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MEDICOLEGAL CONSIDERATIONS ON THE CURRENT ITALIAN REGULATORY FRAMEWORK REGARDING THE RIGHT TO ATTENDANCE ALLOWANCE WITH PARTICULAR REFERENCE TO THE VISUALLY IMPAIRED

CONSIDERAZIONI MEDICO LEGALI SULLA NORMATIVA ATTUALMENTE VIGENTE IN ITALIA PER IL DIRITTO ALL'INDENNITA' DI ACCOMPAGNAMENTO CON PARTICOLARE RIFERIMENTO AGLI IPOVEDENTI

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Key words: Attendance allowance , law no.18/1980 , working capacity of the visually impaired

Parole chiave: indennità di accompagnamento, Legge n. 18/1980, capacità lavorativa per gli ipovedenti

Abstract

Objectives: Pursuant to article no.18/1980 an essential requirement to be entitled to attendance allowance in case of civil invalidity is a condition of total disability of such a nature as to actually preventing the “civilian blind” from finding and/or keeping a job. The purpose of the present study is to compare the distress associated with this condition and the benefits under the law.

Methods: The Research is based on a critical analysis of article no.18/1980, with particular reference to the visually impaired.

Conclusions: Some medico-legal considerations are proposed about this contradictory regulatory framework which limits both the development of the potential working abilities of the visually impaired and their inclusion into the work force. An adaptation of this law towards an actual social integration of these seriously disabled persons is consequently recommended.

Abstract

Obiettivi: La legge n.18/1980 presuppone come condizione "***sine qua non"*** per l’ottenimento dell’indennità di accompagnamento in caso di invalidità civile, il riconoscimento della totale inabilità che al contempo impedisce ai cosiddetti ciechi civili il mantenimento e/o l’acquisizione di un posto di lavoro. Scopo dello studio è comparare il disagio che deriva da tale condizione con i benefici di Legge ottenuti.

Metodi: La ricerca si fonda su un’analisi critica della normativa inerente proprio il riconoscimento dell’indennità di accompagnamento in caso di invalidità civile di cui alla Legge n.18/1980, con particolare riferimento ai gravi ipovedenti.

Conclusioni: Vengono formulate alcune considerazioni medico legali su tale incongruità normativa che limita lo sviluppo delle capacità lavorative potenziali particolarmente per gli ipovedenti, limitando altresì il loro inserimento nel mondo del lavoro ed auspica quindi un adeguamento della stessa, anche allo scopo di favorire una reale integrazione sociale di questi grandi invalidi.

Introduction

The norms and standards on civil disability and retirement age contemplated by medico-legal ophthalmology should be flexible and based on a case-by-case approach, as they refer to a complex matter involving both physical, psychological, and social aspects of the individual (1).

They should therefore be aimed at the recognition of economic assistance for which strict tabular references fail to systematically cover every possible case. In other words, forensic medicine, which deals with health issues from a juridical perspective, cannot simply enforce standards pursuant to rational and consistent criteria even because it has to stay focused on the applicant. Therefore, the evaluation of disabling conditions has to be discretionary and based on

each single case observed, thus moving away from the pure tabular references that cannot include all the cases but need refer exclusively to cases in the abstract (2, 3, 4, 5).

Furthermore, the prevailing case-law takes no account of legal counseling as means of proof in civil matters associated with the recognition of civil disability and does not contemplate the recourse to it in view of obtaining the evidence the parties have the burden to provide (Court of Cass. Civ. Ch. 18.12.1970 no.2713, Court of Cass. Civ. Ch. 09.06.1972 no.1811, Court of Cass. Civ. Ch. 25.07.1972 no.2534, Court of Cass. Civ. Ch. 15.03.1975 no .1008, Court of Cass. Civ. Ch. 05.04.1976 no.1184, Court of Cass. Civ. Ch. 945 dated 08.03.1977, Court of Cass. Civ. Ch. 15.09.1986 no.5607, Court of Cass. Civ. Ch. 17.10.1988 no.5645). Therefore, each case must be judged individually, since it is not the disease that has to be assessed, but the patient and each patient, as it is commonly recognized, is a reality different from all the others.

This is the reason why this study aims to explain and refute, if possible, the eligibility requirements established by law for the obtention of attendance allowance (Art. 1 Law 18/1980) as a result of occupational disability, which today is the "sine qua non " for its recognition. Such a strict application of the law , of course, is not only the result of decisions made by the public administration bodies responsible for assessing the eligibility criteria (i.e. the competent Medical Committees of first instance on civil invalidity or the Civilian Blind) but also by the court-appointed experts with respect to each specific dispute.

In conclusion , as we shall see, such lack of recognition often results into a misinterpretation of the rule as compared to the one based upon current literature in forensic medicine as well as on the various judgments published over time and constituting settled case-law, which unfortunately are still failing to be recognized or implemented by the above mentioned bodies.

Discussion

Through the exam of a number of legal aid applications it has become evident that despite general consensus on the need for an urgent reform of the law governing the right to attendance allowance , some doubts still persist as to its recognition in case of severe pathologies that do not presuppose a state of complete psychophysical prostration with bed rest and immobilization and / or a serious loss of the higher intellectual functions that preclude the performance of daily routines, or an independent ambulation. This is particularly true not only with respect to the large group of neuromuscular diseases that cause an impairment of limbs functionality such as spastic quadriplegia, muscular dystrophy, multiple sclerosis, etc…, but also, having regard to our specific ultra-specialist areas of interest, to more strictly sensory diseases, and especially those developing into severe bilateral visual impairment conditions, such as proliferative diabetic retinopathy, retinitis pigmentosa, adverse outcomes of bilateral retinal detachment, the outcomes of glaucoma and congenital cataract, Stargardt's disease, etc. (6, 7, 8).

We cannot fail to highlight that the latter can often cause an extremely decreased visual acuity (close to legal blindness conditions), as they can determine residual visual acuity values bilaterally ranging from slightly above 1 / 10 up to the mere perception of hand movement which is legally considered also equivalent to the perception of "shadow and light" (9, 10, 11, 12).

This severe visual reduction, which of course is associated with a predictable state of depression often leading to a real psychotic manifestation, is hardly fully understood and addressed in its severity by family members, as is often underestimated even by doctors of other specialties, consequently leading to a state of deep frustration in the visually impaired subject.

Therefore, it is the direct observation of such patients which does allow us to assert their need for continuous assistance in daily routines. Nevertheless, and much to our surprise, their right is often still failing to be recognized since they are considered as " not yet totally blind". Moreover, they are also paradoxically likely to run the risk of
being denied, in the fortuitous event their right to allowance is recognized, the right to job retention or the possibility to find a job since they are still necessarily considered as totally disabled.

In this respect, it is indeed worth mentioning that art.1 Law no. 18 dated 11/02/1980 states that , regardless of age and income and excluding residents in State-funded care institutes: ***" the mutilated and civil invalids who are completely unable to work as a result of their physical or psychic conditions…… who are unable to walk***

unassisted or, as they are unable to carry out the activities of daily living, require round-the-clock care .....” are entitled to the attendance allowance.

The peremptory nature of the provisions such as those resulting from this Law leads to some considerations which have not been fully transposed yet by the legislator (13, 14, 15, 16).

Firstly, it should be remembered that the above mentioned benefit represents a social security instrument, originating from specific socio-historical needs, as a tool of economic compensation for the so-called “loss of profit” and “damage sustained” and whose recognition results , indeed, from the combination of three factors : the economic, the social and the biological one. More to the point, the economic factor sees “loss of profit” and “damage sustained” alternating, the latter being associated with the economic effort incurred by these patients in order to receive the medical support they require.

The social aspect is instead concerned with the obvious which is that either the patient is often devoid of any earning capacity or his/her family carer loses it: therefore and however that may be, the loss of profit represents always and in any case a severe impairment of vegetative and social life.

On the other hand, this invalidity is referred to as being “civil” hence it is also by virtue of its very meaning that this term is open to an all-encompassing evaluation for all the socially relevant activities, without this necessarily implying that disability be referred to the expression of psychophysical energies limited to the specific work activity.

Last but not least, the biological aspect concerns the total inability to work which needs to be considered as permanent.

It is actually worth pointing out that “permanent” is not used to describe pathological conditions which remain unchanged over time, but rather morbid conditions failing to have a clearly defined and limited in time prognosis, that is to say without any predictable clinical improvement over time: this is the reason behind the institute of revision which was originally set up with regard to pension benefits resulting from INPS invalidity/inability (art.9 Law no.222/1984) but which has been subsequently invoked by other relevant public bodies (INAIL and civil invalidity) whenever the conditions underlying entitlement to the specific economic treatment undergo a change over time.

However, regardless of the above mentioned legal considerations, it is far from uncommon to observe individuals who, although suffering from very severe disabilities, fortunately still retain a minimum residual work capacity which can be used in practice but who at the same time are unable - due to nature and degree of their condition - to carry out unassisted the common daily life activities (dressing, shopping, feeding, personal hygiene, reaching the workplace, etc.).

In other words, by applying the total invalidity requirement for the payment of the above mentioned allowance, an unfair limit is set on the applications forwarded by the invalids who, although requiring assistance, are not totally unable to work.

In particular, having regard to the severely sight impaired, even though the tables for the calculation of disability ratings published by the Ministry of Health (Decree dated 05.02.1992) contemplate a 100% total invalidity in case of bilateral residual visual acuity below 1/10, regardless of any other eventual systemic condition and of the eye disorders and diseases which caused such a severe visual impairment, we cannot agree that these individuals, who unfortunately are able to perceive only large objects at close range (hence they cannot be considered self-sufficient for normal life activities) must be denied access to the world of work (17, 18, 19, 20, 21).

In conclusion, only two radically different solutions are possible under the present strict regulation :

1) A reduction in the working capacity of less than 100% but which results into an a priori denial of entitlement to attendance allowance which remains ultimately undeniable for the severe forms of invalidity as above described. Therefore, a partial invalidity assessment, although representing the actual residual psychomotor capacity of the applicant, excludes the above referred “damage sustained” from a fair compensation;
2) The invalid is declared totally disabled and requiring constant assistance, but in so doing he/she is denied any minimum and residual specific work capacity which represents a valid precondition for dismissal or which, in other cases, precludes the invalid still seeking employment from accessing the world of work.

Indeed, according and pursuant to current legislation, dismissal can occur, apart from the cases of lawful dismissal for misconduct or based on justifiable grounds, even when upon request of the applicant or his/her employer, the relevant medical board ascertains the loss of any residual capacity to work, or should a serious damage to health and integrity of other co-workers or to plant safety occur.

In the light of the above, the tight application of the law provisions governing attendance allowance is not only misleading in terms of social expectations but it is also in stark contrast to the existing welfare guidelines for the civilian blind who, instead, benefit both from economic assistance and from a privileged job placement with respect to the activities more in tune with their conditions (receptionists, rehab therapists, etc.).

Hence, there appears to be a blatantly unfair and unequal treatment between the totally blind worker and, for example, a quadriplegic or an individual with a severe visual impairment who do not benefit from the economic assistance provided by Law 18/1980, hence they find themselves obliged, in order to be able to keep and get on with their work, to reach the workplace or to require assistance for their daily activities at their own expense.

Therefore, it can be clearly seen that what is often overlooked is that social security must always focus on the invalid rather than on the disabling disease. On this basis, the tables published by the Ministry of Health for the calculation of disability ratings provide a mere orientation for the decisions to be taken and need to take social, attitudinal and working conditions of the individual into proper account.

In other words, even if the above mentioned tables consider body impairment as the disabling condition to refer to, by associating the concept of work capacity to a mere anatomical aspect, it is now crystal clear that the relevance of the "physical" aspect of a job compared to its more "intellectual" component, has rightly become obsolete.

Developments in scientific knowledge have indeed resulted into a downsizing of work activities with a predominant motor component and have shifted towards diversified activities more and more focused on the conceptual component.

In this context, the traditional difference between "normal" and "disabled" person, as identified by the physical diversity in carrying out manual production activities, is narrowing over the course of time.

Therefore, the state of total invalidity provided for by the legislator in some cases can turn out to be, rather than a biological requisite, an administrative component causing social iniquity and distorting the social care approach of the law.

This is probably the reason why on 21.11.1988 it was stated, under the third subparagraph of Law no.508, that :" …the attendance allowance is not incompatible with the performance of working activities…", in accordance with Circular no.500 of the Ministry of Health dated 11.02.1987 set out in an attempt to remedy this critical issue, by supporting the possibility to work even for the individuals who require constant assistance, albeit limited to merely residual working activities.

Similar guidelines are also contained in Circular n.14 of the Ministry of the Treasury dated 28.09.1992 which, in relation to some clarifications on the criteria used to ascertain the civil invalidity status, reads as follows on page 10 :"…. The payment of attendance allowance is linked to the performance of functions which are not necessarily associated with the working activity carried out , but which are instead necessary to ensure the autonomy of the individual having regard to a number of, at least basic, conditions pertaining to vegetative and social life".

It follows that individuals can be eligible for the benefit regardless of the requirements prescribed for carrying out the work activity and therefore no matter the conditions which, while maintaining the working capacity of the individual, require the constant presence of a person in order to guarantee him/her the performance of daily routines.

Such is, for example, the case of the quadriplegic with normal mental functions, of people suffering from progressive muscular atrophy or from severe muscular dystrophies, etc. at least for as long as the disease progresses to more severe forms...".

These measures, however, are still too far from a radical and desirable legislative reform, since the above mentioned circulars continue to consider total invalidity as the key requisite for attendance allowance.

Conclusions

Although the existing regulations governing attendance allowance go back to 1980, a date from which it is necessary, as already mentioned, to ascertain a condition of inability in order to grant the benefit to the applicant, in subsequent years – under the influence of specialist doctrinal research – there has been agreement on the need to object to the tight disabling requisite with a number of legal interpretations, but unfortunately it remains unclear what is the specific condition implementing this right.

It is also of common knowledge that even the most severe organic lesion leaves at least a minimum work capacity, as long as the disabled carries out an activity not deemed to be incompatible with his/her disability, just as an appropriate recovery training of the disabled can enable him/her to perform an activity tailored to his/her attitudes.

In those circumstances, because each individual is socially relevant as an economically significant working presence - this principle being protected under the following constitutional provisions : "…Every citizen has the duty, according to personal potential and individual choice, to perform an activity or a function that contributes to the material or spiritual progress of society (art.4)…, the disabled and handicapped are entitled to receive education and vocational training (art.38)…" – it is clear therefore that job placement for people with disabilities must not be on the grounds of disability or biological disvalue but rather, with the appropriate rehab and vocational training measures, on the grounds of his/her real skills and/or personal abilities.

Conversely, it is indeed inconceivable that individuals, with normal mental efficiency but with impaired or totally compromised sensory and/or motor functions, are deprived of attendance allowance just because they could have a work more suited to their reduced abilities and as such they are not considered as 100% invalid, even because their earning capacity or the possibility of ensuring themselves a profitable integration into the labour market, is a precondition for dignity and for socioeconomic redemption. Therefore, an operational work commitment, whenever possible and especially for the younger generations, is far from being a mere means of living as it also and mainly reflects the need for the human being - who needs to receive the best protection and care by a State like ours with a significant civil and cultural level - to achieve personal fulfillment.

Table containing invalidity ratings

Criteria and guidelines currently applied for the assessment of civil invalidity are described in the Ministerial Decree of 05/02/1992 containing the "Approval of the new table with invalidity ratings for disabling diseases and handicaps". This new table makes reference to the incidence of illnesses affecting working capacity, hence the following elements should be taken into account when assessing ophthalmologic anatomo-functional deficits:

1) A decreased visual acuity must be assessed based on the best corrected visual performance, unless anisometropia is such as to determine a condition in which the power of the lens prescribed is too high, which will determine an increase by five percentage points;
2) Perimetric defects resulting from congenital or acquired glaucoma will always be assessed separately;
3) Bilateral visual field defects shall be assessed according to a specific table in which global visual acuity is described in a horizontal and a vertical column (one for each eye) whose intersection will represent the invalidity rating percentage.

TABLE ORGANISED IN PERCENT BANDS

91% - 100% :

Binocular blindness = 100%;

Monocular blindness with visual acuity in the contralateral eye < 1/20 = 91% - 100%.

81% - 90% :

monocular blindness with visual acuity in the contralateral eye > 1/20 and < 3/50 = 81% - 90%.

71% - 80% :

Monocular blindness with contralateral visual acuity > 3/50 and < 1/10

and reduction in the visual field of 30 ° = 71% -80%;

Concentric narrowing of the visual field,

with residual vis.field < 10 ° in both eyes = 80%.

51% - 60%:

Bitemporal hemianopia = 60%;

Monocular hemianopsia without preservation of central visual acuity = 60%.

41% - 50%:

Inferior hemianopsia = 41%;

Occipital syndrome with contralateral hemianopsia = 41% - 50%.

31% - 40%:

Anophthalmos without possibility of applying aesthetic prosthesis = 31% - 40%;

Homonymous hemianopsia = 40%;

Concentric narrowing of the visual field,

with residual field between 10 ° and 30 ° in both eyes = 31% -40%.

21% - 30%:

Anophthalmos with possibility of applying aesthetic prosthesis = 30%;

Monocular blindness = 30%;

Diplopia in primary position = 25%;

Plegia of the extrinsic oculomotor muscles (3rd cranial nerve) = 21% - 30%.

11% - 20%:

Diplopia on downward gaze = 20%;

Binasal hemianopsia = 20%;

Monocular hemianopsia with preservation of central visual acuity = 20%;

Concentric narrowing of the visual field,

with residual field < 10 ° in one eye = 15%;

Parietal syndrome with quadrantic hemianopsia = 20%;

Acquired glaucoma = 11% -20%.

1% - 10%:

Cataracts without visual impairment and possible surgery = 5%;

Keratoconus with possibility of correction

with glasses or contact lenses = 5%;

Diplopia on downward gaze = 5%;

Diplopia on lateral gaze = 10%;

Congenital or acquired dyschromatopsia = 1% - 10%;

Nasal hemianopsia = 10%;

Superior hemianopsia = 10%;

Diseases of the vitreous with visual acuity < 5/10 = 10%;

Quadrantanopsia (superior or inferior) = 10%;

Concentric narrowing of the visual field with residual field between 10 ° and 30 ° in one eye = 10%;

Coloboma = 5%;

Chorioretinitis (scarring without visual impairment) = 5%;

Retinal detachment (with functional recovery following operation) = 5%;

Ectropion = 8%;

Entropion = 1% - 10%;

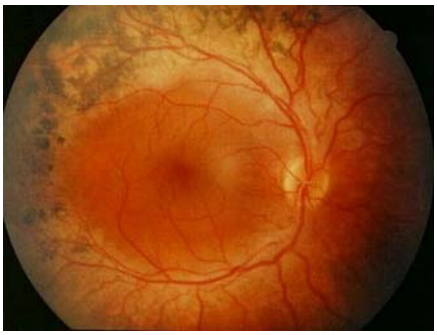
Congenital glaucoma = 10%;

Dry eye = 1% - 10%;

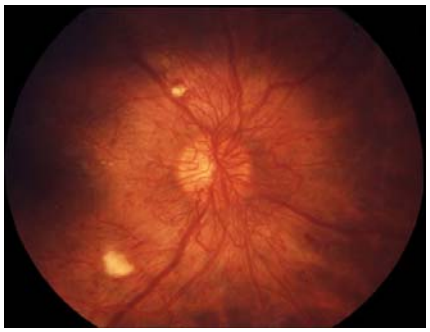
Paralysis of the orbicularis muscle = 1% - 10%;

Plegia of the extrinsic oculomotor muscles (4th or 6th cranial nerve) = 1% - 10%;

Epiphora = 1% - 10%.



pigmentosa retinitis



proliferative diabetic retinopathy

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