The chameleon's CHALLENGE

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Post-traumatic stress disorder and the law.

While lawyers have long been familiar with the term 'nervous shock' as a ground for claims of psychiatric injury, it has more recently been the specific condition of post-traumatic stress disorder (PTSD) that has evolved into a mainstay of civil litigation. It has become an injury frequently asserted as a consequence of sexual and other assaults, of exposure to robberies, murders and a vast array of acts of brutality and malice. Moreover, it has become the primary basis of a great many applications for criminal injuries compensation. Its experience regularly forms the basis for victim impact statements tendered during the sentencing process and its manifestation as rape trauma syndrome or battered woman syndrome has the controversial potential to play a role in determining criminal liability. Finally, the existence of PTSD is an integral part in many claims under workers' compensation and industrial accident compensation schemes, as well as in the assessment of disability pension entitlements.

In spite of the ubiquity of PTSD as a psychiatric disorder featuring in the resolution of litigation, its parameters are unclear, as are the circumstances in which it can properly form the basis for claims for damages or compensation. This article analyses the legal and psychiatric policy ramifications of the emergence of PTSD as a mental health phenomenon under diagnostic manuals of classification. It highlights the difficulties that increasingly confront those seeking to transplant it from psychiatric manuals into forensic disputation.

History

PTSD only came to be so categorised under the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* in its third edition (DSM–III) in 1980. The DSM is the system of diagnostic classification currently most commonly used in Australia although it was argued in 1993 that neither the DSM classificatory system nor its main rival (ICD–10) 'as they currently stand are satisfactory for use in legal settings'.[1] Neither DSM–I, published in 1952, nor DSM–II, published in 1968, contained a diagnostic category comparable to the present entity. Both manuals required that neurotic illnesses consequent upon traumata were to be classified according to the presenting symptoms or as 'transient situational disturbance of adult life'.

However, the realisation that distressing incidents can cause long-term psychiatric harm is not new. The concept of traumatic neurosis had long been recognised by the psychiatric profession prior to 1980 and in the 19th century railway accidents and people's reactions after witnessing the horror of dead and dying passengers prompted considerable medical debate about the emotional consequences of exposure to such traumata. Subsequently, many studies were conducted with victims of 'shell shock' and other incidents of battle during the Boer War and, more particularly, the First World War.

In literature too, interesting accounts exist of the impact of trauma. Samuel Pepys's description of his symptoms following witnessing the Great Fire of London in 1666 and Charles Dickens' description of his

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problems in readjustment after witnessing a train accident in which 10 people lost their lives and 49 were injured, have since been interpreted as indicative of PTSD.[2]

Diagnostic criteria and the legal system

The specific criteria for diagnosis of PTSD have come to be vital to the prospects of victims' recovery in civil actions and compensation claims. Multiple problems arise in the context of the criteria. Under the DSM the criteria for diagnosis of mental disorder changed fundamentally after the first two editions and then significantly between 1980 and 1987 and between 1987 and 1994, at intervals of every seven years. Many problems of diagnosis and interpretation still exist as the criteria remain controversial and in flux. For instance, there is the problem of the victim who has been exposed to several traumatic incidents, as well as reference of an instance of trauma to the current state of the victim. In addition, problems arise for the particularly vulnerable victim and the victim exposed to drawn-out trauma that may not technically qualify as the trigger for PTSD.

To make matters more complex, two different diagnostic regimes currently exist, emanating from the United States on the one hand and the World Health Organisation on the other; and one appears more restrictive in the scope of its diagnostic criteria than the other. There is the American Psychiatric Association's Fourth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV), published in 1994, and the World Health Organization's Tenth Edition of the International Statistical Classification of Diseases and Related Health Problems (ICD–10), published in 1992.

A threshold question for the law is the use that should be made of such manuals. A cautionary statement in the 1987 version of the DSM warned that diagnostic classifications emanating from the DSM 'may not be relevant to considerations in which DSM–III–R is used outside clinical or research settings, for example, in legal determinations' (xxvi). However, DSM–IV incorporates a much more extended qualification to the uses to which its system of classification, so far as it is concerned, can legitimately be put. It addresses the 'tick-a-box' phenomenon that has proliferated from earlier versions of the DSM and which is said by many to have been encouraged by the legal system. It stresses that, 'It is important that DSM–IV not be applied mechanically by untrained individuals' (xxiii). It also warns the user that 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 the information contained in a clinical diagnosis' (xxiii).

At one level this can be interpreted as a perceptive recognition of the different, and often irreconcilable, agendas that exist for clinical and legal practitioners. At another, it might be criticised as a retreat from accountability. The DSM purports to set out the state of the art in psychiatric 'consensus about the classification and diagnosis of mental disorders' (xxiii). The law needs scientifically falsifiable and sound data on which to base decisions. The decisions may fundamentally affect entitlement to liberty in relation to civil commitment and the appropriateness of imposition of criminal incarceration, as well as entitlement to damages and compensation. The best the law currently has are DSM–IV and ICD–10. It may be that many psychiatrists would prefer to say that the categorisations present in both regimes are artificial and in practice nowhere near as clear-cut as the regimes would suggest. It is also the case that many experts choose to stay away from legal process because of discomfort at being required to defend their diagnoses in terms of the arbitrary classifications asked for by the law and supplied in effect by the DSM and the ICD. The problem that the law has, however, is that it is forced to deal on the margins, to explore the parameters; the existence, nature and severity of mental disorders become vital and proof of such matters on the balance of probabilities or beyond reasonable doubt is often at the heart of the forensic contest. The only provenance of assistance to which it can have resort in its quest for reliable data is mental health professionals and their statements of 'consensus'. Thus it is that DSM–IV and ICD–10, problematic as they are for psychiatrists, psychologists and lawyers, play a vital role in the resolution of litigation. Thus it is too that the exact criteria they propound for the existence of various disorders must, and do, come under the closest of scrutiny in the courts.

DSM and ICD criteria for PTSD

There are six key criteria under DSM–IV for the diagnosis of PTSD:

First, the person must have been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
(2) the person's response involved intense fear, helplessness, or horror.

Secondly, the traumatic event must be persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thought, or perceptions.
(2) recurrent distressing dreams of the event.
(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated).
(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
(5) physiological reactivity or exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

Thirdly, there must be in the subject persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
(2) efforts to avoid activities, places. or people that arouse recollections of the trauma
(3) inability to recall an important aspect of the trauma
(4) markedly diminished interest or participation in significant activities
(5) feeling of detachment or estrangement from others
(6) restricted range of affect (eg, unable to have loving feelings)
(7) sense of a foreshortened future (eg, does not expect to have a career, marriage, children, or a normal life span).

Fourthly, there must be persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

(1) difficulty falling or staying asleep;
(2) irritability or outbursts of anger;
(3) difficulty concentrating;
(4) hypervigilance;
(5) exaggerated startle response.

Fifthly, the duration of the disturbance, namely the symptoms in the second, third and fourth criteria, must be greater than once a month and sixthly, the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

DSM–IV also introduces a new disorder entitled 'Acute Stress Disorder' (ASD), which shares many of the features of PTSD. However, the essential feature is the development of characteristic anxiety, dissociative and other symptoms within a month of exposure to an extreme traumatic stressor (as in PTSD) and lasting for a minimum of two days and a maximum of four weeks.

Under ICD–10, however, post-traumatic stress disorder is defined as a 'delayed and/or protracted response to a stressful event or situation (either short or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone' (1992 at p.147). ICD–10 provides that the disorder should not generally be diagnosed unless there is evidence that it arose within 6 months of a traumatic event of exceptional severity. In addition to evidence of trauma, there must be a repetitive, intrusive recollection or re-enactment of the event in memories, daytime imagery, or dreams. Conspicuous emotional detachment, numbing of feeling, and avoidance of stimuli that might arouse recollection of the trauma are said often to be present but are not classified as essential for the diagnosis — the autonomic disturbances, mood disorder and behavioural abnormalities are all said to contribute to the diagnosis but not to be of prime importance. ICD–10 notes that there is usually a state of autonomic hyperarousal with hypervigilance, an enhanced startle reaction, and insomnia. Anxiety and depression are stated to be commonly associated with its symptoms and signs, and suicidal ideation is stated to be not infrequent (at 148).

Significantly, under DSM–IV, there is a requirement that 'the response' of the victim of PTSD and ASD to the stressor be one of 'intense fear, helplessness, or horror'. It is unclear whether the response (as distinct from the experience of the disorder) has to be immediate or whether it can be delayed, as envisaged by ICD–10. This is a most important ambiguity because should the requirement be one of immediate response, the criterion would eliminate people who deal with their trauma in the short term by dissociation or other temporary coping mechanisms. The formulation of ASD suggests that this disorder is intended to deal with immediate responses, although the situation is confused by the similar criteria that are prescribed for the disorder in response to the impact of the stressor.

Another vital difference between DSM–IV and ICD–10 is in the nature of the triggering trauma which must be of personal threat under DSM–IV but may be of a generally 'catastrophic nature' (that is, not personally endangering) under ICD–10. In addition, under DSM–IV there is a requirement that a numbing of general responsiveness ensue in the aftermath of the stressor. This fails to cater for those who are already suffering numbing or the like arising from another cause and is inadequate for sufferers who experience chronic traumata, such as those living in circumstances of long-term domestic violence.

Current knowledge about PTSD

Considerable amounts of research have been conducted over the past two decades in an effort to formulate objective diagnostic indicators for PTSD. However, comparatively few studies have focused on the pathophysiology of PTSD, while most studies on the physical stress manifestations have been conducted as yet on animals. While it is an anxiety disorder of a prevalence comparable to that of panic disorders, bipolar disorders or schizophrenia, namely in the order of 1% by way of lifetime prevalence in the community,[3] it has been argued that pharmacologic treatments have not been carefully studied in controlled studies and that relative to other anxiety and affective disorders, treatment of PTSD is still 'at an early stage'.[4] In 1993 Baum maintained that 'the field of traumatic stress research . . . is still in its infancy'.[5] Similarly, in 1990 Orr argued that 'The diagnosis of PTSD is established primarily on the basis of self-reported symptoms and experiences'.[6] This remains the case under both the DSM–IV and ICD–10 criteria, leaving the assessment of the claimant's experience of PTSD fundamentally within the psychiatrist's or psychologist's clinical judgment. A further problem is that PTSD often enough arises in those with a predisposition to or a current experience of other psychiatric disorders. PTSD, like other mental disorders, does not occur within a medical or social vacuum. Multiple psychiatric and lifestyle problems are a clinical reality, resulting in what can be an artificial and deceptive exercise for the clinician to be forced to state categorically that a patient suffers or does not suffer from one specific disorder found in the pages of DSM–IV or ICD–10. Kolb in 1989 remarked on the 'heterogeneity' of PTSD commenting that it 'is to psychiatry as syphilis was to medicine. At one time or another [this disorder] may appear to mimic every personality disorder'.[7]

It is also significant that the psychiatric goalposts continue to move. An evolution over the past 15 years has occurred in the requirements under the different editions of the DSM. The DSM–III (1980) criterion for the activator of PTSD was 'a recognisable stressor that would evoke significant symptoms in almost everyone'. By 1987 DSM–III–R required a person to have 'experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost everyone'. By 1994 what was required under DSM–IV was that the person 'experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others'. In other words, a considerable tightening to eliminate false-positive and false-negative diagnoses may be discerned through the various DSMs which have classified PTSD.

At the present time, controversy exists among psychiatric clinicians and researchers as to:

- the extent of physiologically demonstrable symptoms of sufferers of PTSD,
- the extent of personal threat that must be present in the trigger for it, and whether the trigger can be cumulative rather than explosive,
- the response required for diagnosis of the victim,
- the precise nature of the diagnostic criteria for the disorder,
- the significance of multiple diagnoses, one of which is PTSD, and
- the effectiveness of different forms of treatment.

Mullany and Handford have summed up the problems of causation that flow for the legal system from this complexity tellingly but tactfully: 'The etiological facts of PTSD have not yet been fully determined'.[8] Much the same might be said of many other aspects of the disorder. The practical consequences for the conduct of litigation of the as yet developing understanding of PTSD by mental health professionals are profound.

Expert evidence about PTSD

A number of cases have suggested a new rigour on the part of the legal system in relation to the existence and sufficiency of experts' expertise as a condition precedent to allowing them to give evidence. This stringency recognises the potential for selective exposure of decision makers to different schools of thought within disciplines such as psychiatry and psychology, the difficulties that lay decision makers have in assimilating such expert evidence effectively, and the dangers that such witnesses may not be impartial or be effectively cross-examined so as to reveal their partiality during trial processes. It represents an important demand by the judiciary for accountability of those who contribute from other disciplines to legal processes. Partly it is an attempt to ward off those whose evidence is inexpert and unreliable, and partly it is an attempt to protect its decision makers from evidence that they are in no adequate position to evaluate.

Courts' concerns to refuse evidence from people not demonstrated to possess the requisite degree of expertise is particularly evident in relation to evidence given by mental health professionals, especially when diagnosing conditions, such as PTSD, considered by some judicial figures as the exclusive province of psychiatrists. For instance, in the controversial decision of *R v MacKenney and Pinfold* (1983) 76 Cr App R 271, Ackner LJ affirmed the decision of a trial judge to refuse to hear evidence from a psychologist on the existence of mental illness:

> No doubt [Mr I's] training as a psychologist gave him some insight into the medical science of psychiatry. However, not being a medical man, he had of course no experience of direct personal diagnosis. He was thus not qualified to act as a psychiatrist. Mr I's evidence was not medical evidence, and was not admissible.

Similarly, Wood J in the New South Wales Court of Criminal Appeal commented in 1990:

> I consider it necessary to observe once again that it is important that clinical psychologists do not cross the barrier of their expertise. It is appropriate for persons trained in the field of clinical psychology to give evidence of the results of psychometric and other psychological testing, and to explain the relevance of those results, and their significance so far as they reveal or support the existence of brain damage or other recognised mental states or disorders. It is not, however, appropriate for them to enter into the field of psychiatry.' *[Peisley v R* (1990) 54 A Crim R 42 at 52]

In relation specifically to evidence of PTSD, Judge Strong of the Victorian Administrative Appeals Tribunal in two 1994 judgments was highly critical of experts who, in his judgment, went beyond the scope of their expertise in offering views in relation to crimes compensation appellants suffering from PTSD. In *Gregory Hood v Crimes Compensation Tribunal* unreported Victorian AAT, 24 March 1994, after reviewing the nature of the American Psychiatric Association's DSM–III-R and its treatment of PTSD, Judge Strong commented:

> [T]he diagnosis and treatment of mental disorders is, principally, the province of psychiatrists. I do not doubt that suitably qualified and experienced health professionals of other disciplines can competently identify mental disorders of the kind described in DSM–III-R. But my recent experience at this Tribunal has, frankly, left me with some concern that the growth of the Crimes Compensation jurisdiction has encouraged psychologists in particular — some of them seemingly unsuited for the task — to arm themselves with DSM–III-R and enter the fray. [at p.5]

Five days later His Honour broached the subject once more in *Linda Williams v Crimes Compensation Tribunal* unreported, Victorian AAT, 29 March 1994, taking exception to what he regarded as excessively liberal use of the diagnosis of PTSD by persons not 'medically qualified':

> T [a clinical psychologist] correctly notes, and emphasises '... that definitive diagnosis of this condition must be made by a registered medical practitioner.' Most psychologists appear not to appreciate or acknowledge this requirement. [at p.3]

While some of these decisions are problematic in their own context, not recognising the clinical need for psychologists to form working diagnoses, and not taking into account the contribution made by psychologists to the framing of DSM–IV, they are indicative of what is likely to become an increasing demand by the legal system to be reassured that those allowed to offer their opinions as experts are relevantly expert. Courts will increasingly require that expert evidence emanates from a sphere of specialisation which is sound, and that the experts providing their testimony and reports are not unrepresentative of views held within their disciplines. The demand arises from a validly based concern to impose a check and balance on the process of information provision within the legal process to avoid miscarriages.

In addition to the medicalisation of diagnosis as an impediment to expert evidence being given about the existence of a 'mental disorder', developments in United States and Canadian law may also have an impact on the admissibility of diagnostic evidence relating to PTSD, from whomever it emanates.

Recent law in Australia has imposed the *Frye* test in relation to new areas of scientific endeavour, both in relation to battered woman syndrome and in relation to DNA profiling evidence.[9] This test imposes the requirement that the technique or theory has gained 'general acceptance' within the relevant expert community. However, the United States Supreme Court decision of *Daubert v Merrell Dow Pharmaeuticals* 113 S Ct 2786 (1993) and the Canadian decision of *R v Langdon* (1992) 69 CCC 395 at 413 have repudiated the *Frye* general acceptance test and substituted a test focusing upon 'reliability' of the technique or theory. The concept of 'reliability' has been explicated by the United States Supreme Court in terms of the 'falsifiability' or 'refutability' of the technique or theory. Given the number of Australian cases which have uncertainly embraced the concept of reliability (without explication) as a test of admissibility of expert evidence,[10] it is likely in due course that the reliability criterion will replace the 'general acceptance' criterion in Australian and New Zealand law. For PTSD evidence, this has major ramifications. Because of the extent to which the diagnosis relies on self-report and on subjective assessments, as yet not able to be corroborated by physical data, there must be considerable doubt about whether such evidence would qualify as 'reliable' in terms of being 'falsifiable'. Given the importance to litigants of the decisions made on the basis of expert evidence, the demand for reliable data on which legal decisions can be made may seem revolutionary but in terms of basic commonsense it has much to commend it. In the short term it may involve the exclusion of much evidence sought to be led from psychiatrists and psychologists, including evidence concerning PTSD.

PTSD and the law of torts

In the landmark case of *Victorian Railways Commission v Coultas* (1888) 13 AC 222 at 225 the Privy Council held in the context of a level crossing incident causing 'severe nervous shock' to the occupant of a buggy that psychiatric injury without more was not a form of harm or damage for which damages for negligence could be recovered. By 1937 in Australia at least, though, the situation had changed: 'neurasthenic breakdown amounting to an illness' was held to be a form of damage which without more had the potential to be compensable in damages actions *(Bunyan v Jordan* (1937) 57 CLR 1 at 16). The categories of recovery were further broadened in *Mount Isa Mines Ltd*

v Pusey (1971) 125 CLR 383 where Windeyer J repudiated the notion that 'psychogenic illness' is any less an injury than physical injury (at 395) and Walsh J spoke in terms of recovery for 'all forms of mental or psychological disorder which are capable of resulting from shock' (at 414). It is from this time that PTSD, as it came to be formally described in 1980's DSM–III, could plausibly be claimed as a head of tortious damage.

By 1983, it was held by the House of Lords in *McLoughlin v O'Brian* [1983] 1 AC 410 that a plaintiff could recover for 'nervous shock' from a defendant whose negligent driving had caused a road accident resulting in death and injury to members of her family when she was some distance away and did not even learn of the accident for some two hours after its occurrence.

The landmark Australian case on the subject, *Jaensch v Coffey* (1983) 155 CLR 549, involved a situation where the psychological injury was still further removed from the actual accident. The plaintiff's injury consisted not in witnessing a car accident but in seeing her husband subsequently in hospital in severe pain. He did not die but she was described after seeing her husband in hospital by Brennan J as suffering 'severe anxiety and depression' — her psychiatric condition was accepted as having caused gynaecological problems and a hysterectomy was later performed on her.

The High Court held that the test was whether a defendant could reasonably have foreseen that a person later perceiving the physical consequences of the defendant's breach of a duty of care to a third person might suffer a 'mental or psychological disorder' induced by shock. Thus the spatial propinquity requirement which had arguably previously existed was removed as well as the qualified requirement that at least the plaintiff be close enough to the accident to enable observation of the immediate consequences of the defendant's wrongful conduct. Similarly, in Australia kinship ties do not appear to be a precondition to recovery in negligence[11] when the plaintiff is physically removed from the scene of the accident. This contrasts with the position in England as determined by *Alcock v Chief Constable of South Yorkshire* [1992] 1 AC 310, the case dealing with the aftermath of the Hillsborough Stadium collapse during the FA Cup semi-final of 1989. In that case the House of Lords set out specific categories of kinship as preconditions for recovery by secondary victims, namely those not actually witnessing the victims of an accident. Lord Ackner, for instance, held that in order for remote relatives and friends to come within the necessary emotional proprinquity to the victim to recover in negligence, they would have to be 'so close and intimate that their love and affection for the victim is comparable to that of the normal parent, spouse or child of the victim' (at 403). Thus, in the United Kingdom, siblings, grandparents, grandchildren and other relatives face the prospect of being cross-examined on the extent of their love and affection for the primary victim, should they endeavour to sue the defendant as secondary victims of his or her negligence.

In addition, English law appears to be more stringent than Australian about the time period within which the traumatic exposure must take place for a secondary victim in the aftermath of the primary trauma. It appears that the effluxion of more than one hour may preclude recovery in England, but no such arbitrary time limit has been set in Australia. Interestingly, the justification advanced by the House of Lords in *Alcock* was that where there is no single, sudden, immediate and direct visual perception of the distressing event, 'nervous shock' ceases to be in issue. Lord Oliver, for instance (at 417) held that to extend liability otherwise 'would be to extend the law in a direction from which there is no pressing policy need and to which there is no stopping point'.

This is quite at variance with the psychiatric experience that the onset of PTSD may be gradual or even delayed after the initial stressor (see the DSM–IV condition of ASD, and also DSM–IV at p.426 in relation to PTSD) but it is consistent with the policy wish, present both among defence lawyers in personal injury cases and among psychiatrists, to tighten the criteria for PTSD, and thus its diagnostic prevalence. In *Alcock* the House of Lords held that for relatives to watch simultaneous television transmission of the scenes from the Hillsborough stadium 'could not be equiparated with the viewer being within sight or hearing of the event or its immediate aftermath' (at 405). This appears not to have been based on any empirically assembled data whatever. What it does bear eloquent testimony to is the same fear that activated the Privy Council in 1888 in *Coultas* to recoil at the prospect of opening up a 'wide field for imaginary claims' (at 226). This is an attempt, in the absence of evidence, to limit liability.

The scope for PTSD to act as a major basis of claims for psychiatric damage following exposure of plaintiffs and claimants to a markedly distressing event is substantial. However, this contention may be eroded by developments in expert evidence law, anxiety about the opening of the floodgates to 'psychic injury litigants' and by the changes wrought under DSM–IV. Under the most recent DSM criteria the traumatic trigger must be not one which merely provokes distress or horror but one which presents personal danger to the person. This dramatically confines the circumstances in which DSM–IV PTSD (and ACD) can be diagnosed by contrast with ICD–10 PTSD which can result from any kind of a person's exposure to a catastrophic event provided that it 'is likely to cause pervasive distress in almost anyone'. Thus people watching the Hillsborough disaster on simultaneously transmitted television could be diagnosed with PTSD under ICD–10 but not under DSM–IV.

PTSD and its challenge for the law

It may be, in part, the potential breadth in the ICD–10 criteria for PTSD that has reinforced contemporary English concerns about the opening of floodgates for secondary victims of negligence. It does appear that something of a backlash is also developing in Australian jurisdictions in relation to criminal injuries compensation applications that are dependent on the experience of PTSD by the claimants. The greatest difficulty is that diagnosis of PTSD still remains so dependent on clinical judgment by mental health professionals from whom forensic reports are sought. Also problematic is clinical reliance on the victim's reported symptoms which runs the risk of being self-serving when the reporting to a psychiatrist or psychologist takes place in effect on the litigation threshold.

When a financial incentive for misreporting is combined with the adversary system's pressures toward expert partisanship and criteria for diagnosis that are difficult to falsify, a problematic situation arises both for the public purse and for defendants. The problems are exacerbated by the key differences between the ICD and DSM defintions of PTSD, the DSM–IV definition being significantly more limiting than its forebears and than the earlier ICD–10 definition. It is well to maintain that mental and physical injuries should not be regarded as generically different, but the problem for the legal system is that the potential for the proliferation of secondary and teriary injuries exists almost exclusively in the 'mental context', where the objective criteria for assessment of the

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in the health care system. That is, they can have a beneficial effect on the health care system as a whole, as well as protecting individuals in it.

The development of charters in each State and Territory can serve to expose the lack of nationally consistent standards across Australia. It also raises questions about the role of the Commonwealth Government in providing leadership in achieving nationally agreed charters. The rights of citizens of Australia should not depend on where they live. In fact, one of the worst outcomes of the move to citizens' charters would be that the rights and services people receive are defined by their postcode.

The consumer movement's response to the public hospital patients' charter in the Commonwealth and NSW State spheres has generally been one of great disappointment. In covering only public hospital patients the charter does not go far enough. It also provides little more than minimum standards.

Sydney's Public Interest Advocacy Centre, Melbourne's Health Issues Centre and other community groups have been trying to build on the documents to show what a comprehensive charter for health consumers might look like. PIAC's draft model was released at a seminar in Newcastle in July. It contains a mix of legal rights, policy and administrative practices, and 'moral' rights for consumers in the health care system. Some of these rights may not be enforceable in part or full. However, a charter, by its nature, is a statement of aspirations rather than a straightforward reiteration of the status quo.

Upping the ante

A broader charter of aspirations is the basis for 'upping the ante' in terms of citizens' rights. A charter must be comprehensive to fulfil an educative and informative role. A charter will not by itself create legal rights for which there would be sanctions, unless expressed to do so. However, if a broad charter were adopted by governments and enshrined in legislation, then it would have to be taken into account by departments, complaints bodies, the courts and tribunals, and could be used in a broader process of setting standards for the delivery of government services.

A broad charter is important, but by necessity it cannot provide specific information for all occasions. For example, in the health area, a framework of general health rights is needed, but there is also a need for a charter of rights in specific instances, for example, your rights as a parent of a child in hospital, as an obstetric patient, in psychiatric settings.

The further down the line, the more specific and process-oriented charters will become. But these more detailed charters will operate within an overall framework that acknowledges the rights of all consumers who use that service.

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injuries are weakest.[12] The recent Court of Appeal decision in *Page v Smith* unreported, *The Times,* 4 May 1994, may herald the backlash with that Court purporting once again to articulate a dichotomy between 'physical' and 'mental' injuries.

Until falsifiable, physiologically demonstrable criteria can be articulated for PTSD, perhaps recovery for secondary and tertiary victims ought either to be precluded or become subject to a statutorily imposed ceiling. Such a step would be justifiable not because there is necessarily a distinction to be drawn between somatic and psychiatric injury, but because the one is currently so much more readily susceptible of proof than the other. In addition, the criteria for determining the extent of foreseeability of injury are so much more readily able to be articulated in the former than in the latter. Such a restriction on recovery would recognise the current state of knowledge about PTSD, the deficiencies present in the DSM and ICD regimes of classification, and the difficulties posed by the circumstances in which expert mental health evidence currently comes before courts and tribunals.

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12. See, however, the challenging arguments of D. Mendelson, 'Legal and Medical Aspects of Liability for Negligently Occasioned Nervous Shock' (1995) *Journal of Psychosomatic Stress* (forthcoming); and the useful analysis of relevant cases by P. Handford, 'Compensation for Psychiatric Injury: the Limits of Liability' (1995) 2(1) *Psychiatry, Psychology and Law* (forthcoming).