Commentary: Medical Evidence-Based Law?

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If you work, as I have, with both victims and perpetrators of traumatic events, then it is inevitable that at some point, you will be invited to participate in medicolegal processes that allocate either responsibility or redress for the injury caused. If participating as an expert witness, your contribution will be about the diagnosis, manifestation, and prognosis of mental illness, and your testimony will be expected to reflect reasonable medical practice, or what we might think of as "evidence-based medicine." Adamou and Hale[1] suggest that the law lags behind scientific evidence and is thus potentially unfair. I am going to argue against this position and suggest that the law does not follow medical evidence, but uses evidence in the pursuit of justice. In an adversarial system, the ethical purposes of law are different from those of medicine, and we should be worried if medical evidence becomes the arbiter of justice.

Purposes of Law in Personal Injury

"The law should be at once the recognition of an eternal truth and the solution by a community of one of its temporal problems" (Ref. 2, p 36). How might this apply to personal injury? The "eternal truth" may be that it is just to offer redress for wrongs and harms done to one member of the community by another, when that wrong is the result of negligence, weakness, or deliberate action. The temporal problem for the community is how to decide whether the harm was caused by the wrong, and to what degree, and it is to this end that expert evidence is introduced. There is no role for medical experts in the judgment of an eternal truth.

The difficulty that Adamou and Hale[1] rightly describe is that judges see themselves acting as gatekeepers of justice, because they know that the law works by precedent and argument and not by meta-analyses. Thus, courts may want to use the evidence before them in a way that is very different from the way that physicians use evidence to decide about their clinical practice. Courts may have an eye to the way that arguments may be put in the future and how this may affect the lives of many. They may therefore be reluctant to privilege the interests of an individual in those circumstances. In this sense then, the court may take a purely utilitarian view, deciding that the beneficial long-term consequences of excluding (or accepting) certain expert evidence outweigh the clinical issues.

Eastman[3] suggests that there is always tension between the law and psychiatric expert evidence because the two domains are using very different models of how people function psychologically. The law takes a binary view of mental dysfunction: either people have a mental disorder, or they do not. Psychiatry, like other branches of medicine, takes a more complex view, so that patients may suffer from degrees of disorder or from a disorder that is present but only symptomatic in certain circumstances. The law (in Anglo-Saxon jurisdictions) takes an adversarial view of "facts." There is more than one version of the truth, and it is up to the advocates to make the best argument they can for their chosen versions. Evidence-based medicine (EBM) relies on meta-analyses of results in randomized controlled trials to determine a single truth that will act as guidance for doctors in making difficult choices. It has been argued that EBM reduces individual variation between cli-

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nicians in a way that both promotes fair allocation of resources and reduces clinical autonomy.

No court in the lands of either the United States or the United Kingdom would want to apply EBM to their judicial processes. Each legal case is an individual story, related to past individual stories through the interpretation and application of precedents, whereas EBM not only abolishes individual variation between clinicians, it also abolishes the individual stories that are essential to the adversarial process. EBM, of course, relies on the validity of individual data being processed in meta-analyses; however, the validity of an individual plaintiff's claim is exactly what the courts are testing, and no *a priori* assumption can be made. The expert, therefore, can find himself in the unwelcome position of simultaneously accepting and doubting the validity of the medical evidence to which he must speak, which may require him, like the White Queen on the other side of Alice's looking glass, to believe several "impossible things before breakfast."

The Role of Psychiatry

Why should the law be fair to the diagnosis of PTSD? In adversarial terms, it is a diagnosis that seems naturally to give particular weight to the plaintiff's position from the start. More than most other psychiatric disorders, the diagnosis of PTSD relies on the patient's subjective account of symptoms that may only rarely be verified by an external observer or external measurement. Those symptoms usually closely resemble the plaintiff's statement of alleged facts. As an anxiety disorder with affective features, PTSD is usually comorbid with other disorders. It is thus more common in those with a history of similar disorders, and may be impossible to differentiate from preexisting and pretraumatic mental disorders. Finally, PTSD and other posttraumatic disorders are the psychological equivalent of the eternal truth that is the tort of personal injury: people should not be injured by others, because it is bad for their mental health. In my experience, the sense of injury and anger that accompanies the injury adds an ethical dimension to the experience of psychological illness and distress that complicates the diagnosis.

This is not to rehearse an old calumny: that plaintiffs fake symptoms for compensation, and get better when they are compensated. In fact, there is no evidence for this, and follow-up studies of plaintiffs' problems suggest the opposite. What I mean is that the mental disorder has a moral significance to the plaintiff that most mental disorders do not have for patients; and this moral significance is related to the eternal truth that the court seeks to explore and elucidate. Diagnostic criteria, no matter how well operationalized (and as a clinician, I like the DSM), cannot encompass this moral significance, and so scientific medical evidence always talks a different language from that of the courts.

The authors suggest that a "stressor" criterion should replace the "shock" criterion, and clinically, of course, this makes sense. However, this is to replace a weakly objective criterion with a more subjective one, which puts the courts in difficulty. This tension between the subjective and the objective was clear in earlier versions of the PTSD criteria in DSM III, when Criterion A (the stressor criterion) described the traumatic experience as having to be "outside the range of usual human experience."[4] Naturally, this raised the matter of what would count as "usual human experience," as opposed to "undesirable human experience," and this definition was dropped, as research evidence made it clear that common but undesirable human experiences, such as criminal victimization, cause PTSD. It is hard not to think that the authors of the DSM were faced with exactly the same dilemma as the courts: setting criteria that are not so wide that they are meaningless or so narrow that they exclude people unjustly. The DSM's concept of the usual human (who on earth is he or she?) looks much like the law's "reasonable man" (a necessary legal fiction).

I take issue with the authors' claim that complex PTSD is just another variant of PTSD. There is some evidence to suggest that they are different syndromes, and that one is fear based (with largely phobic symptoms) and the other is guilt based (with largely affective symptoms).[5] Their suggested review of the law relating to psychiatric injury in childhood would indeed be valuable, because there could then be a proper discussion of how to think about compensating for injury caused by repeated childhood abuse or neglect by caregivers. The concepts of "nervous shock" and PTSD do not address adequately the complexity of developmental trauma, with its now well documented longitudinal effects on personality development.[6] Here perhaps is a good example of how empirical research could assist the law. However, the courts still must address a social question, not answered by scientific evidence—namely, to

what extent is it just to compensate adults for childhood injury? Are there social dangers in compensating the least resilient if it means that we do not compensate the most resilient, who may face the same adversity but survive it better? Should we in fact compensate for the insult and wrong done, rather than injury and harm?

I agree with the authors that legal definitions of posttraumatic stressors and resulting disorders often do not fit with the scientific evidence and that there is therefore a danger that the failure-of-fit may lead to confusion and inconsistency in the courts. But I wonder whether the failure-of-fit is due to the different questions being asked of the different professionals in the court and the different ways they have of answering them. Can situations be unfair and still be just? This is the paradox for the personal injury courts. Unfortunately, EBM has yet to come to grips with the paradoxes inherent in every human story.

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