Dr John Ellard, NSW

A psychiatrist's perspective on the law's foray into psychiatry

The term 'nervous shock' has featured in a long sequence of judgments in the British, American and Australian jurisdictions. Originally a medical term that appeared in the second half of the 19th century, it was quickly appropriated by lawyers acting for those making claims for damages for railway collisions.[1]

The related history is much older. For millennia there have been descriptions of paralysis, blindness and other disabilities that the authors could not attribute to the usual physiological mechanisms. Let us call these disorders manifestations of 'hysteria'. It is a word that served us well for a long time, even though it has been expunged from more recent systems of classification. Until the mid-19th century, hysteria was attributed to bodily mechanisms. For example, Egyptian and Greco-Roman medicine attributed hysteria to wanderings of the uterus about the body and the remedies involved manoeuvres designed to coax or menace the errant organ back to its proper place.

Closer to the notion that psychological stress may have adverse effects is what William Harvey wrote in the 17th century.[2] Not only did he describe the circulation of the blood but, in his most carefully reasoned and constructive book, *De Motu Cordis* he wrote: 'For every passion of the mind which troubles men's spirits, either with grief, joy, hope or anxiety, and gets access to the heart, there makes it to change from its natural constitution, by a distemparature, pulsation and the rest thus infecting all the nourishment and weakening the strength, it not at all to seem wonderful if it afterwards beget diverse sorts of incurable diseases in the members and in the body, seeing the whole body in that case as afflicted by the corruption of the nourishment and defect of the native warmth.'

The term 'nervous shock' covered a wide range of phenomena. My understanding of what the term means in the law is that it has almost become a term of art to describe a recognised psychiatric injury that is not the result of a physical injury.

SOME FUNDAMENTAL DIFFICULTIES

Decades ago pulmonary tuberculosis was an endemic disease: there were mass radiological surveys endeavouring to identify those afflicted so that they could be treated. Professor J C Scadding observed that some who had the radiological appearances of pulmonary tuberculosis did not have that infection and speculated as to whether they had a disease at all. Being a wise man, he realised that he could not answer that question until he could define a 'disease'. Being honest, he realised he could not do so.

Most attempted definitions are circular. Disease is an absence of health and health is an absence of disease. There have been some brave

Dr John Ellard is a psychiatrist specialising in forensic matters.

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attempts. It was suggested that anyone with a condition that threatened to shorten their life, or diminish their ability to procreate, was in a state of disease. Then a wit pointed out that a Catholic priest who rode a motorbike was in exactly this category!

The search for a definition of disease goes on - there is extensive literature. It is for this reason that questions such as 'Is alcoholism a disease?' cannot be answered because there is no accepted definition.

One cannot escape that difficulty by using synonyms, such as 'disorder', as in DSM-IV.

On the other hand, there is commonsense. Few would argue that cancer or stroke are not diseases, even if we do not know exactly what the word means.

An additional problem is that many of the conditions to be considered are not categorical, but dimensional. The readings of systolic and diastolic blood pressure, which provide a diagnosis of essential hypertension, change as more and better outcome studies are done. There are many more examples in general medicine: the problem is not confined to psychiatry.

A PROBLEM

In the army of psychiatrists and psychologists are battalions of the tidy-minded, engaged in the endless pursuit of precisely defined categories. To achieve this they require measuring instruments that give consistent results when applied to the same population. If a number of trained scorers get much the same result when measuring a specified variable they are triumphant, for they have achieved a high level of reliability of measurement.

There is a problem, however. For example, I can assert that a good estimation of the amount of psychiatric injury can be achieved by ascertaining the circumference of the patient's head with a tape measure. Careful application of my technique produces very consistent results - a high level of reliability. Unfortunately, the technique has no validity at all. Likewise, many measuring instruments are worse than useless, for they may be grossly misleading.

In psychiatry the pursuit of reliability involves much use of questionnaires. Here one submits the patient to batteries of leading questions embodying the researchers' hypotheses about the issue under investigation. Not only are the subjects interrogated in a carefully structured and limited area, but there is no way in which they can speak of other things that concern them. The researchers have excluded all material that, from their point of view, is irrelevant. Even worse, the questions may be administered, not by the researchers, but by a lay interviewer, by telephone, or even by a computer with no human involved.

One outcome study demonstrates what can happen.[3] Four brief screening ▶

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measures for depression were administered to 197 patients who were receiving palliative care for advanced cancer. The research showed that such measures had some use, but that for diagnostic purposes they did not approach the validity of a single item interview, which asked, in effect, 'Are you depressed?'

CHANGES IN THE LAW

The *Motor Accidents Compensation Act* 1999 (NSW) provides an example of how far the pursuit of what is believed to be precision can produce labyrinthine error. The general guidelines for assessing injuries under the Act are based on the American Medical Association Guides to the Evaluation of Permanent Impairment (4th edition) (*AMA Guides*). When the authors of the *AMA Guides* contemplated psychiatric impairment they backed off, the reasons being given on page 30:

'The use of percentages implies a certainty that does not exist, and the percentages are likely to be used inflexibly by adjudicators, who are then less likely to take into account the many factors that influence mental and behavioural impairment. Also because no data exist that show the reliability of the impairment percentages, it would be difficult for *Guide's* users to defend their use in administrative hearing.'

The tidy-minded however were not defeated. They went right ahead. Numbers were given to the person's performance in six activities and then an arithmetic process was provided for reducing these scores to one number. One wonders what the authors of the *AMA Guides* would have thought of that. Since both physical pain and psychological pain are not reliably assessable, they do not rate a mention in the local guidelines. I agree that it is difficult to give a number to the suffering of a particular individual. Ignoring it is one solution.

RECOGNISING A PSYCHIATRIC CONDITION

The law compensates only recognisable psychiatric conditions. Guideline (to the NSW Act) 7.19 states, 'the impairment must be attributed to a recognised psychiatric condition'. It would have been useful if in their search for objectivity and precision the authors had stated exactly what they meant.

Usually the stipulation is met by turning to the most used compendium of psychiatric diagnoses - DSM-IV. The aim of DSM-IV is to simplify communication between psychiatrists. It follows that it is essential that those using DSM-IV for other purposes are aware of its limitations. The introduction to DSM-IV makes it quite clear. 'The diagnostic categories, criteria and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. It is important that DSM-IV not be applied mechanically by untrained individuals. The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgement, and are not meant to be used in a cook book fashion.'

There is also a precise and clear statement about the use of DSM-IV in forensic settings. 'When DSM-IV categories, criteria and textual descriptions are employed for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and information contained in the clinical diagnosis. In most situations, the clinical diagnosis of DSM-IV mental disorder is not sufficient to establish the existence for legal purposes of a 'mental disorder', 'mental disability', 'mental disease' or 'mental defect'.

A PRAGMATIC APPROACH?

We have a choice between pseudoscience and pragmatism. In discussing some of the subtleties of the law in *Tame v NSW; Annetts v Australian Stations Pty Ltd,*[4] the Chief Justice states: 'The distinction is not based on science or logic; it is pragmatic, and none the worse for that'. If I may be permitted to say so, these are very wise words that go to the heart of the matter.

The administration of the law is essentially pragmatic. My argument is that psychiatric assessment in a legal setting should not be done by rigid categorisation and adding numbers and that judgements should be made by judicial officers, not committees.

The psychiatrist's role should be to explain to the court what is wrong with the injured person and to define such technical terms as are helpful. There will be areas of uncertainty, but careful cross-examination should clarify them as much as can be done. The best possible judgement should result.

CONCLUSION

Assessing impairment due to psychiatric injury by numbers and a potential reliance on DSM-IV means we have a law based firmly on two foundations that were known to be inappropriate before they were used in this context. Worse yet, the law turns its back on the existence of pain and suffering. Anyone with the slightest knowledge of human condition can see the absurdity of such an assertion.

For the sake of those trapped within this disaster, and for the reputation of the law and those who make it, I hope that it is not too late to start again and get it right. Saving money is a proper goal, but one must be careful about what is sacrificed in the process. PL

Endnotes: **1** JE Erichsen, *On Concussion of the Spine: Nervous Shock and Other Obscure Injuries of the Nervous System in their Clinical Medico-legal Aspects*, Longmans, Green and Co., 1882. **2** W Harvey, *Exercitatio Anatomica de Motu Cordis et Sanguinis in Amimalibus*, 1628, translated Geoffrey Keynes, Birmingham, Classics of Medicine Library, 1978, p94. **3** H M Chochinov, K G Wilson, M Ennis, S Lander, 'Are You Depressed?': screening for depression in the terminally ill, *AJP*, 1997, Vol 154, pp 674-6. **4** *Tame v NSW; Annetts v Australian Stations Pty Ltd* [2002] 191 ALR 449.