COMPENSATION AND REHABILITATION[1]

STANDARDS OF PROOF, STATEMENTS OF PRINCIPLE AND GARP

Introduction

In earlier *Wings* articles, I have overviewed some of the key provisions of the *Veterans' Entitlement Act 1986* (VEA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA). This quarter I'd like to drill down on three key features that are common to both Acts: Standards of Proof, Statements of Principle (SOP), and Guide to the Assessment of Rates of Veterans' Pensions (GARP).

Why do I need to know about these issues?

Ideally, every justified claim will be determined in your favour at the primary claim stage. To maximise the likelihood of this outcome, I do not believe you should leave the success of your claim solely to your Pension Officer.

Therefore, before you consult your GP or a specialist during the claim (or appeals) process, I recommend you make yourself familiar with:

- the causal links between your medical conditions and your service that have been accepted by the Repatriation Medical Authority (RMA);
- the wording that is used in GARP to describe the level of impairment resulting from your medical condition, and
- the standard of proof that the Delegate will be using when assessing your claim.

If you are not familiar with these matters, I believe you are placing too much reliance on your Pension Officer's knowledge, skills and available time. This observation is not intended to create doubt about his/her ability to advance your case. I am simply reflecting on the pressures on a volunteer's time. The bottom line is that you and your dependents will be the beneficiaries of a successful claim. It is therefore in your interest for your claim to be successful.

What more do I need to know about Standards of Proof?

You will remember that the Delegate must use one of two standards of proof, and that his/her choice is determined by the nature of your service:

- **Reasonable Hypothesis:** If you had operational, peacekeeping, warlike, non-warlike or hazardous service, the Delegate will determine your claim(s) using the reasonable hypothesis standard of proof. This means that, if the Delegate is *satisfied beyond reasonable doubt* that the hypothesis you advance is reasonable and causally links your service to your condition(s), he/she must accept your claim. The reasonability test will fail if a hypothesis is "fanciful, impossible, incredible, not tenable, too remote or too tenuous". As discussed below, your hypothesis must employ a factor from the SOP that applies to your condition. Where no SOP exists, the hypothesis must be grounded in sound medical scientific fact.
- **Balance of Probabilities:** If you rendered Eligible War Service during WWII (ie, you served in Australia outside the geographic and temporal boundaries specified for operational service) or have at least 3 years continuous fulltime service in peacetime, the Delegate will use the balance of probabilities to determine your claim. For your claim to be successful, the Delegate *must be satisfied that it is more likely than not* that a causal link connects your service and medical condition(s).

What do I need to know about SOP?

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[1] This article has been prepared by R. N. (Dick) Kelloway, Pension Officer and Advocate.

You will remember that SOP are legislative instruments that must be used by Delegates when assessing claims under the VEA and MRCA. There is an SOP for a most comprehensive array of medical conditions – all the way from *accidental hypothermia* to *Wilson's disease*.

When you open the SOP link <http://www.rma.gov.au/SOP/main.htm >, you will see that you have three choices of access to your medical condition(s). Following the dot points from the top down, you can locate your condition:

- **Alphabetically:** You will need to know the medical name for your condition – your GP is your first point of inquiry, but in the absence of consultation, you might look up Wikipedia using the search window:

  < http://en.wikipedia.org/wiki/Main_Page >

  or, you might look in The Merck (Medical) Manual:

  < http://www.merckmanuals.com/professional/index.html >

- **Category**: To search by category you will need to be able to know the medical term for the applicable human system and the medical name of your condition. Wikipedia and Merck will again point you in the right direction if your GP has not advised the medical name. The list of categories and some of the conditions in each follows:

  - **Infectious and Parasitic Diseases:** Some of the diseases that are included in this category are dengue fever, hepatitis, HIV, hookworm, malaria, Ross River fever, and scrub typhus.

  - **Neoplasms:** This category covers (at the time of writing) 49 difference forms of cancer. A very common condition is non-melanotic malignant neoplasm of the skin. Another that may be relevant is the accepted link between prostate cancer and at least 30 days service in Vietnam.

  - **Endocrine, Nutritional, Metabolic Diseases and Disorders of the Immune System:** Amongst the conditions in this category are rheumatic fever and gout.

  - **Blood and Blood-forming Organs:** This category will be self-explanatory.

  - **Mental Disorders:** Anxiety and depressive disorders, PTSD and alcohol dependence and abuse are amongst the conditions in this category.

  - **Nervous System, Sense Organs:** Some of the conditions in this category that are typical, especially amongst older veterans, are cataract, Alzheimer-type and vascular dementia, conductive and sensorineural hearing loss, tinnitus, macular degeneration, and glaucoma.

  - **Circulatory System:** Some of the more common conditions in this category are cardiomyopathy, hypertension and ischaemic heart disease.

  - **Respiratory System:** Asthma, chronic bronchitis and emphysema are listed under this category.

  - **Digestive System:** Common conditions that are included in this category include cirrhosis of the liver, diverticular disease of the colon, ulcers, haemorrhoids, hernias, and irritable bowel syndrome.

  - **Genitourinary System:** Benign prostatic hyperplasia and renal stone disease are included in this category.

- **Pregnancy, Childbirth and Puerperium:** At this stage there are no accepted conditions under this category.

- **Skin and Subcutaneous Tissue:** Some of the common conditions in this category are dermatitis, psoriasis, and solar keratosis.

- **Musculoskeletal System and Connective Tissue:** Many of the normal activities of RAAF service seem to lead to a range of conditions from within this category. Typical are intervertebral disc prolapse, osteoarthritis, and cervical/lumbar/thoracic spondylosis.

- **Congenital Anomalies / Hereditary Conditions:** Sixteen congenital or hereditary conditions are currently listed here.

- **Injury:** Amongst the 24 injuries currently listed in this category are cut/stab/abrasion/laceration, electrical injury, external burn, fracture, and barotrauma.

- **Other:** Chronic fatigue syndrome and sudden unexpected death are two of the eight conditions in this category.

- **SOP number**: This option is less likely than the others to be helpful.

Once you open a link to any medical condition, you will find that:

- The layout is common across all SOP. Of the contents, the following paragraphs will be most relevant to you:

  - "**Kind of injury, disease or death**": This section describes the disease that the RMA has accepted;

  - "**Factors**": This section lists the various factors, one of which (just **one**) you must satisfy to establish a causal link between your service and your condition; and

  - "**Other definitions**": This section is located towards the end of the SOP. It contains definitions that are crucial to establishing a causal link. If you find a factor that seems to connect your service and your condition, read any related definition carefully.

- Two SOP are listed for every accepted condition: one applicable to operational service (left hand column) and the other to peacetime service (right hand column). If you compare the two SOPs for the same condition, you will see that the factor that is connected to operational service is (generally) less demanding than one related to peacetime service. This is understandable. It reflects the differences in the nature of service you have rendered.

Finally, if there is no SOP for your condition, the Delegate can determine your claim by reference to expert medical advice. Should you find yourself in this situation, it is in your best interest to have your GP refer you to the most eminent medical expert who specialises in that condition - even if it means travelling. If your claim is successful, you can apply to DVA for reimbursement of the costs incurred.

What do I need to know about GARP?

You will recall that, to process your claim, the Delegate will first determine the Commonwealth's liability for your condition. If liability is established, he/she will forward your GP or specialist's medical assessments to the Departmental Medical Officer (DMO) for assessment of the level of impairment arising from your condition(s). The DMO uses descriptors that are correlated in GARP with a Medical Impairment Point (MIP) – a number that represents your level of impairment.

Clearly, the DMO's task is facilitated if your GP or specialist's assessments align as closely as possible with the GARP descriptors. Unfortunately, many GPs and specialists are not aware of either the descriptors or the wording used in GARP. It is in your best interest to advise your GP or specialist

how DVA will assess your claim. I therefore recommend that you take a copy of the relevant table(s) from GARP with you.

When you open GARP at the following website:

<http://www.dva.gov.au/pensions_and_compensation/pensions_and_rates/Pages/garp.aspx>

you will see that it is a legislative instrument. In other words, the Delegate and DMO must use it. After three introductory sections, its chapters are roughly aligned with the categories in SOP:

- **Chapter 1 - Cardiovascular Impairment:** This chapter leads the Delegate through an 8-step process that includes assessment of effort tolerance, lung function, cardiorespiratory functional impairment, effect of cardiac failure (if any) and moderation of the total impairment for the effects of any non-accepted conditions.

- **Chapter 2 – Hypertension and Non-Cardiac Vascular Conditions:** This chapter provides guidance on assessing the impairment effects of hypertension, vascular conditions of the lower limbs, and other non-cardiac vascular conditions.

- **Chapter 3 - Impairment of the Spine and Limbs:** This chapter facilitates assessment of the impairment for loss of lower limb function, loss of upper limb function and the spine (each of which is age-adjusted), as well as resting joint pain and the range of joint movement.

- **Chapter 4 – Emotional and Behavioural:** This chapter guides the assessment of the emotional and behavioural consequences of psychiatric conditions.

- **Chapter 5 – Neurological Impairment:** This chapter facilitates the assessment of communication, and cognitive and sensory functioning that result from nervous system disorders.

- **Chapter 6 – Gastrointestinal Impairment:** This chapter guides the assessment of impairment from diseases of the digestive system (including the alimentary tract, liver, pancreas and gall bladder), abdominal wall hernia and obesity.

- **Chapter 7 – Ear, Nose and Throat Impairment:** This chapter focuses on the assessment of hearing loss and tinnitus, the ears, upper respiratory tract and nasal conditions, and the throat.

- **Chapter 8 – Visual Impairment:** This chapter guides a Delegate's assessment of impaired eyesight and other ocular conditions (such as conjunctivitis).

- **Chapter 9 – Renal and Urinary Tract Function:** This chapter separates assessment of kidney function and urinary tract functions, as well as separating assessment of urinary excretion and urinary tract infection.

- **Chapter 10 – Sexual Function, Reproduction and Breasts:** This chapter addresses male and female impairments separately and uses different functional metrics.

- **Chapter 11 – Skin Impairment:** Although this chapter focuses on the loss of function consequences from a skin condition, importantly, it also permits assessment of functional loss on the basis of the effects on the Activities of Daily Living (Chapter 16).

- **Chapter 12 – Endocrine and Haemopoietic Impairment:** The endocrine system includes all the hormone-secreting glands and tissues as well as the mechanisms that regulate those secretions. The haemopoietic system includes all blood-producing tissues (eg, bone marrow and lymph nodes).

- **Chapter 14 - Malignant disorders:** This chapter covers the assessment of losses of function and reduced life expectancy resulting from cancer.

- **Chapter 15 – Intermittent Impairment:** The Delegate will use this chapter to assess conditions that result in varying levels of impairment, or when episodes of a significantly greater impairment of another type are superimposed on a basic level of impairment. Metrics are provided for the severity, duration and frequency of episodes.

- **Chapter 16 – Activities of Daily Living:** This chapter provides descriptors and metrics for a defined set of normal, daily self-care activities. The following abilities are assessed:

  - movement in bed;

  - transfer (ie, changing between location and posture);

  - locomotion;

  - dressing;

  - personal hygiene, and

  - feeding.

- **Chapter 17 – Disfigurement and Social Impairment:** This chapter assesses the level of embarrassment a sufferer experiences and extent to which he/she avoids ordinary public places as a result of a condition.

- **Remaining Parts.** You need not worry about the last part of GARP. It is used by the Delegate to calculate the combined level of impairment from your various accepted conditions. The instructions are, however, pretty straight forward if, out of interest, you want to read into that aspect of claim processing.

Some examples
Let's now look at two examples, the first is simple and includes two cases studies, while the second is a more complex interrelated series of conditions.

Example 1 – Sore Back

You have never deployed to a war-zone or on peace-keeping duties, and you have had a sore back for several years after leaving the RAAF. In the first case study, you are ground-crew, and feel your condition may be the result of wrestling with maintenance supply items on the hanger floor. In the second, you are aircrew, and feel your condition may result from the in-flight vibrations of the helicopters you flew.

For both cases, you have seen your GP many times and he has prescribed pain killers, physiotherapy and gentle exercises. You have found that this therapy gives you short-term relief, but the pain and stiffness always come back. As you can't remember the medical term your GP used you search in Wikipedia:

< http://en.wikipedia.org/wiki/Back_pain >

and find that your pain appears to be in the lumbar region.

Investigating the various links, you find descriptions of intervertebral disc prolapse and lumbar spondylosis. Reading into these conditions, you feel that your peacetime service may have caused either. You check through your service medical records and find that you had reported to Medical Section with a sore back during your service.

Case Study 1 - Ground Crew. You remember that you experienced sudden pain when lifting an MSI and twisting to locate it into the equipment bay. The pain lasted for over a week despite the MO's treatment.

You check the alphabetical listing and the musculoskeletal category of SOPs, and find that the RMA has accepted the possibility of a link between service and both intervertebral disc prolapse and lumbar spondylosis.

On opening the SOPs for these conditions, you find that the SOP 40/2007 has been amended by SOPs 81/2008 and 39/2010. You read through each and find that 40/2007, Factor 6.(a) accepts the following causal link:

> "having a trauma to the relevant disc within the 24 hours before the clinical onset of intervertebral disc prolapse;"

You then check towards the back of 40/2007 where you find that "trauma" is defined as:

> "… an injury … to the affected intervertebral disc that causes the development of symptoms and signs of pain, and tenderness, and either altered mobility or range of movement of that part of the spine. These symptoms and signs must last for a period of at least ten days following their onset; save for where medical intervention for the trauma to the relevant disc has occurred and that medical intervention involves either:
> (a) immobilisation of that part of the spine by splinting, or similar external agent;
> (b) injection of corticosteroids or local anaesthetics into that part of the spine; or
> (c) surgery to that part of the spine."

To complete your research, you then turn to SOP 38/2005, which you find has been amended by SOPs 79/2008 and 37/2010. You read through each, and find that 38/2005, Factor 6.(f) seems to fit your service experience. It reads:

> "having a trauma to the lumbar spine within the twenty-five years before the clinical onset of lumbar spondylosis;"

Although you think that you understand how trauma is defined, nevertheless you back to the "Other Definitions" and find that "trauma" is defined in 38/2005 in the same way as in 40/2007.

So, you make an appointment to see your GP and tell him what happened when you were in the RAAF and remind him of your current symptoms. He refers you for X-rays and a CAT Scan of your lumbar spine. In time, he receives a diagnosis of lumbar spondylosis. A check of your service medical records shows that you saw the Base MO five times over a three-week period before she cleared you for unrestricted duties. On calculating, however, you realise that you suffered the trauma 33 years ago.

You feel disheartened that you seem to be outside the time-frame stipulated in the SOP.

Case Study 2 - Helicopter Aircrew. You remember that as your time in the aircraft increased your back became increasingly, and more often, sore. For the last five years of your service, even though you were desk bound, you took pretty strong anaelgsics from time-to-time to keep pain at bay. You didn't complain too much though because you were concerned about your flying category, and with 3 years before 20 years of service you hope for another flying posting.

Opening the RMA web site, you find that SOP 40/2007 has been amended by 81/2008 and 39/2010, and SOP 38/2005 by 79/2008 and 37/2010.

New Knowledge: The most recent SOP is the one that, if an amended or new factor is applicable to your claim, the Delegate must use it to determine the claim.

Knowing this, you read the following:

> SOP, 39/2010 Factor 6. (da).(daa): "flying in a helicopter as operational aircrew, for a cumulative total of at least 5000 hours within the ten years before the clinical onset of intervertebral disc prolapse;" and
>
> SOP, 37/2010 Factor 6. (ia).(iaa): "flying in a helicopter as operational aircrew, for a cumulative total of at least 5000 hours within the ten years before the clinical onset of lumbar spondylosis."

Looking up your Flying Log Book you find that you had accumulated 5165 hours in Squirrel, Iroquois and Blackhawk. You were very lucky during much of your flying career as there had been plenty of deployments and you had been both a squadron QFI and maintenance test pilot. You had accumulated your helo hours in just over 9 years.

You then compare your service medical and service records and find entries showing you saw the Base MO about a sore back at the 15, 18 and 19-year points in your career, and mentioned your back problem on your discharge medical. Reading your service records, you are reminded that your last flying posting ended at the 15 year point and that after Staff College and ground postings, you resigned your commission with 22 years service. That was now almost 10 years ago. You are disappointed that you seem to be outside the SOP timeframe by some 17 years.

However, you run across a fellow at a RAAFA Branch meeting who has just been accepted by DVA for a back condition that was related to his service as an airframe fitter. He had wrenched his back lifting MSI into an aircraft many years before he claimed for his condition. He told you how his GP had worked out that clinical onset had occurred a long time before X-rays and CAT scans showed that he had lumbar spondylosis.

Common Next Steps. New Knowledge: the time of clinical onset is when you identify the signs and symptoms of a condition. This will usually precede the date of diagnosis by a doctor in all but acute cases.

Case Study 1. When you tell your GP that you seem to be outside the SOP criterion he reminds you that his records show you have been seeing him for 8 years about your back. He asks how long it was before you first consulted him that feel pain and stiffness in your back. You recall that you put up with the pain and stiffness for about 4 years before you saw him. He advises you that this, most probably, was the latest date of clinical onset of your lumbar spondylosis. Careful re-reading of the factor shows that you meet the SOP: You injured your back 33 years ago, you have been consulting your GP for 8 years, but you put up with the pain and stiffness for 4 years before that. The SOP requires that clinical onset of lumbar spondylosis occurred within 25 years of a trauma. In your case it occurred in around 21 (33 - 8 - 4) years.

Case Study 2: Armed with your new-found information, you go back to your GP. He asks when you first felt pain and stiffness in your back. You reply that you first saw a RAAF MO near the end of your flying career. Your GP points out that this, most probably, was the latest date of clinical onset. Careful re-reading of the factor shows that you meet the SOP: you flew helicopters for more than 5000 hours in the nine year period up to the 15-year point of your career. You later recall a conversation over a beer at staff college with other ex-helo types about their back problems, and decide to get a supporting statement from one of them, which you intend to attach to your claim.

For both case studies: You discuss your findings and GP's diagnosis with a Pension Officer, and he/she agrees that a Delegate will *more probably than not* determine there is a link between your service and your back condition. Your Pension Officer assists you to complete a claim form and prepare a statement of attribution, and lodges the package on your behalf.

Example 2 – Stroke

You were an aircrew member on Dakota aircraft during the Berlin airlift, flying into and out of Gatow or Templehof over the period 1 November 1948 to 30 May 1949.

You have recently suffered a stroke and are partially paralysed in your right arm and leg, having trouble speaking, and feel totally befuddled. In fact, you've not been in good health for many years and this seems to be yet another episode in an ongoing deterioration in your general health and wellbeing. Less than a week before the stroke you had "been under the knife" to replace a bad aortic valve, and for many years had been suffering from high blood pressure and heart disease.

Your GP, and your wife, have been telling you for fifty years that you need to slow down your drinking, and you've finally started to do so in the last few years – but you're finding it very difficult. When you joined the RAAF in 1945, you had put down your age by twelve months because you were concerned the war would end and you'd miss out on going overseas to do your bit. In time-honoured custom, you started drinking while on flying training, but had only been a moderate drinker until an incident during the Airlift.

On that occasion, winter weather had set in early and you were on a GCA approach into Templehof, in a line of USAF C-47 and C-54, and RAF transports. The aircraft ahead were reporting heavy cloud base to below minima and rain; however, most were getting in with the controller talking them to touchdown. As you intercepted glideslope a propellor ran way and you had to shut down the engine. Trying to sort out the aircraft and follow the GCA controller lifted the workload (and your heart rate) to incredible heights. But you managed to stay close enough to glideslope for the controller to be discernibly anxious but not to the point he was screaming. When you came visual, you were badly low and off runway centerline; but, with one engine out, going back into the "gloom" was not an option. A judicious power application, heaps of rudder and some pretty coarse banking ensured you avoided the buildings and towers all around you. You quickly "arrived" at the runway – albeit nowhere near centerline. Drinking became easy after that.

Your GP, who has been treating you for over 50 years, provided a medical assessment for Repat in 1960 when your blood pressure started to become a problem. Your claim that your blood pressure had been high ever since you almost killed yourself in that approach in 1949 was rejected. Circumstantially, you had made an appointment with another GP at the same clinic when your normal GP was away. She had reviewed your whole medical history and, feeling that there might be grounds for a claim to DVA, had referred you to a Pension Officer.

The Pension Officer heard you out and advised that since 1994 there have been these things called SOPs, which clarify connections between service and medical conditions. He added, that in 2004 the Government declared Berlin Airlift to be non-warlike service. He said, this means your claims will be determined on the Reasonable Hypothesis standard of proof. He then advised you that one medical condition can be a "sequela" to a following medical condition. This can be used to establish an extended causal link. As you couldn't remember any details, he asked you to get from your GP a list of all your current medical conditions. He also had you sign an FOI request for your service and service medical documents, and an authorisation for him to act on your behalf.

When next you meet, your Pension Officer notes that amongst the list of your current conditions are, in reverse order of their occurrence, cerebrovascular accident, aortic valve sclerosis, ischaemic heart disease, hypertension, and alcohol dependence. Having refreshed his memory from the SOPs, he advises that there may be a causal link between your near death experience and your recent stroke. Although you are having trouble keeping up with him, your wife who is as alert as when you married, follows him exactly.

You and your wife hear the following:

- The "Other definitions" in SOP 1/2009, which related to alcohol dependence, defines "experiencing a life-threatening event" as a "category 1A stressor". Your Pension Officer tells you that Factor 6.(a) in the SOP accepts as a reasonable hypothesis "experiencing a category 1A stressor within five years before the clinical onset of alcohol dependence". Your Templehof experience seems to satisfy this factor.

- Having ascertained that since 1957 you have been, and still are drinking between 1½ and 2 bottles of whiskey a week, he calculates that this equates to between 33 and 44 standard drinks per week (a standard drink contains 10 grams of pure alcohol).

- He notes that SOP 35/2003 has been amended by 3/2004 and 11/2008. In the latter, Factor 5.(b) accepts as a reasonable hypothesis “consuming an average of at least 300 grams of alcohol per week for a continuous period of at least the six months before the clinical onset of hypertension.” Your clinical records show that by the mid-1960s your blood pressure was permanently within the hypertensive range (see “Kind of injury, disease or death” in SOP 35/2003).

- Your clinical records show that your GP diagnosed ischaemic heart disease in 1986 and aortic valve disease in 1993. Your Pension Officer advises that Factor 6.(a) of SOP 89/2007 (as amended, non-applicably, by 43/2009 and 96/2010), accepts as a reasonable hypothesis “having hypertension before the clinical onset of ischaemic heart disease”. Your clinical history seems to satisfy this factor.

- Having seen that you had an aortic valve replacement six months ago, your Pension Officer reads to you from SOP 54/ 2002, which at Factor 6.(e) accepts as a reasonable hypothesis “the presence of hypertension at the time of the clinical onset of aortic stenosis”.

- Finally, seeing in your clinical records that you had an aortic valve replacement just five days before your stroke, your Pension Officer reads to you from SOP 51/ 2006 that Factor 6.(xi) accepts as a reasonable hypothesis “having a potential source of cerebral embolus at the time of the clinical onset of cerebrovascular accident”. Once again, your clinical history seems to satisfy this factor.

(We will return to this case study in my next article on Extreme Disablement Adjustment.)

Your Pension Officer helps you to complete a claim form, and helps our wife prepare a written account of the sequence of events and diseases you have experienced, which you sign. He then lodges the package on your behalf.

Where can I find more Information?
Please see the following:

- Fact Sheet DP21 for an introduction to the Repatriation Medical Authority.

- Fact Sheet DP22 for general information on SOP.

- Weblink: < http://www.rma.gov.au/SOP/main.htm > for electronic access to all SOP (in pdf format: if Adobe Reader is not installed on your computer, there is a link on the web-page to download it).

- The weblink for an electronic copy of GARP (in pdf format) is:

  <http://www.dva.gov.au/pensions_and_compensation/pensions_and_rates/Pages/garp.aspx >.

- Fact Sheet DP23 for general information on GARP.

- Fact Sheet HSV64 for information on reimbursement of privately incurred medical expenses.

- Form D1181, Application for Refund or Payment of Medical Expenses Privately Incurred.

- Fact Sheet DP18 for information on making a claim/applying for an increase in a Disability Pension (DP).

- Fact Sheet DP28 for comparative information on the rate of DP at the General Rate.

- Fact Sheet DP29 for information on the rate of DP at the Intermediate and Special Rates.

Conclusion
This article will make you an expert on the three key elements of claims determination. I hope, though, that it will have demystified Standards of Proof, Statements of Principle and the use of GARP, and the relationship between them.

As always, before preparing a claim, I strongly advise you to seek the support of a VEA/MRCA-trained and authorised Pension Officer or Advocate. But, before you make an appointment, know the standard of proof that your claim must satisfy to be successful, know the factor(s) that most probably link your medical condition(s) with to your service, and know from GARP which descriptor best describes the severity of impairment resulting from each of your conditions.

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