCULAR

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
80–87 inclusive.

Extensions:
No. 5.
No. 7, paragraphs 7 to 10 and 25.
No. 9, paragraphs 1 and 5.

GASTROENTEROLOGY

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
88–94 inclusive.

Extensions:
No. 4, paragraphs 15, 16, 17.
No. 4–B.
No. 5.
No. 7, paragraphs 6 and 23.
No. 9, paragraph 6.

TROPICAL DISEASES

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
64–67.
102, codes 7807–08, 7810–12–13–99.
92, codes 7321–22, 7323–24.

Extensions:
No. 4, paragraphs 12 and 13.
No. 5.
No. 7, paragraphs 6 and 28.
No. 9, paragraph 1.

LIST OF MEDICAL SPECIALTIES WITH PERTINENT REFERENCE PAGE IN RATING SCHEDULE AND EXTENSIONS—continued

GERONTOLOGY

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
20–23.
28–29.
66–67.
73–74, codes 6600–01, 6602.
80–87.
88–91.
95, paragraph 1, code 7502.
96, code 7507.
101.
110–112.
121–133.

Extensions:
No. 4, paragraphs 22 and 23.
No. 5.
No. 7, paragraphs 3, 7, 9, 10, 12, and 25.
No. 9, paragraph 1.

GENERAL SURGERY

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
12–19.
26–50.
78, code 6818.
85–87.
88–94.
102.

Extensions:
No. 3.
No. 4, paragraphs 3 to 6, 15, 16, 17, and 21.
No. 4–B.
No. 5.
No. 6–A.
No. 7, paragraphs 1 to 4, 6, 9, 10, 22 to 27, and 29.
No. 9, paragraphs 1, 4, 5, 8, and 9.

ORTHOPEDIC

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
12–50.
85–87.
102.
114–119.

Extensions:
No. 3.
No. 4, paragraphs 3 to 6.
No. 5.
No. 6–A.
No. 7, paragraphs 1 to 4, 9, 10, 22, 24 to 27, and 29.
No. 9, paragraphs 1, 4, 5, 8, 9.

NEUROSURGERY

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
42, code 5285.
43–50.
102, codes 7800–01, 7802–03–04–05.
108 to 119.
Less code 8900.

Extensions:
No. 3.
No. 4, paragraphs 3, 5, 6.
No. 5.
No. 7, paragraphs 12, 26, 27, 29.
No. 9, paragraph 1.

PLASTIC SURGERY

Pages:
1, paragraph 1 and 3.
3–7, paragraphs 10–21.
102, codes 7800–01, 7802–03–04–05.
7899.
134–135.

Extensions:
No. 5.
No. 7, paragraphs 17, 26, 27, 29.

AUDIOLOGY AND OTOLARYNGOLOGY

Pages:
1, paragraphs 1 and 3.
3–7, paragraphs 10–21.
61–63.
72–73 less codes 6600–01.
102, codes 7800 and 7899.
111, code, 8100.

Extensions:
No. 4, paragraph 10.
No. 5.
No. 8 and No. 8–A.
No. 9, paragraph 11.

APPENDIX H

VETERANS' COMPENSATION RATES FIXED BY LAW FOR SPECIFIC DISABILITIES

DISABILITIES	WAR RISK INSURANCE ACT, AS AMENDED				WORLD WAR VETERANS' ACT, 1924, AS AMENDED										VETERANS REGULATIONS (PROMULGATED UNDER PUBLIC NO. 2, 73RD CONGRESS, MARCH 20, 1933), AS AMENDED(a)						
	PUB. NO. 90 65TH CONG. ACT OF OCT 6, 1917	PUB. NO. 26 66TH CONG. ACT OF AUG. 9, 1919	PUB. NO. 104 66TH CONG. ACT OF DEC. 24, 1919	PUB. NO. 370 67TH CONG. ACT OF DEC. 18, 1922	PUB. NO. 242 68TH. CONG. ACT OF JUNE 7, 1924	PUB. NO. 448 69TH. CONG. ACT OF JULY 2, 1926	PUB. NO. 522 71ST. CONG. ACT OF JULY 3, 1930	PUB. NO. 866 76TH. CONG. ACT OF OCT. 17, 1940	PUB. LAW 312 78TH. CONG. ACT OF MAY 27, 1944 (f)	PUB. LAW 662 79TH. CONG. ACT OF AUG. 8, 1946	PUB. LAW 436 81ST. CONG. ACT OF OCT. 29, 1949	PUB. LAW 356 82ND. CONG. ACT OF MAY 23, 1952	PUB. LAW 427 82ND. CONG. ACT OF JUNE 30, 1952	PUB. LAW 695 83RD. CONG. ACT OF AUG. 28, 1954	PUB. NO. 2, 73RD CONG. ACT OF MAR. 20, 1933	PUB. NO. 198 74TH CONG. ACT OF JULY 19, 1939	PUB. LAW 312 78TH CONG. ACT OF MAY 27, 1944 (e)	PUB. LAW 182 79TH CONG. ACT OF SEPT. 20, 1945 (h)	PUB. LAW 662 79TH CONG. ACT OF AUG. 8, 1946	PUB. LAW 427 82ND CONG. ACT OF JUNE 30, 1952	PUB. LAW 695 83RD CONG. ACT OF AUG. 28, 1954
Loss of both hands.	$100	$	$	$	$100	$	$100 + 25(e)	$100 + 35	$115 + 35	$138 + 42	$150 + 42	$172.50 + 42	$172.50 + 47	$181 + 47	$150	$	$165	$200	$240	$266	$279
Loss of both feet.	100				100		100 + 25(e)	100 + 35	115 + 35	138 + 42	150 + 42	172.50 + 42	172.50 + 47	181 + 47	150		165	200	240	266	279
Loss of sight of both eyes.	100				150				165	198			220	231	175		190	200(i) 235 265	240 282 318	266 313 353	279 329 371
Loss of one hand and one foot.			100		100		100 25(e)	100 + 35	115 + 35	138 + 42	150 + 42	172.50 + 42	172.50 + 47	181 + 47	150		165	200	240	266	279
Loss of a hand or a foot.							25(e)	35		42			47		25(e)	35			42	47	
Regular aid and attendance.															150		165	200	240	266	279
Total deafness.					100				115	138	150	172.50		181	(g)						
Loss of one hand or one foot in addition to a portion of the other hand or foot.							25(e)	35		42			47		25(e)	35			42	47	
Helplessly and permanently bedridden.	100(b)				100				115	138	150	172.50		181	150		165	200	240	266	279
Additional allowance for nurse or attendant (Total Disability)	20				50					60			67	70							
Loss of both hands and both eyes, or loss of both feet and both eyes or loss of both hands and both feet.		100(c) -100			(c)										250		265	300	360	400	420
Double total and permanent disability			200		200		200 25(e)	200 + 35	215 35	258 + 42			286 47	300 - 47							
Blind, legless or armless and in constant need of nurse or attendant. (Additional allowance)				100 -50																	
Loss of one foot and the sight of one eye.			100		100		100 25(e)	100 - 35	115 - 35	138 - 42	150 42	172.50 + 42	172.50 - 47	181 + 47	25(e)	35			42	47	
Loss of one hand and the sight of one eye.			100		100		100 25(e)	100 - 35	115 - 35	138 + 42	150 + 42	172.50 - 42	172.50 - 47	181 + 47	25(e)	35			42	47	
Organic loss of speech.						100			115	138	150	172.50		181	(g)						
Arrested tuberculosis.						50(d)				60			67							67	
Loss of use of a creative organ.							25(e)			30			47							47	
Loss of two extremities preventing natural elbow or knee action with prosthesis in place.					100		100 + 25(e)	100 - 35	115 + 35	138 + 42	150 - 42	172.50 + 42	172.50 - 47	181 + 47	150		165	235	282	313	329
Loss of two extremities so near shoulder or hip as to prevent use of prosthetic appliance.					100		100 - 25(e)	100 + 35	115 - 35	138 + 42	150 + 42	172.50 + 42	172.50 - 47	181 + 47	150		165	265	318	353	371
Loss of both hands and one foot.					100		100 + 25(e)	100 - 35	115 + 35	138 + 42	150 - 42	172.50 + 42	172.50 - 47	181 + 47	175		190	235 270 or 300 (j)	282 324 or 360	313 360 or 400	326 376 or 418
Loss of both feet and one hand.					100		100 - 25(e)	100 - 35	115 - 35	138 + 42	150 + 42	172.50 + 42	172.50 - 47	181 + 47	175		190	235 270 or 300 (j)	282 324 or 360	313 360 or 400	326 376 or 418
Blind both eyes and loss of one hand or foot.					200		200 + 25(e)	200 - 35	215 + 35	258 + 42			286 + 47	300 - 47	200		215	235 270 or 300 (j)	282 324 or 360	313 360 or 400	326 376 or 418

(a) All rates set forth are for wartime cases. Rates of compensation for injury or disease incurred or aggravated in peacetime service currently are fixed at 80 percent of the wartime rates (P.L. 876, 80th Cong., July 2, 1948), except full wartime rates are payable for disability (1) the direct result of armed conflict; (2) due to extrahazardous service including service under conditions simulating war; (3) incurred while United States is engaged in war; (P.L. 868, 80th Cong., July 1, 1948) or (4) due to service on or after June 27, 1950, and before February 1, 1955 (P.L. 28, 82d Cong., May 11, 1951).

(b) No provision for additional allowance for nurse or attendant in addition to the $100 monthly rate under the Act of October 6, 1917.

(c) Case of individual veteran prompted legislation (Public 26, 66th Congress, August 6, 1919). Congressional debate indicates a rate intended for double total permanent disability of $200 per month, but in lieu thereof the act provided $100 per month for nurse or attendant. Later this provision was superseded by a rate of $200 for double total permanent disability (Public 104, 66th Congress, December 24, 1919). Such combination of disabilities also deemed to be double total permanent disability under the World War Veterans' Act, 1924, as amended.

(d) Payment of the statutory award for arrested tuberculosis may not be made in addition to the schedular evaluation rate for the condition.

(e) This allowance is in addition to the statutory rate prescribed (schedular evaluation as to creative organ) under the World War Veterans' Act, or the schedular evaluation for the named disabilities under the Veterans Regulations.

(f) With respect to statutory awards, a 15 percent increase under Public Law 312, 78th Congress, was computed only on that portion of the award as was equivalent to the basic rate for total disability ($100).

(g) No specific separate rate is authorized under the Veterans Regulations, as amended, for total deafness or organic loss of speech. These conditions are rated at 100 percent under the Veterans' Administration Schedule for Rating Disabilities, 1945 Edition. (The current rate for total deafness with total blindness is $420 per month (Public Law 182, 79th Congress, September 20, 1945, as amended)].

(h) Rates for the severe disabilities outlined in subparagraphs (k) through (p), paragraph II of Veterans Regulation 1 (a), part I, may be increased by $35 per month for each additional loss of a limb or eye (as provided in subparagraph (k)) under the Act of September 20, 1945; by $42 per month under the Act of August 8, 1946; and by $47 per month under the Act of June 30, 1952.

(i) Rates are authorized as follows: (1) lower rate for blindness, both eyes, 5/200 visual acuity or less; (2) intermediate rate for blindness both eyes, requiring regular aid and attendance; and (3) highest rate for anatomical loss both eyes.

(j) Dependent upon severity of condition.

Note: Subparagraph (p), paragraph II, Veterans Regulation 1 (a), part I, grants discretionary authority to the Administrator in cases where the disability exceeds requirements for the rates prescribed in Veterans Regulation 1 (a), part I, for specific disabilities, to allow the next higher or, an intermediate rate, but not to exceed a maximum of $420.

OFFICE OF LEGISLATION
VETERANS' ADMINISTRATION
JANUARY 3, 1956

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UROLOGY

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INDUSTRIAL MEDICINE

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APPENDIX I

YARDSTICKS FOR DETERMINATION OF TOTAL DISABILITY; EXTRACTS, PARAGRAPHS 16 AND 17, PAGES 5 AND 6; AND EXTENSION NO. 5 OF THE VETERANS' ADMINISTRATION SCHEDULE FOR RATING DISABILITIES (1945)

(*Par. 16, pp. 5 and 6, VA schedule*)

* * * * * * *

Total disability ratings based on unemployability of the individual.—Total disability ratings under Veterans Regulation 1 (a), parts I and II, (compensation for service-connected disabilities during wartime and peacetime), and, when the requirements of permanence are met, under part III, (non-service-connected disabilities for pension purposes), may be assigned without regard to the specific provisions of the rating schedule when the disabled person is, in the judgment of the rating agency, unable to secure or follow a substantially gainful occupation as a result of his disabilities: provided that, if there is only one disability, this disability shall be ratable at 60 percent or more, and that, if there are two or more disabilities, there shall be at least one disability ratable at 40 percent or more, and sufficient additional disability to bring the combined rating to 70 percent or more. Total disability ratings, when the above conditions are met, may be granted for deafness, the organic loss of speech, for the amputation or loss or use of either hand or of either lower extremity above the knee when followed by unemployability, as single disabilities, or for other organic disabilities or combinations including organic disabilities. For the above purpose of one 60 percent disability, or one 40 percent disability in combination, or the reduced numerical requirements ac-

cording to age, the following will be considered as one disability: (1) Disabilities of one or both upper extremities, or of one or both lower extremities, including the bilateral factor, if applicable; (2) disabilities resulting from a single accident; or (3) disabilities affecting a single body system, e. g., digestive, respiratory cardiovascular-renal, neuropsychiatric; or (4) multiple injuries incurred in action

17. *Special consideration of age in nonservice cases.*—For the purpose of Veterans Regulation 1 (a), part III only, (pension purposes), the above specified 60 percent, 40 percent, and 70 percent requirements are reduced by 10 percent on the attainment of age 60; and by an additional 10 percent on the attainment of age 65; and there is no specified percentage requirement for total disability ratings in the cases of unemployable veterans who have attained the age of 70. The attainment of age 70 will not of itself warrant rating as of permanently and totally disabled; in addition thereto disability sufficient to produce unemployability will be required.

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VETERANS' ADMINISTRATION,
Washington, D. C., October 7, 1948.

EXTENSION 5, 1945 SCHEDULE: PERMANENT AND TOTAL DISABILITY RATINGS, VETERANS REGULATION 1 (A), PART III

1. Paragraph 17, page 6, Schedule for Rating Disabilities, is rescinded and the following substituted:

For the purpose of Veterans Regulation 1 (a), part III only, the percentage requirements of the preceding paragraph are reduced, on the attainment of age 55, to a 60 percent rating for 1 or more disabilities, with no percentage requirement for any 1 disability. The requirement at age 60 will be a 50 percent rating for 1 or more disabilities. At age 65, there will be no percentage requirement other than 1 disability ratable at 10 percent or more. When these reduced percentage requirements are met, and the disabilities involved are of permanent nature, rating as permanently and totally disabled will be assigned if the veteran is determined to be unable to secure and follow substantially gainful employment by reason of such disability. In making such determinations the following will be used as guides.

(a) Marginal employment, for example, on own farm, in own business, or at odd jobs, at less than half the usual hours of work or less than half the usual remuneration will not be considered incompatible with a determination of unemployment and unemployability, if the restriction, as to securing or retaining better employment, is due to the disabilities.

(b) The fact that unemployable persons meeting the percentage standards have also physical, mental, or personality defects of congenital or developmental nature, which may be a partial cause of the unemployability, will not preclude favorable rating.

(c) As it is the policy of the Administration that all veterans who are basically eligible and who are unable to secure and follow a substantially gainful occupation by reason of disabilities which are likely to be permanent shall be rated as permanently and totally disabled for the purposes of Veterans Regulation 1 (a), part III— therefore—the cases of all veterans who fail to meet the percentage standards, who meet basic entitlement criteria, but who are unemployable, will be referred to central office under R and P R–1142, with statement as to unemployability by the rating board.

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